The Addictions Newsletter

The American Psychological Association, Division 50

Special Issue: Spirituality in Addiction and Recovery

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President's Column

Clinical Care, Research, and Education

Building a Better Balance for Psychologists Interested in Addictive Behaviors

Sandra A. Brown
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One of the most remarkable discrepancies for me as a clinical psychologist is how little many psychologists know about addictive disorders, the most prevalent type of mental health problem facing Americans today. In truth, it is not our fault. Even within our Division, most of the more senior people never had a course on alcohol, drugs, or other addictive behaviors during graduate training. Unfortunately, the majority of graduate students today still do not have this opportunity. Even more unfortunate is that addictive disorders are not routinely integrated in core graduate courses such as psychological assessment, psychotherapy, ethics, and social behavior. It is difficult to understand how psychologists can expect to provide optimal treatments to clients when this major part of the mental health puzzle is so often missing.

While the theme of education is one I hope to have the opportunity to explore in each President's Column this year, it became even more salient to me when Bruce Liese, Editor of *The Addictions Newsletter (TAN)*, called to inform me it was time to write my first President's Column and the theme for this edition of *TAN* was "Spirituality." Although not quite panic stricken, I felt far from a scientific expert in this arena. Certainly, like most other psychologists working in the area of addictive disorders, I had much clinical experience in programs

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Editor's Corner

Spirituality and Addiction Treatment

Is it really a Match Made in Heaven?

Bruce S. Liese
University of Kansas Medical Center

I have chosen to focus this special issue of *TAN* on "Spirituality" for the same reason I have chosen to work in the field of addictions: I like to be where the *action* is. Like addictive behaviors, spirituality has received an avalanche of attention in recent years. Religious and spiritual issues have increasingly become cover stories in popular national magazines like *TIME* and *Newsweek* with topics like "Spirituality for Sale" (*Newsweek*, 10/20/97); "America's Fascination with Buddhism" (*TIME*, 10/13/97); Does Heaven Exist?" (*TIME*, 3/24/97); "The Mystery of Prayer: Does God Play Favorites?" (*Newsweek*, 3/31/97), and; "Science finds God" (*Newsweek*, 7/20/98).

A stroll down the aisle of any major bookstore quickly reveals that the number of books on spirituality has grown dramatically over the past few years. Even the American Psychological Association (APA) has entered the scene by publishing various texts on spirituality and psychology/ psychotherapy. Just yesterday I received an APA promotion in the mail that included a "bestseller" list. Sure enough, the first book on the list was: *A Spiritual Strategy for Counseling and Psychotherapy* (Richards & Bergin, 1997). APA has also published another well-received text (Shafranske, 1996) entitled, *Religion and the Clinical Practice of Psychology*.

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Letters to the Editor

Project MATCH

I continue to read–-and to react in equal parts with amusement and dismay–-the ongoing debate over Project MATCH and its outcome. Realizing that the 12-Step approach to recovery from substance abuse did not originate from my own field of clinical psychology, I can appreciate in part why no one has stepped forward (you should excuse the expression) to advocate for it in this debate. However, I did appreciate Dr. Longabaugh's response to some of Dr. Peele's more strident criticisms.

I have read several criticisms of the 12-Step approach in *TAN* : that it is of limited utility beyond question; that Twelve-Step Facilitation (TSF) as delivered in MATCH differs radically from "typical" 12-Step treatment; that TSF is "not the same" as AA; and that 12-Step oriented treatment is dominated by spirituality and is overly confrontational. Given all of these deficiencies, I find it interesting that a 12-Step oriented treatment should be associated with significant reductions in drinking that are sustained over time.

Many critics of the 12-Step approach to recovery seem to have a hard time getting past the word "powerless" that appears in the first of the twelve steps. They also seem to see AA and its sister fellowships as anything but spiritual organizations. I also once had such reactions and harbored such stereotyped beliefs. When I first stepped into the Hazelden Foundation as a professional in residence and found myself sitting in a conference room with a huge banner proclaiming the 12-Steps (complete with references to God and powerlessness!) staring at me from the opposing wall, my first urge was to run. After all, I too had been schooled in cognitive-behavioral therapy, and if asked I probably would have said that it had been invented by psychologists. I had not yet seen the l975 AA publication entitled *Living Sober*, much less read its contents, most of which turn out be suspiciously "cognitive-behavioral."

The truth is that 12-Step recovery has nothing to do with powerlessness, as James Fowler has pointed out, and everything to do with empowerment. AA is nothing if not a testament to the "power" of group support over individual effort in containing addictive behavior. In achieving this end it is at least as pragmatic as it is spiritual. This is reflected in the TSF therapy manual.

Perhaps more disturbing to me than the 12-Step bashing is the sense I got in reading *TAN* that at least some of my colleagues find it hard to believe that *any* of the MATCH treatments could have been as effective as they were or that they could be more efficacious than a control condition. Studies of "natural recovery," like studies of so-called "no-treatment control groups" in psychotherapy, tell us that this is a naïve notion in any case, since all but those who might be said to be in the

precontemplative state of change in fact *do something* about their personal and interpersonal problems. With respect to addiction, this something often appears to have much to do with overcoming hopelessness, with seeking out group support of some kind, and with implementing homemade cognitive-behavioral strategies such as response incompatibility and self-reward. In this respect, saying that TSF is "different from AA" is like saying that natural recovery is "different from treatment." Of course it is.

But the broader, more disturbing question, for me is: Why should we be so surprised? Why should we be shocked that a cadre of selected therapists, utilizing carefully crafted treatment

manuals, and receiving regular clinical supervision, prove to be successful at significantly reducing drinking behavior over time? To question this seems to imply the opposite: that psychological interventions could not possibly be so effective. In contrast to this idea, maybe we should consider Dr. Dunn's comment in his letter to the Editor: that all three treatments in MATCH were surprisingly effective precisely because of the conditions under which they were implemented. Dare we take a step forward and suggest that treatment programs seeking to maximize their effectiveness consider modeling themselves in key ways after Project MATCH?

Joseph K. Nowinski, Ph.D.
Tolland, CT

Harm Reduction

In working with seriously and persistently mentally ill substance users at an outpatient setting of a state psychiatric facility, I found harm reduction to be an exciting undertaking. It was one of the only treatment methods effective with such a refractory population. Prior treatment was limited to abstinence-only approaches. In fact, abstinence was a requirement to enter treatment, when it should have, if possible, been a long-term goal. Prohibition was being revisited. Tolerance was not shown to the cognitively impaired, low functioning, intellectually challenged, or those who could not embrace 12-Step programs. Using a harm reduction approach, however, the patients began decreasing use, and their lives began to show improvement. The overall rates of recidivism declined, and program compliance improved, even though many never reached total abstinence.

Generalizing this approach to private practice has always left me with an uneasy feeling and many questions. Like Dr. Tatarsky, I have had successes in a private practice setting, but I maintain that there are many issues of concern. First, given the current political climate and the continuing "war on drugs,"

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Be a Part of Division 50's 1999 Convention Program!

Michael Sayette
1999 APA Convention Program Chair

I am pleased to serve as Division 50 Program Chair for the 106th Annual Meeting of the American Psychological Association (APA). This year's conference will be held in Boston, August 20-24, 1999. Submissions for presentations must be received by **December 2, 1998**. Proposal information and application materials were included in the September 1998 issue of the *APA Monitor*.

Two themes selected by APA to be targeted at the convention are particularly relevant to Division 50. They are cancer and ethnic minority issues. The Program Committee encourages submissions representing a variety of addictive behaviors (including substance and non-substance related behaviors) across the full range of severity (from use to dependence) as well as the consequences associated with addictive behaviors (e.g., physical, social). There will be no paper sessions. Symposia that fit into APA's conference themes and/or bridge the interests of Division 50 and other Divisions (e.g., Division 28 "Psychopharmacology and Substance Abuse") are particularly encouraged.

I will be working with other Division program chairs (including 28 and 38) to offer a balanced program in addictive behaviors and to enhance visibility and attendance for all presentations with relevance to our membership. If you would be willing to serve as a reviewer of proposals in early December, please e-mail (sayette+@pitt.edu) or call (412-624-8799), and let me know your area of expertise. I will make every effort to ensure that we have expert reviewers in all areas of addictive behaviors.

High quality and diverse submissions will help ensure that we have an exciting and informative conference. I look forward to receiving your submissions and to seeing you in Boston.

Submissions can be mailed to: Michael Sayette, Ph.D., Department of Psychology, 604 OEH, University of Pittsburgh, Pittsburgh, PA 15260. There will be a masked review of all submissions (i.e., unmasked submissions will *not* be reviewed!), so it is critical that your name only appear on the face page. Please do not fax submissions.

Nominate a Colleague for a Division 50 Office!

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The Addictions Newsletter
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Can We Study Spirituality?

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Those of us who work in the addiction field are accustomed to hearing about spirituality. Read just about any periodical for people with addiction disorders or for the clinicians who treat them and you will find articles on spiritual aspects of problems and recovery. Even the scientific journals of the field are publishing more work on this subject, and interest has spread well beyond the traditional 12-Step approach to spirituality.

To move beyond opinion to a scientific understanding of the role of spirituality we need to be able to define and measure the phenomenon. Does it make sense to take a scientific approach to spirituality, to try to measure it? I believe it does if we think that spiritual aspects may be important in the etiology, course, treatment, or recovery of substance use disorders. Our 12-Step colleagues tell us that spirituality is not only important but *central* in understanding addiction. If we want to give this perspective honest consideration, why not open ourselves to the scientific study of spirituality?

There seems to be at least two perspectives that oppose such investigation. The first is the belief that spirituality cannot be studied and is somehow "unscientific," not a proper topic for investigation. This is the raised eyebrow of scientific colleagues: "You're going to study *what*?" David Larson calls it the "anti-tenure" topic. My own graduate training communicated to me basically that I should keep quiet about my spirituality, and certainly keep it separate from my work as a psychologist. We were trained to talk to our clients comfortably on just about any other topic, no matter how personal: emotions, sex, money, family relationships, drug use, whatever. Yet we were never taught how to talk to our clients about what is often, to them, the most important aspect of their lives. It would be difficult, I think, to find a topic that has been more taboo for psychologists to discuss than religion and spirituality. If discussed at all, it is often as alleged sources of psychopathology. Yet if one accepts the scientific evidence to date, quite the opposite is true: active spiritual or religious involvement is generally associated with decreased risk of physical, mental, and substance use disorders.

A second, symmetrical concern is that empirical measurement fails to capture the essence of spirituality. Scientific method is seen as irrelevant, even antithetical to the realm of spirit. This is not an unfamiliar problem in clinical psychology. There are many elusive phenomena that psychologists seek to understand, where the essence may be thought invisible to quantitative eyes: quality of life, character, and psychotherapy itself. We measure such complex phenomena only in part, imperfectly. In extreme, this concern not only highlights the limitations of our methodology but actively *objects* to the use of scientific method as a way of understanding spirituality.

Defining spirituality. Part of the problem is that psychologists, as a group, are often relatively inexperienced with religion, if not with spirituality. As a group, we are among the least religious of all professions or sciences. I have often sensed that there is some kind of mutual exclusivity of psychology and religion, as if one had to choose between them.

Our clients, however, are much more likely to be involved in religion, to regard spirituality as central to their identity, and to report that their faith is an important source of strength and guidance. Go to any AA meeting and ask members how they succeed in staying sober, and you will hear about a willful higher power, prayer, meditation, and spiritual awakening. With both our clients and our clinical colleagues telling us that spirituality is important, how could we define it in a way that allows us to study it?

In a recent expert panel on spirituality and addictions that included a number of members of Division 50 (see the article by Bennett, this issue), a very useful approach emerged: to regard spirituality not as a variable but as a latent construct like intelligence or personality. This gets one out of the problems involved in trying to decide whether specific individuals are "spiritual or not" or even ranking people along a single dimension as "more" versus "less" spiritual. In this approach, spirituality is multidimensional, and every person can be located somewhere in multidimensional space. This way of conceptualizing spirituality includes everyone. We do not usually seek to classify people as having or not having a personality or as having more versus less personality. Rather, for clinical or scientific purposes, we are interested in understanding particular aspects of the latent construct, be it personality or spirituality.

Perhaps the most difficult task is to set boundaries around the construct itself, because spirituality by its very nature eludes limitations. Ernie Kurtz once observed that a religion is defined by its boundaries but spirituality by its transcendence of boundaries. Religion is far easier to operationalize as behavior: endorsement of particular beliefs, observance of certain practices, and affiliation with organized groups. But what are the defining characteristics of spirituality? Although a latent-construct perspective eschews classifying *people* as spiritual or not, we seem to need a way of judging whether particular *phenomena* or *variables* are part of spirituality. Otherwise, everything and nothing can be defined as "spiritual."

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Spirituality and Addictions
What Do We Know?

Melanie Bennett *
University of New Mexico

There is a long history linking spirituality and addictions. Religions often have strong opinions with regard to substance use. Some religious traditions assign sacred uses to alcohol and some other drugs. In contrast, Biblical teachings suggest that excessive drinking limits or hinders spirituality. The widespread 12-Step fellowships such as AA stress the spiritual aspects of addiction and recovery. Societal views on substance use and problems have often been rooted in spiritual and religious perspectives.

Despite these close ties, spirituality has not received much research attention in the addictions field. Although many studies of substance use have included some measure of religiousness, surprisingly little has been written about this association. Larson et al. (1992) reviewed studies published in two leading psychiatry journals over a 12-year period and found that although religious affiliation was often related to positive mental health outcomes, researchers rarely discussed these findings. A similar trend is found in the substance abuse literature--many studies have yielded strong findings, but religion is typically a "nonfocal" variable (Gorsuch, 1988).

Recently, a group of addiction met for a series of conferences to discuss, among other things, what we know about the relationship between spirituality and addictions. This article represents a summary of these efforts. First, the group listed assertions for which we believed there would be at least some research attention in the addictions literature. Second, we reviewed the literature to determine how much and of what quality was the empirical support for these assertions. Research was gathered and reviewed, and subgroups of individuals rated the overall body of work for each assertion. Assertions with good evidence, including multiple replications and sound research designs, earned a rating of +3. Assertions with reasonable evidence, including at least some replication, earned a rating of +2. Assertions with some supporting evidence such that the assertion was plausible earned a rating of +1. Those assertions with no empirical support received a rating of 0.

It is important to keep in mind the many serious limitations of research investigating the relationship between spirituality and addictions. Probably the most important limitation is the lack of good definitions of the major constructs. Spirituality and religion are often measured with simple, single items that are included in studies mainly

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* *Author Note*. This article is based on Miller, W.R., & Bennett, M.E. (1998). "Addictions: Alcohol/Drug Problems" In D.B. Larson, J.P. Swyers, & M.E. McCullough (Eds.), *Scientific research on spirituality and health: A consensus report* (pp. 68-82). Rockville, MD: National Institute on Healthcare Research.

Additional panel members included: John Allen; Stephanie Brown; R. Lorraine Collins.; Gerard Connors; Frederick Glaser; Richard Gorsuch; Steven Hayes; Michie Hesselbrock; Harold Holder; Byron Johnson; Richard Longabaugh; G. Alan Marlatt; John Martin; Margaret Mattson; Peter Nathan; J. Scott Tonigan; John M. Wallace; and Allen Zweben.

addressing alcohol and drug use. This lack of precision is often found along with the use of crude measures of substance use. Second, the vast majority of this research is correlational, enabling us to draw only the most simple of conclusions from the literature. Keeping these limitations in mind, what can research tell us about spirituality and addictions?

Things we can say with the greatest confidence (rating of +3). There are several things that we can say with confidence regarding the relationship between spirituality and addictions. First, religious/spiritual involvement predicts less use of, and problems with, alcohol and drugs. Various studies and reviews of the literature have found a consistent negative correlation between religious behavior and substance abuse. In his review of the literature, Gorsuch (1995) found that "almost all studies analyzing religious preference or membership supported the same conclusion: religious people reported less substance abuse than nonreligious people" (p. 6). This review found this strong relationship despite varying definitions of substance abuse and religiosity and also noted that it is apparent in both adult and youth populations. Other reviews (e.g., Gartner, Larson, & Allen, 1991) have yielded similar findings. Overall, 66 studies between 1974 and 1995 were identified that found this negative correlation between substance use and religion/spirituality, and the quality of these studies was judged to be good generally.

Second, there are denominational differences in risk for substance use problems (Cochran, 1993; Engs, Hanson, Gliksman, & Smythe, 1990). For example, Jews tend to report a high prevalence of drinking but very low rates of alcohol problems. Catholics tend to report higher rates of both heavy drinking and alcohol-related problems. In his 1995 review, Gorsuch concluded that, overall, all religious groups have fewer alcohol abusers than are found among the nonreligious population. In addition, reviews of this literature conclude that the more proscriptive the religious denomination, the less likely that participants of that denomination are to drink (Payne et al., 1991).

Third, interventions with a spiritual component help many people in recovering from substance use problems. Several reviews have found that involvement with Alcoholics

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Some Meditations on Spirituality

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Bruce Liese sent out a call for contributions to the topic of spirituality for this issue of *The Addiction Newsletter*. Since he and I carry on a friendly e-mail dialogue about a variety of topics, I dashed off a few thoughts about spirituality to him but said I had other commitments. I also said was hesitant to write about my skeptical view of the current movement to bring spirituality into the mainstream of research and treatment. Bruce, however, is an excellent newsletter editor and managed to play on just the right combination of guilt, friendship, and ego to convince me to share my thoughts with fellow members of Division 50. What follows are a few of those thoughts.

Introductory comments. On my best days I am an avowed agnostic and a lapsed Unitarian, which should place me clearly in the mainstream of psychologists who do not accord a central role to conventional religion in their lives (Shafranske & Gorsuch, 1984; cited in Worthington, Kurusu, McCullough, & Sandage, 1996). However, like many other mental health professionals, issues of spirituality and morality are important to me. More important to this discussion, however, is my devotion to scientific values. As a good scientist, I worship at the altar to empirical observation. That altar has presented me with icons for the importance of Alcoholics Anonymous (AA) in the lives of many in recovery and has revealed to me that spirituality is part of the core of the AA program of recovery. That altar has also shown me that the vast majority of those living in the United States believe in God, worship regularly, and see religion as an integral part of their lives. Given these "facts," it is clear that as psychologists, and as psychologists providing clinical service and conducting research in the field of addictive disorders, we cannot be ignorant about religion and spirituality. I also recently participated in two meetings on scientific research on spirituality and health. Through these, I had an unique opportunity to reflect on these issues with a group of individuals who had a high level of interest in spirituality as it relates to the areas of health, mental health, and addictive disorders. In thinking about the issues of addictive disorders and spirituality, I have come to a series of questions rather than a set of answers. The balance of this paper poses these questions, with some of my tentative "answers."

Is spirituality important? As noted above, the majority of those in the United States report that they believe in God and that religion is important in their lives. Similar data suggest that those in recovery often see spiritual practices as important to their recovery. Thus, the simple answer to my first question is "yes." Whether spirituality is important to us as psychologists may require a more complex answer. As psychologists, we study psychological processes--cognition, affect, behavioral excesses and deficits--and attempt to use psychological principles to change these processes when they are

a concern to the individual. I am not sure that spirituality itself falls within our domain or that we can study it directly. Clearly we can study the presumed manifestations of spirituality--people's reports of their beliefs, ratings of the importance of spirituality in their lives, the frequency and duration of use of a variety of spiritual practices. Are these important? As a psychologist, I would suggest that these are important only as they relate to psychological processes and problems as defined above. If what we can measure as presumed markers of spirituality are unrelated to psychological functioning, then it, perhaps, is not important to us! However, a variety of data (summarized in Larson, Swyers, & McCullough, 1998) demonstrate that there are relationships between these markers of spirituality and health and mental health outcomes, suggesting that spirituality may be important to us.

Can we define and measure spirituality? The definition of spirituality is complex and has received the devotion of serious scholars. I would not presume to think that I could provide any better definition and offer, instead, the definition of spirituality offered by Larson et al. (1998): "The feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term 'search' refers to attempts to identify, articulate, maintain, or transform. The term 'sacred' refers to a divine being or Ultimate Reality or Ultimate Truth as perceived by the individual" (p. 21).

Providing a definition implies that the definition will be useful in guiding research or clinical practice. Certain aspects of the definition offered by Larson et al. (1998)--feelings, thoughts, and behaviors--lend themselves well to empirical research. Of course, the only one that can be studied directly is behavior, but rich empirical traditions have focused on methodologies for the assessment of affect and cognition. What is more difficult about the Larson et al. definition is its links to the "search for the sacred." Views of the "sacred" are personal and individual, and may encompass experiences and searches different from those offered by their definition.

Operationalizing any aspect of this carefully considered definition of spirituality is also difficult. What metric allows comparison of Zen meditation, a Native American ceremonial dance, the atonement of Yom Kippur, the experience of the confessional, and a centered communion with nature in the mountains of Colorado? Scales that capture the full range of possible spiritual experience are likely to be so general (or so long) as to yield little meaningful information. More specific scales become linked to specific types of practices, often associated with a particular religious tradition. The task is not insurmountable but is complex.

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The Act of Surrender
Then and Now

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Alcoholics Anonymous (AA) describes alcoholism as "an illness which only a spiritual experience will conquer" (AA World Services, 1976, p. 44). From its inception, AA considered itself a spiritual, but not religious, program, although the influence and practical wisdom of such religious movements as the Oxford Group can be detected in its 12-Steps (Kurtz, 1979). Over the years, treatment models that include AA and its concepts, such as the Minnesota-model, have advocated the value of a spiritual focus in treatment. Only recently has the efficacy of spiritual concepts been put to the empirical test. This review focuses on the origin and development of one such concept, that of surrender. Current empirical evidence is presented; much remains to be studied.

Harry M. Tiebout was the first psychiatric ally of the budding AA movement (Kurtz, 1979). Tiebout had the distinction of briefly treating AA's co-founder, Bill Wilson, as well as one of AA's more colorful affiliates, Marty Mann (Kurtz, 1979). Tiebout introduced Mann, the "lady ex-lush," to AA (Kurtz, 1979). She was the first woman to achieve lasting sobriety through AA (AA World Services, 1984). Mann became a dedicated alcoholism educator, founding the National Council on Alcoholism and serving as its first Executive Director.

When Marty Mann was in treatment for alcoholism with Tiebout, he suggested she read the Multilith copy of the "Big Book" that he had been given for review (AA World Services, 1984). Mann could not stand "all those capital G's." "I didn't believe in God. I didn't want to read a book that was all about God," Mann declared (AA World Services, 1984, p. 211). She squabbled with Tiebout for months. One day in a fit of rage she read in the Big Book that alcoholics cannot live with anger. She got down on her knees by her bed and cried for some time. She later reported, "I felt something in that room, and the main feeling I had was that I'm free. I'm free!" (AA World Services, 1984, p. 211). The next day she began attending AA meetings.

Tiebout published a series of papers (1944, 1949, 1953, 1954, 1961) describing the therapeutic process that he observed in AA affiliates who had undergone successful treatment of alcoholism. He observed that some recovering alcoholics clearly had a religious or spiritual experience and that this experience was the central therapeutic force (Tiebout, 1944, 1961). He used the term "conversion" to describe the change he observed; he defined conversion as "a psychological event in which there is a major shift in personality manifestation" (1949, p. 48). He went on to explain, "[The] key to an understanding of that experience may be found in the act of surrender, which, in my opinion, sets in motion the conversion switch" (1949, p. 49).

Tiebout (1961) admitted that surrender was not in his psychiatric vocabulary until a woman named her personal experience of change through AA. One Monday morning, Tiebout recounted, she reported she had heard a hymn that described her experience--she had "surrendered."

At its core, AA's treatment approach addresses preoccupation with self (McCrady & Irvine, 1989), as illustrated in the suggestion contained in its first three steps that one admit powerlessness, and come to believe in, and hand one's life over to, a Higher Power. The Big Book tersely proclaims, "Selfishness-self-centeredness! That, we think is the root of our troubles....The alcoholic is an extreme example of self-will run riot" (AA World Services, 1976, p. 62). Tiebout was the first to recognize that AA's approach to treatment was directed at the narcissistic dimension of the disorder (Mack, 1981).

Colleagues and I decided to put Tiebout's idea of spiritual surrender to the test. We developed a Surrender scale (Reinert, Allen, Fenzel, & Estadt, 1993) based on Tiebout's description of the concept (Tiebout, 1944, 1949, 1953, 1954, 1961). The instrument was designed to measure Tiebout's concept of surrender, summarized as acceptance of one's limitedness, giving up control or "letting go," acceptance of a power greater than oneself, a resultant shift in feelings from negative and aggressive to more positive ones and a sense of being at one with the world. In initial studies of community AA affiliates (Reinert et al., 1993; Reinert, Estadt, Fenzel, Allen, & Gilroy, 1995), we found that surrender was inversely related to pathological narcissism. We also found that those who were more actively involved in AA tended to score higher on Surrender than those less involved in AA or those attending Rational Recovery (RR), a program that does not advocate surrender.

Reinert (1997) reported results of a series of three studies using a revised 25-item version of the original Surrender scale. Study 1 was a factor analysis of the Surrender instrument, completed by community AA affiliates (N = 120). The mean length of sobriety for those marking the scale was 52.9 months (SD = 59.2). Validity of the scale was supported by the factor analysis, which suggested there are four interrelated components corresponding to the various dimensions of Tiebout's surrender concept. However, from a theoretical and a practical viewpoint, only the full scale appears to be meaningful.

In Study 2, Reinert (1997) surveyed 70 alcoholics at a *(continued on page 22)*

The Not-So-Neutral Spirits

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When I was a young boy I spent a lot of time in bars, taverns, veterans clubs, and other businesses whose primary purpose was to provide a steady source of alcohol to their patrons. In those days in Massachusetts it was not legal to serve alcohol on Sunday morning, and I can recall many Sunday mornings when my father wanted a drink. So we went to the so-called "social clubs," places like Saladini Hall or Colombo Hall, where it was either legal or at least possible for him to get a whiskey and a beer (and a soda for my sister and me).

One day while waiting for him to finish his drink I must have been bored because I happened to read the back of a whiskey bottle. I noticed a reference to something known as "neutral spirits" in that bottle. Well, I never considered that there might be a genie or some other kind of benevolent spirit in there. On the other hand, it took me several more years before I was old enough to realize that at least some of the spirits in those liquor bottles were not so "neutral."

In fact, it never occurred to me that the "spirits" in the bottle of whiskey might have anything to do with the "spirits" that I learned about in church and Sunday school. There was no reason to wonder about any possible connection back then. However, it is many years later and I have since wrestled with and wondered about all kinds of spirits--some of them dwelling in the inner deserts of my spiritual struggle and some of them in the inner depths of a bottle. I have discovered that there is at least one similarity between those spirits. Perhaps that is why some of us allow the not-so-neutral spirits in the bottle to substitute for the spirits that we seek to encounter on our journeys as spiritual persons.

How are they alike and how are they different? The spirits in the bottle promise an escape from the pain of day-to-day living and for a time they even deliver on their promise. In fact, they can deliver long enough that we become dependent on them. One day we even wake up and are convinced that we absolutely need what they offer us. Even worse, we get to the point where we require it every day just to function. Yet, only in the sense that they offer us something more than what we now have are the spirits of the bottle and the spirits of the desert truly alike. In every other way they are very different.

The spirits in the desert, unlike those dwelling in the bottles of alcohol, do not promise immediate relief from pain. In fact, in the process of coming to terms with who we are as spiritual persons and who our Higher Power is, we may encounter a great deal of inner and outer pain. The spirits in the inner desert may offer us strength to endure the pain. Yet, they will not help us to maintain the illusion that we can control our world if we just drink enough alcohol. We many wonder why alcohol fails to warm the depths of our spiritual selves even while it seems to warm the insides of our bodies and bring a glow to our minds.

Nor do the spirits in the bottle of alcohol keep the spiritual struggle safely "out there." They may mislead us into believing that our problems originate in other people. However, the reality is that our spiritual battles can only be won by running "to" the battle within ourselves, not away by attacking someone else for their alleged or real inadequacies. Amazingly enough, those spiritual battles, like the one fought by Jacob at the River Jabok (The Holy Bible, Genesis 32:22ff), may last what seems like an impossibly long time, and we may resent the exhaustion that they leave us with.

Those who traveled through the desert of the inner self have learned over the centuries that we cannot avoid our struggles if we intend to grow as spiritual persons. We must not hide in the company of anyone or anything, even so-called neutral spirits, if they distract us from our efforts to discover and to grow closer to the center of spiritual power. The spiritual battles we face require leaving behind anything that distracts us from the awareness of our own inner spirits. Meister Eckhart (1982), the 13th century mystic, framed our spiritual struggle well when he wrote, "To get at the core of God's greatness, one must first get into the individual core of oneself at...least, for no one can know God who has not first known oneself. Go into the depths of the soul, the secret place of the Most High, to the roots, to the heights, for all that God can do is focused there" (p. 246).

Of course, there are some of us who do not want to delve "into the individual core of (ourselves)" for a variety of reasons. We may be ashamed of what we know is there. We may suspect that we would be ashamed if we ever got in touch with what is there. Or, we may simply have old memories of shame and not want to relive them. Alcohol can be a very effective tool to use in obstructing the road to inner self-awareness. In fact, it can even destroy that which is within us, both good and bad, by destroying our capacity to know ourselves.

We might not have been told that by looking within ourselves we could discover, in addition to the reality of guilt and shame, an even greater capacity for human intimacy, togetherness, and community. Healthy forms of spirituality offer us the opportunity to share our strengths, to find or create experiences of meaning together, and to affirm reasons to hope even with someone who is afraid to hope alone. Those of us, instead, who rely upon alcohol in one form or another will ultimately discover that our capacity for and even interest in

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A Spiritual Interpretation of the 12-Steps of AA

From Resentment to Forgiveness to Love

Kenneth E. Hart
University of Leeds, England

Most alcohol researchers, especially those partial to applied behavioral analysis, are deeply committed to the tacit beliefs that provide the foundation for the reigning paradigm of "reality" known by some as philosophical materialism and others as logical positivism. Because most readers of *TAN* no doubt adhere in some degree to this "orthodox" world view, it will be interesting to observe the reactions of the many agnostics and atheists readers to this special issue. Given this context, I am reluctant to share heretical ideas borrowed from the burgeoning area of Transpersonal Psychology, unorthodox concepts that involve transcendent dimensions of reality and "spirituality." No doubt, transpersonal assumptions and concepts will fail to resonate with many readers and will be completely discordant with others. So be it; to each their own.

Clarifying misconceptions: Authentic and pseudo-AA. The view adopted in this piece is that authentic Alcoholics Anonymous (AA) refers to the spiritually-based 12-Step program described in the 1976 version of the "Big Book" of AA. Historically, back in the 1940's and 50's, people who met at AA meetings spent most of the meeting time supporting each other in their mutual attempts to understand and practice the planned program of spiritual growth and rediscovery described by the 12-Steps. Unfortunately, 60 years later, there is often quite a large schism between what happens in the human fellowship component of AA on the one side (i.e., the meetings) and the spiritual (12-Steps) component on the other side. Thus, in effect, there are currently two AA's. I call the first "authentic AA" (concerned primarily with Higher Power) and the second "pseudo-AA" (concerned primarily with human power). Thus, it is a misconception to think that all people who attend AA meetings are necessarily concerned with spiritual awakening through the 12-Steps. Many, perhaps most, are not. The fact is that there are many agnostics and atheists attending AA meetings, and their personal goal in attending is to stay dry--on human power alone. A significant proportion of people who attend AA meetings simply want nothing to do with "God," Higher Power, or spiritual growth. By definition, these recovering alcoholics do not adhere to the 12-Step program as "manualized" in conference-approved AA literature.

This differentiation between authentic AA and pseudo-AA reveals the source of a widespread misconception among university-based alcohol researchers about the "real" purpose of AA. Many researchers falsely believe that the outcome of prime significance to the 12-Steps of AA is physical sobriety. It would seem that excessive concern with alcohol consumption as an outcome derives mostly from writings of agnostically orientated Ph.D.-level researchers who tend to dwell exclusively upon pseudo-AA. While physical abstinence is important, authentic AA defines the intermediate goal as involvement in the 12-Steps. The ultimate goal, in turn, is achieving a deep and effective spiritual experience that will revolutionize one's whole attitude toward life, toward other people, and toward God's universe. Thus, readers of *TAN* should realize that the long- term outcome of prime concern to members of authentic AA (i.e., those who practice the 12-Steps) is to achieve a measure of spiritual awakening. According to the Big Book, this awakening is considered the sufficient "cause" of both physical sobriety and "emotional sobriety" (contented and joyful abstinence).

Spirituality of the 12-Steps of AA. In the last issue of *TAN*, we briefly described a controlled clinical trial recently funded by the John Templeton Foundation entitled, "Spiritual and Secular Forgiveness Interventions for Recovering Alcoholics: A Patient-Treatment Matching Study." Matching hypotheses were presented previously. In this special issue of *TAN*, we give further description of the "spiritual" arm of the study, which adopts a Project MATCH-like Twelve-Step Facilitation of Steps 8 and 9, the so-called "forgiveness steps."

Our trial seeks to refine and extend previous research pertaining to psychospiritual dimensions of healing (Lukoff et al., 1993). In particular, we are attempting to apply the conceptual orientation of transpersonal (or "spiritual") psychology (Walsh & Vaughan, 1993) to understanding the role of forgiveness in the process of addiction recovery within the context of the spiritual fellowship of AA. The 12-Step program of AA represents a well-structured treatment plan for spiritual growth and regeneration (Miller & Kurtz, 1994; Miller, 1997). Indeed, the 12-Step program is so well structured that it has been manualized in book form (the Big Book of AA). The spiritual nature of the 12-Step program of addiction recovery has been well documented in the scientific literature (Gorsuch, 1995; McCrady & Miller, 1993; Miller, 1997), and this is quite obvious to any lay person who reads the core text of AA, affectionately nick-named the Big Book (*Alcoholics Anonymous*, 1976). For example, the reader of the Big Book will find that the term "spiritual" is mentioned 145 times, "God" 27 times, "Creator" 12 times, and "Higher Power" 18 times. The book contains references to a transcendent divine being, variously named "Father of Light," "Spirit of the Universe," and so forth. The central role of change through spiritual growth and transformation is clearly articulated in the AA literature. The Big Book of AA states, "The great fact is just this and nothing less: That we have had deep and effective spiritual experiences which have

revolutionized our whole attitude toward life, toward our fellows and toward God's universe" (p. 25).

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Changing Addictive Behaviors
Values, Faith, and the Human Spirit

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"Behind the worlds we construct, coloring both our logic and our rhetoric, are the ideologies that give our world views their dominant cast. Such ideologies are complex and not easily analyzed… As forms of human thought ideologies permeate virtually every aspect of our mental life including our science. We ignore them at our intellectual, social and personal peril."

----W. Bevan, *American Psychologist*, 1991

We seek in this essay to condense some ideas that form the content of a book we are currently writing, *Soul and Psyche: Religion and Psychotherapy in America*. Both of us have worked in the fields of addiction intervention, treatment, and prevention for over thirty years and have had a running dialogue on the matters contained here since 1986. We hope to stimulate discussion about the role of values and faith in working with addicts among members and friends of Division 50.

All human knowledge is value-laden. Dr. Bevan (above) warns us that the art and science of psychology is heavily influenced by individual and collective belief systems. Individual emotions, personal experiences, and unique shades of meaning color virtually all our perceptions. Each person experiences the world in a phenomenologically unique manner. It is important to remember that psychology originally grew out of the academic pursuits of theology and philosophy. As early as the 13th century natural science co-existed as an equal along with metaphysics and ethics. Psychology was originally linked with both *Geisteswissenschaft*, literally meaning spiritual science, and *Naturwissenschaft*, meaning natural science. This supposed dichotomy "is simplistic when one considers the complex historical origins of psychology, which became linked with science when it branched out by adding to its metaphysical concerns (the nature of the soul or of persons) the epistemological questions more familiar to students of psychology's history" (Vande Kemp, 1996). The supposed irreconcilability between "God" and "science" has been "elevated to the status of a cultural myth" in America (Woodward, 1998). Scientists and religionists are actually on the cusp of real dialogue for the first time since positivistic rationalism attempted to dislodge religion. America is experiencing a profound resurgence of spiritual pursuits. This should not alarm us. Indeed we should welcome it, whatever our personal beliefs. Albert Einstein stated, "Science without religion is lame. Religion without science is blind." The Arabian philosopher Averroes stated, "What faith decrees as true may be false in the light of reason, just as what reason finds to be true might be false in the light of faith."

Discussions of spirituality invoke human values. Most psychological theorizing involves extensions of personal belief and conviction. Religion and psychology often agonize over the same human conflicts and moral dilemmas. It is no surprise that psychologists, much like clergy, have fretted long and hard over its codes of ethical conduct. A recent article in the *American Psychologist* asked psychologists to examine the moral underpinnings of our work: "The consequences of operating without a lucid set of guiding principles can be grave. Numerous assumptions and practices inscribed in our professional mentality can lead to excesses or abuse of power" (Prilleltensky, 1997). The clinical practice of psychology strives for goals that are deemed socially valuable such as providing healing for the sick and comfort for the bereaved. Just browse the topics covered in the *APA Monitor* and the *American Psychologist*. Our new APA President admonishes us for falling prey to managed care and medical paradigms and urges us to return to the study of work, play, and love.

The personal beliefs, biases, and ideologies of researchers heavily influence psychological research both in theory and experimental methodology. The demand characteristics of the experiment are never absent. All data are "theory-laden." We need to remember that science is a method, not a body of knowledge. Thus, data are theory-laden and theory (especially applied theory) is value-laden. Certainly, the relative meaning, importance and value of psychological research findings are hotly contested within and without the research community. The sometimes fractious relationship between clinicians and empirical researchers is itself evidence of values-in-action (Dawes, 1994). All aspects of psychology, as indeed all forms of human knowledge, are heavily value-laden.

Addictive behaviors often involve illegal, immoral, and unethical actions. Addictive lifestyles embrace broken promises, broken laws, broken hearts, and broken spirits. Addiction treatment represents a positive value system offering honesty, integrity, human relatedness, and the restoration of physical, psychological and spiritual health. Many of the people who work in this field are often passionately committed to their work, espouse humanistic and spiritual philosophies, and believe that, in the absence of empirical data, "the heart has a mind that the brain does not comprehend" (Cohen & Levy, 1992).

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The Transtheoretical Model as an Integrative Framework for Intervening in Addictive Behaviors

Jason E. Maddock, Robert G. Laforge, & Joseph S. Rossi
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As we were reading our letter in the last issue of *TAN* (Maddock, Laforge, & Rossi, 1998), we noticed that we inadvertently stated that "smokers who move just one stage are twice as likely to quit in the near future than those who stay in action." This should say "than those who stay in the same stage." When we brought this to the attention of the Editor, he invited us to write a brief introduction to the Transtheoretical Model (TTM) for those readers who may not be familiar with it.

The Transtheoretical Model of behavior change has been widely used to explain how people successfully change a problem behavior (Prochaska et al., 1994). The TTM has been applied to a wide variety of both addictive and non-addictive health related behaviors, including smoking cessation, cocaine use, condom use, dietary fat reduction, exercise adoption, weight control, ultraviolet light reduction, HIV prevention, and cessation of alcohol use among alcoholics (Prochaska et al., 1994).

The central organizing construct of the TTM is stage of change. The model postulates that people move through a series of five stages of change in their attempts to modify their problem behaviors (DiClemente et al., 1991; Prochaska, DiClemente, & Norcross, 1992). The five stages of change are precontemplation (not planning on changing), contemplation (considering change in the next six months), preparation (getting ready to change in the next month), action (currently changing), and maintenance (maintaining change for at least six months).

Another of the main constructs of the TTM is decisional balance. This construct was originally developed from Janis & Mann's (1968) conflict theory of decision making. It has been adapted for the TTM for smoking cessation (Velicer, DiClemente, Prochaska, & Brandenburg, 1985) and for numerous other health behaviors (Prochaska et al., 1994). In the TTM, decisional balance has been operationalized as the pros and cons of changing a behavior.

A third construct of the TTM is the processes of change (POC), which is the use of different strategies to change a problem behavior (Prochaska & DiClemente, 1983). Appropriate use of these processes has been shown to be a predictor of movement to the next stage of change (Prochaska et al., 1985). The POC have consistently been shown to have two higher order factors: an experiential factor, which contains processes that are cognitive and affective in nature, and a behavioral factor, that contains processes that are primarily action oriented (Rossi, 1992). For some behaviors, there may be fewer or more relevant processes than the original 10 identified for smoking cessation (Maddock, Laforge, Rossi, & Plummer, 1998; Maddock, Rossi, Redding, Meier, Velicer, & Prochaska, 1998; Rakowski, Dube, & Goldstein, 1996). For most behaviors, the use of the experiential processes has been shown to peak in the earlier stages of change, while the use of the behavioral processes peaks in the later stages (Prochaska, Velicer, DiClemente, & Fava, 1988). Precontemplators have continually been shown to use the least amount of processes (DiClemente et al., 1991; Prochaska & DiClemente, 1983).

The final construct of the TTM is self-efficacy. This construct was originally developed from Bandura's (1977) self-efficacy theory. It has been conceptualized within this framework as confidence to resist a problem behavior across a number of tempting situations (Prochaska et al., 1985). This construct has been able to discriminate subjects across stages of change and predict relapse five to seven months later (DiClemente, 1981; Prochaska et al., 1985).

Interventions using the TTM have been successful, in part, because they are based directly on how people change on their own (Prochaska & DiClemente, 1983). Current TTM interventions are stage matched to individuals in all stages being intervened upon. Recent stage-matched interventions have employed individualized and interactive feedback using expert system reports and all of the constructs of the TTM (Prochaska, DiClemente, Velicer, & Rossi, 1993; Velicer et al., 1993). The treatment-subject matching takes place at the individual level, providing stage-matched feedback to each person based on their responses to the TTM constructs, both cross-sectionally and longitudinally. This type of interactive intervention was able to outperform generic self-help manuals, individualized self-help manuals, and personalized counselor calls in a randomized study of smoking cessation (Prochaska, DiClemente, Velicer, & Rossi, 1993). These results have been replicated on large population-based samples of smokers (Velicer et al., in press) as well as on other problem behaviors (Rossi, Redding, Maddock, Cottrill, & Weinstock, 1997).

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Report on the August 1998 Meeting of the APA Council of Representatives

Jalie A. Tucker
Division 50 Council Representative

Division 50 has enjoyed continuous representation on APA's governing body, the Council of Representatives, because of your support on the annual apportionment ballot that will be distributed later this fall. Herbert Freudenberger represented the division well during its initial years of existence, and I am honored and challenged to follow him during these times of tremendous change for psychology, especially in the practice arena. When you receive your ballot, I urge you to give as many of your 10 votes as possible to Division 50 so that we may continue to have a voice on Council and to let me know of your concerns and questions (tuckeja@mail.auburn.edu).

At its August 1998 meeting, Council acted in three areas of relevance to many Division 50 members. First, like the rest of America, APA is aging and can no longer rely on membership increases to raise revenues. APA is facing a budget deficit unless costs can be cut and new revenues generated. Compared to similar organizations, APA generates proportionately more revenue from its journals and books but owns two buildings in Washington, DC (APA occupies one and leases the other) that are costly to finance and maintain. To avoid a budget crisis in anticipation of these continuing trends and financial commitments, the APA Finance Committee (Gerald Koocher, Chair), with approval from the APA Board of Directors, recommended a preliminary budget for 1999 that involved over $2.5 million in cuts. Council unhappily, but handily, passed the recommended budget without revision.

The budget does *not* include a general membership dues increase, but convention registration costs will increase in 1999 by 25% over 1998 costs, and the special assessment imposed on licensed psychologists will increase by $20 in 1999, with cost of living adjustments thereafter. The latter action was deemed necessary for CAPP (Committee for the Advancement of Professional Psychology), who administers the special assessment funds in conjunction with the APA Practice Directorate, to continue APA initiatives on behalf of practitioners during the era of managed care. Cuts were made in about 30 areas. Among the more worrisome ones were those that reduced the frequency of meetings of key APA committees and groups, including suspending meetings of CRSPPP (Commission for the Recognition of Specialities and Proficiencies in Professional Psychology) in 1999, holding the Division Leadership Conference in alternate years, and changing the structure and reducing the frequency of the Consolidated Meetings of APA boards and committees. Council encouraged development of a long-range approach to managing APA's shrinking revenue base, while recognizing the immediate necessity of the 1999 budget reductions and changes.

Second, Council narrowly approved (by a vote of 55 to 47) changes in the charge of the College of Professional Psychology to allow it more flexibility to develop certificates for practitioners. The change rescinded the original requirement that limited the College to developing certificates only for proficiencies and specialties that had been recognized by CRSPPP and gave the College a "fast track" option wherein, after conducting a needs assessment, it can seek approval for certificate development directly from Council and forgo the CRSPP review process. Objections to this new option included: (1) the need for independent oversight of and input into College activities, which CRSPPP ably provided and for which Council is a poor substitute; (2) maintaining mechanisms to support the involvement of professional groups (e.g., divisions) in the definition, development, and administration of certificates that directly affect them; and (3) avoiding undue "Balkinization" of professional psychology through a piecemeal College certification program that is aimed primarily at protecting the pocketbooks of current practitioners.

Division 50's experience with the College during the development of the substance abuse certificate took place under circumstances like those now possible as part of the fast track mechanism. Division 50 did not have access to the CRSPPP review process (or the protection it provided) when the College developed its initial and only current certificate for the Treatment of Alcohol and Other Psychoactive Substance Use Disorders because that proficiency was defined and approved directly by Council in August 1994 before CRSPPP existed. Divisions 50 and 28 had to fight hard to be participants in the certificate development and oversight process. Although the final product was a success and the College has since developed in positive ways under the competent leadership of Vicki Vanderveer, the process was flawed and repeatedly revealed the need for a standing mechanism to support the involvement of expert groups who will be affected by a given certificate.

More generally, passage of this item continues to move the College in the direction of being a reactive body that responds to the immediate needs of current practitioners, rather than one that provides leadership in promoting necessary evolutions in roles for applied psychologists in the future health care environment. That leadership will need to be found elsewhere if APA is to find an effective balance between responding to issues raised by taking short- and long-term time horizons on practice issues.

Finally, to end on a positive note, Council passed a resolution supporting, in principle, changes in mandatory minimum drug sentencing laws. The main resolution, which follows, addresses issues familiar to many Division 50 members, including the arbitrary and excessively punitive nature of the laws, particularly in cases involving simple drug

possession, and the lack of allocation of resources for treatment and prevention. Mark Stern, Council Representative for

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Division 32 (Humanistic Psychology), initially introduced the motion in February 1998, and the final version approved by Council in August 1998 was the result of a spontaneous and productive collaboration between Dr. Stern and Council representatives from several other divisions, including Divisions 50 and 28. Alice Young, Division 28's Council Representative and a Fellow of Division 50, was especially helpful. The resolution gives psychologists who work with drug offenders who have not engaged in violent crimes a policy document that should help support efforts to promote more reasonable and humane treatment in the court and prison system and to redress the racist consequences of the current cocaine sentencing laws. The issues embedded in the mandatory minimum drug sentencing laws cross-cut multiple areas of interest to APA Council members, which is why the resolution passed, and they are of great concern to Division 50 members who work with drug offenders in the criminal justice system.

APA Resolution Concerning Mandatory Minimum Drug Sentencing Regulations

Adopted 8/16/98 by the APA Council of Representatives

MOVER: E. Mark Stern, Ed.D., ABPP, Division 32, Humanistic Psychology

CO-SPONSORS: William J. Shaw, Psy.D., Texas/Oklahoma Coalition; Jalie Tucker, Ph.D., Division 50, Addictions; Melvin Wilson, Ph.D., Division 27, Community Psychology; Edward Shafranske, Ph.D., Division 36, Psychology of Religion; Alice Young, Ph.D., Division 28, Psychopharmacology & Substance Abuse

MAIN MOTION:

WHEREAS mandatory minimum drug sentencing laws reduce judicial discretion and require incarceration of offenders whose criminal behavior is limited to drug possession and use, and who may be first time offenders;

WHEREAS minor drug offenders receive harsh mandatory minimum sentences, regardless of their limited role in the offense, leaving the Chief Justice of the United States, William Rehnquist (commenting on a first-time offender sentenced to life imprisonment) to call such mandatory drug sentencing good examples "of the law of unintended circumstances";

WHEREAS convicted offenders with substance abuse problems typically are remanded to prisons that lack adequate substance abuse treatment and HIV prevention programs that are essential for drug abusers;

WHEREAS mandatory minimum drug sentencing laws have contributed significantly to the more than three-fold increase in the U.S. prison population during the past decade and have disproportionately involved minorities and the poor, especially African American and Hispanic males;

WHEREAS research on the cost-effectiveness of different drug control strategies has shown that substance abuse treatment, even with its known limitations, is a cost-effective strategy to reduce drug use;

WHEREAS the U.S. federal drug control budget heavily favors interdiction approaches to the U.S. drug problem to the detriment of providing adequate funding for drug treatment and prevention;

WHEREAS research on cocaine dosage forms has shown that the differences in the severity of sentences for powder and crack cocaine are not based on supportable differences in the psychological or biological impact of those dosage forms;

BE IT THEREFORE RESOLVED that the American Psychological Association supports in principle the restoration of reasonable boundaries in mandatory drug sentencing laws, the phasing out of such laws at both the state and federal levels for drug-related offenses that do not involve drug trafficking and when no other offense or harm to others is involved, and the proper emphasis on prevention and treatment of substance-related problems as an alternative to and in addition to legal actions.

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APA Division 50 Executive Committee Meeting

Selected Reports and Presentations from the Minutes
1998 APA Convention, San Francisco

Gregory T. Smith
Secretary-Treasurer

Incoming members present (voting): Barrett (Member-at-Large), Brown (President), Fromme (Member-at-Large), Horvath (President-Elect), Leonard (Member-at-Large), Smith (Secretary-Treasurer), Tucker (Council Representative), Zucker (Past President). **Outgoing members not present** (non-voting): Platt (outgoing Member-at-Large), De Leon (outgoing Past President). **Others present** (non-voting): Jim Sorensen (Fellows), Mac Horton (1997 Program Chair), Michael Sayette (1999 Program), Mariela Shirley (2000 Program Chair), Rudy Vuchinich (Division 28), Susan Tate (Graduate Student Representative), Barbara Wallace (incoming Fellow).

All motions were approved unanimously.

Secretary's Report (Smith). Moved to accept the minutes of the 2/9/98 meeting, the motions of which were printed in *TAN* (Spring, 1998, *5*, p. 10; Approved).

The President noted that four committee chairs were stepping down: George DeLeon, Jim Sorensen, Mark Sobell, and Jerry Platt. We need to fill the following positions:

1. *Chair for Education and Training Committee.* Current committee member Mark Meyers was suggested (Approved to ask Mark). Need new committee member to replace Mark Myers. Holly Waldron was suggested. (Approved).
2. *Chair for Continuing Education Committee.* First, the report of the committee was read. The report reviewed changes thought necessary if the committee becomes a profit-making CE enterprise. For a new chair, Mac Horton suggested Robert Elliott (Approved). A key goal of this committee is to get certification as a CE provider this year. Joan Zweben, Carlo DiClemente, Rob Thompson, and Eric Wagner also suggested for membership (Approved).
3. *Chair for the Fellows and Awards committee.* The executive committee hopes Jerry Platt will continue on the committee. The President suggested Peter Nathan, who has agreed (Approved). The report of Fellows and Awards committee was given. Tremendous thanks were offered to Jim Sorensen for his effective leadership of that committee.

To seek formation of an ABPP certification, the executive committee sought to form a new ABPP credentialing committee. The following members were suggested: Tom Horvath, Mac Horton, Fred Rogers, and Barbara Wallace. Mac and Tom, both present, agreed to serve. The President is authorized to appoint an ABPP'ed member to be chair (Approved).

There is a need to prepare a petition for renewal of the Proficiency Certificate in the Treatment of Alcohol and Psychoactive Substance Use Disorders. All proficiencies, including this one, must be reviewed every seven years. Our proficiency certificate will next be reviewed in 2001. This is standard procedure for CRISP: the APA Committee for the Recognition and Identification of Specialties and Proficiencies. An ad hoc committee should be formed: Jalie Tucker and Barbara Wallace were suggested as members. It was moved that we establish the ad-hoc committee that includes Jalie and Barbara and that we ask the President to appoint a chair and other members after informal consultation with the Board (Approved).

Jan Ciucco came to report on the College and the Practice Directorate. About 2,500 individuals currently hold the College certificate (2,000 were initially admitted and will need to take the exam for the first time in 1999).

There is a need for a speakers list for training to prepare for the College credential. It was moved that any member who can document having taught all or part of a state or APA-approved CE course on addiction, or any willing Fellow, be placed on the list. In addition, the committee is to propose additional criteria for inclusion on this list, to be approved at the next meeting of this Board (Approved). President Brown will work with the Chair of Education and Training Committee to begin this process.

Report on the Council of Representatives (Tucker).

1. The council approved a resolution advocating the phasing out of mandatory drug-sentencing laws at both the state and federal levels for drug-related offenses that do not involve drug trafficking and when no other offense or harm to others is involved. The resolution also encourages the proper emphasis on prevention and treatment of substance-related problems as an alternative to, or in addition to, legal actions. The executive committee applauded Jalie's efforts on this resolution.
2. The College of Professional Psychology now has a fast-track mechanism for approval of specialty certificates: with approval from the Council of Representatives, the College can offer a certificate to practitioners in an identified area of urgent need, so practice privileges are protected in the era of managed care. These certificates, based on a needs assessment, are likely to be somewhat limited in scope. Division 50 members already have access to a CRISP-approved proficiency credential, as noted above, so this fast-track mechanism does not appear to be relevant for the Division.

3. It was moved that Division 50 contribute $500 toward the effort for a Level II proficiency petition in

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psychopharmacology, which we are working on with Division 28. Rudy Vuchinich provided an update and information on APA matching funds (Approved).

With Sandra Brown serving as President, we need to replace her as liaison to the College of Professional Psychology. The chair of the ad-hoc committee to prepare the CRISP petition will serve as that liaison.

Newly elected members were acknowledged: Tom Horvath (President-Elect), Greg Smith (Secretary-Treasurer), and Kim Fromme (Member-at-Large).

We need to appoint a Division Program Chair for the APA convention in the year 2000. Tom proposed Mariella Shirley (Approved).

Several guests spoke:

1. Dr. Richard McCarty and Dr. Jeff Mumford visited from the Science Directorate and Public Policy office. They reported on recent efforts to enhance support for the science of psychology. They cited our division as a model of integrating science and practice and congratulated the Division on the Miniconvention at APA conducted in conjunction with NIAAA.

2. Paula Tribusky reported on NIH's overhaul of their review process. Members can investigate this and give feedback using the web page: http://www.apa.org/ppo/peer.html.

3. Dr. Chris Hartel from the Science Directorate also visited. She reported on new Human Subjects recommendations that could become enacted by government that might lead to excessive policing of scientists by IRB's. She hopes to reduce the impact of those recommendations before they are enacted. Drs. Brown, Leonard, and Zucker will provide feedback on draft recommendations. These guests left.

Dr. Karen Anderson visited from the Education Directorate and reported on their recent efforts.

Treasurer's Report. A modest reduction in membership was noted. It has been produced by nonrenewal of memberships. Budgetary impact and means of increasing membership were discussed. President Brown will follow-up through contact with the Membership Chair. President will explore having a mid-winter meeting by video or telephone to reduce the expense of a full travel meeting.

Mid-winter Executive Board meeting was scheduled tentatively for Monday, February 8th, to be held either in Washington, D.C. or via videoteleconferencing. The Board also discussed the feasibility of an informal progress report at AABT if sufficient membership will be in attendance.

It was suggested that the annual Executive Committee meeting take place outside of APA Convention program hours next year, to allow more program hours for presentations or symposia. However, any "official" meeting of APA, that uses convention hotel facilities, does count against program hours. One possibility is to have the meeting over two or more 8:00 a.m. hours, since 8:00 to 9:00 a.m. scheduled events do not count against program hours.

The success of the Division's journal, *Psychology of Addictive Behaviors*, was discussed. Special thanks were offered to Susan Curry for her excellent work as our journal Editor.

The Editor Selection Committee moved that Tom Brandon be the journal Editor for a 5-year term, beginning January 1999 (Approved).

Dr. Kim Fromme reported on the 1998 Convention Program Committee's work. Dr. Fromme was enthusiastically thanked by the Executive Committee for the outstanding Division program at the APA Convention.

The board enthusiastically thanked Bruce Liese for his ongoing efforts with the newsletter.

Ken Leonard presented a brief report on APA efforts to promote an anti-violence and anti-substance abuse media campaign.

Curt Barrett reported on further developments with the National Committee on Problem Gambling.

Our Division 50 Journal

Psychology of Addictive Behaviors

Seeks Reviewers

Psychology of Addictive Behaviors, the peer-reviewed journal of Division 50, seeks to expand its list of reviewers and potential consulting editors. The journal seeks reviewers representing both basic and applied research across the range of addictive behaviors (e.g., alcohol, tobacco, illicit drugs,

gambling, etc.). Diversity in training, background, ideology, and experience is sought.

Please send a cover letter describing your areas of expertise and a current c.v. to: Thomas H. Brandon, Ph.D., Tobacco Research & Intervention Program, H. Lee Moffitt Cancer, Center & Research Institute, 4115 E. Fowler Ave., Tampa, FL 33617.

Letters to the Editor *(con't)*

Lichtman (continued from page 2)

many people incorrectly see the paradigm as promoting drug use, rather than reducing harm, as the title implies. In essence we are giving tacit approval, which brings up many ethical and legal issues. Risk management and informed consent are two considerations. It is our duty to inform our patients of the risks involved in any treatment and do a cost-benefit analysis with them at the outset of therapy. The Hippocratic oath should apply to the caregiver as well as to the patient. "First, do no harm," needs to translated into, "Bring no harm unto one's self." I have seen a number of clinicians referring to themselves as being a "harm reductionist," treating active users who only want to maintain their addictions. These "patients" want to appear as if they are doing something about the problem and they know how to play the game quite well. Yes, they are experts at manipulation, fooling even us specialists.

The clinical application of harm reduction has had its successes. It is an effective tool, originally proven by outcomes in needle exchange and methadone programs. The latter is sanctioned by the federal government, and both are currently condemned by the present administration in New York City despite their positive results. Many studies cite statistics indicating that there has been a reduction in crime and the spread of AIDS by IV drug users due to these two programs. Harm reduction has a much broader base than the limitations of those applications. The groundbreaking work of Alan Marlatt of the University of Washington and Kate Carey of Syracuse University are seminal examples of the comprehensive utilization of the paradigm. Harm reduction has been practiced in many foreign countries. Researching the World Wide Web and the literature will produce many examples of successful applications.

In states where physicians can recommend the medical use of marijuana, it has proven useful in relieving the wasting syndrome of AIDS and with the side effect of nausea in chemotherapy. These are just a few of the many uses of the drug. Other people, though, have seen this as an opportunity to procure the cannabis for less noble reasons. Let us not be so naive as to believe that in addition to pain relief there is not the added benefit of psychoactive effects.

Colleagues are also coalescing with associations that are promotive of illicit drug use for medicinal as well as psychoactive effects. This is evident in the publications generated by these associations and in the acceptance of advertising that sells everything relative to the cultivation of high-grade cannabis and the rhetoric about legalization.

I believe that we have to be very careful as clinicians when treading in this area. It is a virtual no-man's land loaded with mines. Colleagues by association are inadvertently aligning themselves with the legalization advocates in a political battle that may in the long run do them harm. As scientist-practitioners, our real focus should be to concentrate on finding the best pathway among many for our patients and to act as a guide, hopefully helping them to make the best choice. This needs to be done in the most value-free way. Our work must not be misinterpreted and appear as if we have joined the enemy camp.

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Spirituality and Addictions *(Responses to the Editor's Call for Letters for this special issue of TAN.)*

I am encouraged by recent trends towards combining science and spirituality to better treat addictions. The AA program and its history have been masterfully described (Kurtz, 1979) and clearly differentiated from models with which it is often confused (Miller & Kurtz, 1994). AA's mechanisms of change (Khantzian & Mack, 1994; Snow, Prochaska & Rossi, 1994) and its effectiveness (Emrick et al., 1993; Tonigan et al., 1996) are being increasingly studied. Gorsuch (1993) wrote an excellent discussion on assessing spiritual variables and differentiating between "Christian," "general," and "AA" spirituality.

One definition of spirituality in recovery that might be useful is: *A lifestyle of thinking and behaving that continually improves one's relationships with people, places, and things.* This is sort of a personalized "continuous quality improvement" (CQI) program for the recovering person's life. Although the three Project MATCH treatments--Cognitive-Behavioral Therapy (CBT); Twelve-Step Facilitation (TSF); and Motivational Enhancement Therapy (MET)--may appear incompatible, I have seen clinicians in addictions treatment blend elements of all three approaches and more. Of the three, TSF might seem to be the most spiritual to some. Considering its underpinnings of unconditional positive regard, empathy and warmth, the runner up for "most spiritual" might be MET. Of the three, CBT might seem to be the least spiritual approach, although I do not know many CBT clinicians whom I would label "nonspiritual." Even Albert Ellis wants his clients to get along better with people, places, and things.

As long as clients receive careful, informed consent and clinicians do not confuse themselves or their clients by blending ideologies, it seems reasonable to mix and match. For example, one might use MET to help clients resolve their

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ambivalence about attending AA, or use CBT techniques to refute irrational negative thoughts about being an AA member. It might even be effective to lend cognitive-behavioral techniques to AA members "working the 12-Steps."

In 1991, I conducted an analog study using cognitive-behavioral techniques to enhance the abilities of (mostly nonalcoholic) student participants to perform a spiritual task similar to the 4th Step of AA. Their task was to write a confidential list of their resentments, fears, and harmful acts and give specific examples of each. What makes this a spiritual task is that it might help people identify those relationships with people, places, and things that need improving. This intervention targeted the first step of the CBT problem-solving model, "problem identification." The better one can identify or describe a problem, the more effective will be one's solution.

The outcomes of interest were how many such items participants could generate and how specific each of their examples were. The rationale for these variables was that the more items one can generate and the more specifically one can provide examples for each item, the better one can inventory one's maladaptive patterns of thinking, feeling, and acting that need changing. The intervention tested was a 20-minute videotape using cognitive modeling techniques to show viewers how to use a "who, what, when, where?" approach to covertly think their way through this difficult task. This intervention was compared to two other randomized conditions: a comparison group who read instructions culled from AA literature on how to write a 4th Step inventory and a no-treatment control group. The videotape group significantly outperformed the other two groups by generating more items and providing problem examples (descriptions) of higher specificity.

A few responses to this research are worth telling. Some AA members guffawed at the thought of "improving upon the Big Book." One even kidded me, suggesting that if the experiment were successful, I should then write a book called *As Chris Sees It* (Bill Wilson started AA and wrote a book called *As Bill Sees It*). A reviewer from an addiction journal attacked the manuscript for not using a sample of real alcoholics, calling it "a textbook case of methodological rigor and ideological zilch." It may prove to be effective for clinicians to use science-based techniques to facilitate spiritual growth in their clients, but we may have to weather a few border skirmishes.

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If spirituality is understood as involving belief in a powerful non-material being or beings, then SMART Recovery is a secular program because SMART recommends neither for nor against such a belief. However, if spirituality is understood to involve an individual's highest (or largest) frame of reference, then SMART can be a spiritual program for the participant who wishes to consider how addictive behaviors conflict with that highest frame of reference.

Addictive behavior is problematic because it interferes with something else. If there is no or negligible present or future harm in an (occasional) indulgence, the act is not an addictive one. Addiction begins as harm increases. Harm is assessed in the context of a higher frame of reference. If your jailer offers you a bottle of liquor on the night before your execution, the cost-benefit analysis of drinking in that context is considerably different from getting drunk in ways that interfere with long-term plans.

For many individuals, addictive behavior interferes enough with lower frames of reference that recourse to conflict with the highest level is unnecessary for recovery to occur. For instance, addictive behavior may interfere enough with socializing, saving money, or sleeping well that reference to "doing God's

will" or self-actualization may be unnecessary to mobilize motivation to change. However, for some individuals an appeal to the highest frame of reference may be needed for recovery to occur. In

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many cases such an appeal may involve an extended exploration or re-discovery of what this highest frame actually is.

SMART's Four Point Program involves enhancing and maintaining motivation, coping with urges, solving other problems, and balancing momentary and enduring satisfactions. The first Point can open the discussion to consideration of the individual's highest frame of reference by means of a cost-benefit analysis. If costs are viewed as interfering with the highest frame of reference, than eliminating those costs could be construed as a spiritual task ("I cannot do God's will when I am hung over"). The last Point presupposes an understanding of enduring satisfactions, and these presumably are those which align with the highest frame of reference ("It is more satisfying to be a good parent on the weekend than to spend it in the casino.")

Although the spiritual approach of the 12-Steps has established a broad appeal, we need to consider that there are many different spiritual approaches to recovery because there are many different highest frames of reference. Not to have a higher power as part of one's spiritual approach to recovery is therefore entirely possible. A spiritual approach involving a higher power that is quite different from a 12-Step higher power is also possible, because not all conceptions of a higher power necessarily include, for instance, the possibility of "turning over" problems to it.

One of SMART's advantages is that in addition to encouraging the participant to consider the conflicts that are arising between addictive behavior and the individual's highest frame of reference, SMART also teaches many cognitive-behavioral motivational, urge coping, and problem solving techniques. These techniques are likely to be useful regardless of the particular spiritual orientation of the participant.

SMART sponsors about 250 weekly support groups in North America, for individuals who desire to abstain from any type of addictive behavior. The next SMART National Training Conference will be held in Washington, DC, Saturday, November 7, 1998. Further information about the conference or about SMART can be obtained at (216) 292-0220, SRMail1@aol.com, or www.smartrecovery.org.

Tom Horvath
President-Elect of Division 50
President of SMART Recovery

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It seems that spirituality is making a comeback. Some would say it never left and they would, of course, be correct. Spirituality, matters of the soul, or shall I say the essence of our beings not to offend anyone, have always been around, but many of us may have stopped noticing. Perhaps the industrial revolution and everything that ensued gave us so much to do and so many tools to do it with, opened so many previously unthinkable possibilities that we began to believe that we could do it all. We could be totally self-reliant, with our push-button solutions and cure-all, over-the-counter medicines in our modern disposable world. I once heard that people in India are more spiritual than we are in Western society because it provides them with the only hope, given their daily conditions. In our modern Western world, with our modern solutions, many suffer not only physically but also psychologically and emotionally. For various reasons, our world does not work for them or they cannot make it work for themselves. It does not fit them or they do not fit it.

In the context of an ongoing NIDA-funded longitudinal study of the effectiveness of self-help for people diagnosed with a mental disorder and chemical dependency (funded by NIDA Grant R01 DA11240-01), my colleagues Stephen Magura, Howie Vogel, Ed Knight, and I are looking into the role of spirituality in recovery. The program under study, Double Trouble in Recovery, is a self-help group based on an adaptation of the 12-Step program of Alcoholics Anonymous for the dually-diagnosed. The 12-Step program rests on spirituality, on building and enhancing one's relationship with a Higher Power that some, but not all, choose to call God.

One study participant, E., who has a long history of mental health symptoms and alcohol use and who has worked on his recovery for several years, told us at baseline that he wanted nothing no do with the "God thing." A few months later, he went back to drinking because, from his own account he thought he could get away with it, and he was bored. His heart condition worsened, and he was hospitalized. At the six-month interview, E. was once again working on his recovery, starting this time, to consider the concept of a Higher Power. "I have to get some of that spirituality stuff; everyone I know who is clean and sober has a Higher Power in their lives."

In a recent article on the role of spirituality in recovery from substance abuse, Green and colleagues (1998) wrote, "For a group of people with few material resources, the spiritual path appeared to provide a source of energy and sustenance that enabled the recovering person to confront the myriad of tasks associated with 'living life on life's terms'" (p. 330). How can we help clients in matters of spirituality? Spirituality is a hard concept to fit into Western society because it seems to be at odds with our logical thinking. Spirituality is entirely within the person; it is not visible or observable for the most part. Spirituality it is not definable; it is only recognizable. What does "spirituality" mean? The *New Expanded Webster's*

Dictionary defines spirituality as the "quality or state of being spiritual; not material; mental; intellectual; divine; pure; ecclesiastic." In everyday parlance, virtually everyone holds a slightly different definition of what spirituality means to him or her. Some cannot put it into words at all; it is experienced on the feeling level. That is probably one of the biggest obstacles

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we encounter when dealing with spirituality. Spirituality is not quantifiable; its intensity cannot be measured in number of sessions or number of times a day one prays or meditates, although the latter may provide an indication of magnitude. Only the person him or herself can tell you how spiritual he or she is.

Another obstacle we face when dealing with spirituality in our society is its relationship to religion. Are they the same? Religion is organized; there is usually a recognized leader, accepted rituals, texts, and so forth. What of spirituality? This is important because many people are or have become opposed to the concept of organized religion.

One of the best definitions of spirituality I have encountered is given by several of our study participants: "Spirituality is being the best that we can be." That is a wonderful way to have hope for oneself--it says, "If I work at it, I can be a better me." It also allows for self-acceptance rather than self-castigation because it implies that we all have a certain potential to realize. Therefore, we also all have our pre-set limitations. Another way study participants have defined spirituality is "the feeling of belonging, of being part of with other group members who share the same experiences I have had." One person went on to say that the desire to be part of was what had lead him to start using drugs in adolescence; that is consistent with the finding that 60% of interviewees to date (N = 189) report starting to use drugs and/or alcohol "to fit in, to belong."

I believe that as providers, we can and must give clients that message: "You can be the best that you can be." And we can give them some of the tools to reach their potentials by listening to them and customizing our menu of therapeutic offerings to their needs, wants, and hopes. We must also recognize that our role too, is limited. Mutual aid (self-help groups) and spirituality, however each person defines it, can play an important part in helping clients become whole and reclaim their lives from addiction, and it is incumbent upon us to educate clients and ourselves in these areas.

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Very early in my career I detected what seemed to be a quite dramatic difference between the views of counselors who were in recovery and counselors or therapists who were not in recovery from addiction. I came to refer to this, in my teaching, as internal versus external diagnosis of the disorder. By external diagnosis I referred to approaches such as those in the DSM-IV, and by internal diagnoses I referred to the introspective process that those in recovery seemed to apply. As a psychologist, I respect both views but note that the introspective tradition is among those that we must acknowledge as part of our tradition. I will not comment on the criticisms of introspection here. Time and again, I have seen these two forms of diagnosis in conflict, sometimes heated conflict. Nor will I comment on the rise of behaviorism after the demise of the introspective method to study "mind." (Possibly what we do with many of the cognitive-behavioral techniques can be traced to the early formal introspective method but that is for another time.)

A second influence on my thinking came from military training of the sort that followed the Korean War. Some of my colleagues may recall the furor that followed evidence that some of the U.S. prisoners of war in Korea collaborated with the enemy. They were called "brainwashed" and a great deal of effort was put into studying the conditions, systematically used (we were told) by the Chinese, that permitted brainwashing to occur. The three conditions were Disease, Debility, and Dread. These conditions, we were taught, were able to "demoralize" individuals, and thereafter they became amenable to influence. The "Code of Conduct" for members of the military, published in the late 1950s, was an attempt to inoculate military personnel against brainwashing upon capture. This became the key training device at the beginning of Vietnam and was applied by the "Fourth Allied Prisoner of War Brigade," as our pilots who were imprisoned and tortured in North Vietnam referred to themselves.

The most extreme form of demoralization, reported by Frank, was one that he compared to Voodoo deaths that he said were reliably documented. Prisoners themselves called it "Give Up Itis." Supposedly healthy young men, soldiers in prison, would sit down and die. They did not commit suicide (e.g., by hanging). They did not storm the fences to make guards shoot them as happened in German prison camps during World War II. They just sat and died. Unfortunately, there were not autopsies to be certain that these young men did not die of diseases or heart attacks. The anecdotes, however, would not support that.

In the 1960s Jerome Frank systematized these data in the first edition of *Persuasion and Healing*. The systematic

treatment of this topic is not to be found in later editions of the book, in my opinion. Frank posited "morale" as the essential condition that facilitated behavior change, positive and negative.

Alcoholics Anonymous (AA), as the prototypical 12-Step Fellowship, has strenuously avoided any suggestion that it is allied with any religious sect or that it takes positions on any "outside issues" such as religious beliefs. The history of AA made clear that it had learned lessons from the Washingtonians

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and the Oxford Group. These groups failed, and they failed to help alcoholics. Yet, in the 12th Step, AA indicates "Having had a spiritual awakening, as a result of these steps…" the founding members had come to apply stated principles "in all our affairs." We often hear the Fellowships speak of themselves as "spiritual" rather than "religious" organizations. Recent issues of the *AA Grapevine* have suggested concern in AA about the dominance of Christian prayers in the groups (e.g., the Protestant version of the Lord's Prayer, The Serenity Prayer).

I have come to believe that what AA means by Spiritual and what Frank meant by morale may be one in the same. Military history and economic history abound with examples of a fit organization being routed or even destroyed. Morale is the concept that, in the field of Leadership, accounts for an organization's capacity to succeed, with or without resources. It accounts for failure of organizations with superior odds and resources. There is no accident in the fact that the only collateral duty assigned to the Commanding Officer of a U.S. Navy ship is "Morale Officer." It is clear that ships with poor morale are weak links.

I recall an incident, perhaps apocryphal, in which a U.S. Marine Corps squad of 8 men faced a company of enemy (120 or so men). The ranking enlisted man of the Marines shouted out--Let's go you sons-of-bitches; we have them outnumbered. Similarly, I recall watching Michael Jordan, while ill and dehydrated, continue to play at a high level. What do we make of these things, as psychologists?

In my clinical practice, which for 20 years applied cognitive-behavioral therapy to addictive disorders, the schema I went after first was the patient's "morale schema." "Bottom," as I conceptualized it, did not have to do with whether a person had proceeded to some level of loss, since nearly all addicts did so, but to what schema appeared thereafter. A positive morale schema had to do with making something of the experience and embracing a lifestyle that, without alcohol or drugs, provided a "high." This high was not unlike that found in athletes, members of crack military outfits, and other high morale groups. It contrasted markedly with the schema to be inferred from what Frank said about GI's who became "brainwashed."

Ernest Kurtz, author of *Not God*, closed his talk to us here in Louisville, KY, with the following: "Bought sex is not love. Bought treatment is not AA." Bought treatment, in my experience, usually has not addressed the spirituality or morale aspects. At the very least, bought treatment has not addressed spirituality, or morale, to the extent that the 12-Step Fellowships have or in the way these groups have.

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http://www.nih.gov/grants/guide/pa-files/PAR-99-006.html
Tel: 301-435-2836

APA Council is important to the future of our Division. The more seats we have on the Council, the greater our voice. Please assign your votes to Division 50 when you receive your ballot from APA!

Call for Nominations

Fellows of Division 50

The Fellows and Awards Committee extends an invitation to those wishing to nominate candidates for new Fellow status in Division 50. Self-nominations are also welcome. In addition, those members who are already Fellows in other Divisions who wish to be considered as Fellows in Division 50 should also contact the committee. Correspondence and requests for applications and forms should be addressed to the chair:

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The deadline for receipt of completed applications is **December 15, 1998**, for consideration by the APA Board at the 1999 meeting. Applications received after December 15 will be deferred for consideration until the 2000-01 cycle.

Hey, did you know that the National Cancer Institute (NCI) has a Small Grant Program?

NCI provides small grants for researchers to test ideas or do pilot studies in cancer prevention and control. Total direct costs up to $50,000 are allowed. The total project period may not exceed two years. For more information, contact:

Helen I. Meissner, Sc.M.
Division of Cancer Prevention & Control
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That which is spiritual is usually defined in relation to what it is not: material. Psychologists have used the term *transpersonal* to describe the realm of spirit--that which transcends individual material existence. For the individual, spirituality has to do with one's relation to (search for, understanding of) nonmaterial reality, that which is beyond the individual. How people understand such reality is, of course, a matter of great individuality. In fact, that is part of the interest from a psychological perspective. Some people disavow the existence of any reality beyond the material. (Such materialism is a location on one dimension in multidimensional space.) The vast majority of Americans, however, say that they believe in God or affirm some other absolute reality beyond material existence.

One possibility, then, is that variables or phenomena can be defined as spiritual by virtue of their reference to the transpersonal, that which transcends material reality. Thus belief in God or a Higher Power is a spiritual dimension; belief in Freud is not. The Eastern perspective that all beings are interconnected in a nonmaterial way is spiritual; theories of economic interdependence are not. It is important to remember that each of these are distributed dimensions, with all individuals located somewhere along each particular spiritual continuum.

For mapping a complex latent construct, it can be useful to conceptualize some broad domains, within which there may be many constructs, each of which can be defined by multiple measures or variables. There are at least four such domains that could be studied.

Belief has to do with cognitive components of spirituality. A basic dimension here is the continuum of spiritualism versus materialism: one's beliefs as to the existence and nature of transpersonal reality. Included here are concepts of the divine, about the nature and intentions of an Other, God, unity, or higher power beyond the self. Beliefs about the interconnectedness of beings, the natural world, and the universe are also of interest, as is the individual's more general conception of ultimate meaning or purpose in life.

A second dimension in understanding spirituality is *motivation*. A person's central goals and values are often understood in reference to some transpersonal reality beyond the individual. Does the person have concepts of absolute good and evil? Are there higher values that transcend the self--for which one would, for example, give one's life? What is there that the person regards as most dear, sacred, or holy, with value beyond the self--that which Paul Tillich described as one's "ultimate concern"? Again, frames of reference that embrace nothing beyond the material self as real or sacred are nevertheless locations in the multidimensional conceptual space of spirituality.

Then there is dimension of experience, which many regard as the sine qua non in understanding spirituality. Direct experiences are often influential in shaping a person's unique spirituality. There are, for example, well-defined common attributes of mystical experiences, near-death experiences, and meditative states. With Janet C'de Baca I have spent some years seeking to understand profound transformational experiences that involve a uniquely convicting sense of knowing, as well as profound experiences of peace, acceptance, or unity. Spiritual experiences are often described as numinous or ineffable; they can be very difficult to express in ordinary language and cause us to draw on simile and metaphor. There should be special interest, for those of us in the addiction field, in the fact that the quest for such transcendent experiences has for many centuries been a significant motivation for drug use in widely varying cultures.

Finally, there is individual and social *behavior* related to the above beliefs, motivations, and experiences. Most obvious here are religious attendance and practice, but we need a behavioral domain that is not limited to religion. How do people live their lives--what do they *do*--in relation to the other dimensions of spirituality? How are these domains inter-related, and how in turn do they interact with other behavior?

And therein is a major source for scientific interest. How are things spiritual (transpersonal beliefs, motivations, experiences, and related behaviors) linked to addictive behaviors? In longitudinal research, are there spiritual dimensions that function as risk or protective factors in drug use, abuse, and dependence? How does one's spirituality change over (and possibly alter) the natural history of substance use disorders? What may spiritual variables tell us about the course and stability of recovery? How does one's spirituality affect addictive behaviors, and how do addictive behaviors affect spirituality? To be sure, there are challenges in assessing something as complex as spirituality, and we need to move beyond simplistic measures.

There are, as Melanie Bennett's article indicates, some interesting findings already in the literature. Yet our current scientific knowledge about the role of spirituality in addictive behaviors is relatively small, compared to what we already know about neurotransmitters, genetics, social modeling, public policy, conditioning, and personality factors in the addictions. With all of these predictors, we still typically account for only a small proportion of variance in addictive behavior and outcomes.

I doubt that spirituality will turn out to be the key to understanding a majority of the variance. It is, however, a relatively unexplored domain in the scientific study of addictive behaviors--which is downright odd, given how many clients, clinicians, and 12-Step groups have emphasized spirituality as central in understanding the phenomena of addiction. It strikes me as a proper and promising topic for scientific study. Though they could use some polishing, there are already quite a few tested instruments and methods for studying spirituality.

With well-considered scientific methodology and sound measurement approaches, God knows what we may find to help us better understand, prevent, and treat addictive behaviors!

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Minnesota-model treatment facility within the first week of admission. Surrender scores correlated in the expected direction with a measure of the attitude of acceptance and with clinical scales of the MMPI. Near the end of their 28 days in treatment, 38 participants (54%) completed the post-test instruments. In this study, participants increased in surrender over treatment. In addition, Surrender scores at the end of treatment were useful in predicting sobriety one year following treatment.

In Study 3, Reinert (1997) surveyed 54 alcoholics upon admission to a Minnesota-model treatment facility. Surrender scores correlated with measures of acceptance, internal locus of control, and God-mediated control. Data on 26 participants who completed the protocol prior to dismissal showed that Surrender increased over treatment, as did acceptance and their sense of God-mediated control.

Speer and Reinert (in press) conducted a pilot study to explore the long-term effects of spiritual aspects of treatment at a Minnesota-model facility. Alcoholics (N = 150) who had been out of treatment at least one year were mailed the Surrender scale and the recently developed Speer Recovery Scale. The latter scale was designed as an index of quality of recovery and was composed of items taken from three sources: *Alcoholics Anonymous* (AA World Services, 1976), *Stage II Recovery* (Larsen, 1985), and *Treating the Alcoholic* (Brown, 1985). The 29 respondents were divided into High Surrender and Low Surrender groups based on a median split of scores on the Surrender scale. The High Surrender group had a significantly higher quality of recovery as measured by the Speer Recovery Scale. In addition, the quality of recovery appeared to be significantly influenced by the length of their sobriety and by their refraining from drug use.

Reinert (in press) explored whether being in treatment for approximately one month at a Minnesota-model facility leads alcoholics to make an act of surrender and experience a reduction in pathological narcissism, as suggested by the theory of Tiebout (1961). Over the course of treatment, Surrender scores significantly improved for the 65 participants. To test the theoretical connection between making an act of surrender and reducing pathological narcissism, two groups were formed based on the median split on the degree of change on Surrender over treatment (a High Change on Surrender, n = 36, and a Low Change, n = 29). The High Change on Surrender group experienced a decrease in their pathological narcissism scores over treatment; the Low Change group did not change on pathological narcissism.

Although empirical studies on surrender are largely exploratory, results suggest that the practice of including such spiritual components in treatment is effective for at least a segment of the population that is dealing with alcoholism and other addictive disorders. Results of these exploratory studies hint that Tiebout's act of surrender may indeed be a key one for therapists to foster in those who are disposed to attending to the spiritual dimension of their lives. The role of surrender and other spiritual concepts in treatment deserves additional research and clinical attention as we try to understand the dynamics that foster greater effectiveness in treatment.

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Bennett (continued from page 5)

Anonymous (AA) is associated with better outcomes after outpatient treatment for substance use problems (Emerick, Tonigan, Montgomery, & Little, 1993). The evidence is less persuasive but still encouraging for AA attendance following inpatient treatment (see reviews by Emerick, 1987; Montgomery, Miller, & Tonigan, 1995). In addition, most research has found that meditation-based interventions are associated with reduced levels of alcohol and drug use problems (Alexander, Robinson, & Rainforth, 1994).

Assertions with some supporting evidence (ratings of +2 or +1). Other assertions are less strongly supported but show evidence suggesting that the relationships are worthy of further study. First, clients treated in 12-Step oriented therapies fare at least as well as those treated with other approaches. The evidence here pertains to formal treatment with a 12-Step orientation not to AA attendance alone. Results from Project MATCH (Project MATCH Research Group, 1997) as well as another large-scale study (Ouimette, Finney, & Moos, 1997) suggest that 12-Step oriented treatments are comparable to other treatments for alcohol problems. Second, religious involvement tends to be low among people in treatment for substance use. Several studies have found that people in treatment for substance use problems tend to report less religious involvement and weaker religious beliefs than people without substance use problems (Brizer, 1993; Kroll & Sheehan, 1989). Third, alcoholics often report having had negative experiences with religion and punitive concepts of God. In his 1995 review, Gorsuch found some evidence to suggest that a view of God as forgiving and accepting is related to less substance abuse. Fowler (1993) conducted interviews with alcoholics and recovering alcoholics and concluded that most alcoholics reported negative, punishing views of God and religion.

Finally, we included the construct of purpose or meaning in life as a component of spirituality. In taking this broad view, we found some evidence to suggest that personal sense of meaning in life increases following treatment for substance use problems. For example, Carroll (1993) studied the relationship of spirituality and purpose in life and found that a sense of purpose in life increases with continuing sobriety and practicing the spiritual principles found in AA. Others have found that purpose in life is higher after inpatient treatment for substance use problems (Waisberg & Porter, 1994).

Assertions with no sound empirical evidence (rating of 0). There were several assertions for which no persuasive research evidence was found. First, we did not find good evidence to suggest that individuals in treatment for substance use problems report a lower personal sense of meaning in life relative to the general population. Although several studies have found increases in purpose in life following treatment (Carroll, 1993; Waisburg & Porter, 1994), we found no good evidence to support the idea that prior to treatment abusers have less sense of purpose in life than others in the general population. Second, the one study conducted on intercessory prayer with substance abusers found that it did not improve treatment outcomes (Walker, Tonigan, Miller, Comer, & Kahlich, 1997).

Conclusions. There are several general conclusions that can be reached from this review. First, there is much that already can be said regarding spirituality in addictive disorders. The literature is clear: religious involvement is associated with less substance use and abuse. In addition, there are consistent denominational differences in substance abuse. The literature also strongly suggests that some interventions with a spiritual component (such as AA and meditation) help many people in recovering from alcohol and drug use problems. Other assertions are less strongly supported but show encouraging relationships that are worthy of further study. Given these findings, there is much in this field that is encouraging.

Second, at present the remaining questions far outweigh what is known. There is much to learn about the relationship between spirituality and addiction. Remaining questions span many important domains of research: definitions, measurement, etiology, treatment, and prevention. Clearly the lack of a consensus definition of the construct of spirituality and the lack of reliable and valid measurement devices will hamper the study of these issues. There are populations that require more in-depth study and spiritual experiences that require further description and examination. The study of spirituality in addictions often raises more questions than it answers. Our task now is to build on and improve this literature and begin to answer these many complex questions. Studying spirituality in a rigorous and scientific way remains the most effective way of learning about how spirituality is involved in addictive behaviors.

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We extend our congratulations to

Estee Shapiro

Recipient of the 1998 Division 50 Student Research Award

Liese (continued from page 1)

Regardless of your background, education, or theoretical orientation, if you have worked in the field of addictions for any length of time you have witnessed the influence of spirituality on addiction treatment. As evidence of the popularity of spirituality among addiction psychologists, when I called for papers and letters on spirituality for this issue of *TAN*, I received more manuscripts than I could possibly hope to publish. In fact, this is the longest *TAN* ever (36 pages)!

Writing about a topic as value-laden as spirituality can be risky business, especially when you are writing for 1,500 of your closest friends and colleagues. Hence, I want to take this opportunity to express my sincere gratitude to all who have gone out on a limb and contributed to this issue. I believe each article makes a unique, interesting, and important contribution.

While there were many differences between the articles in this issue, certain common themes emerged. The following is a list of just a few of these:

- Ψ Spirituality involves a search for meaning and purpose greater than oneself.
- Ψ Spirituality plays an integral role in the lives of many people.
- Ψ People who develop addictions tend to become overly focused on their addictive behaviors, often to the exclusion of other important issues (e.g., love, compassion). As a result, they lose certain meaning and value in their lives.
- Ψ Many addicted people have been helped by spiritual interventions where they have shifted from addictive behaviors to a larger search for meaning.
- Ψ Spirituality and related constructs are difficult to objectify and measure. Besides being complex and multifactorial, there are profound individual differences in how people experience "spirituality."
- Ψ Many clinicians, including psychologists, are interested in facilitating others' search for meaning during the "recovery" process. Some are sufficiently skilled, qualified, and competent to do so, but many are not.
- Ψ All clinicians treating addictive behaviors should at least be familiar with spiritual concepts and approaches that are important to their patients and colleagues, even if they themselves have no intention of applying these concepts.
- Ψ Clinicians who choose to employ spiritual techniques should be familiar with associated risks and ethical issues involved in doing so, especially relating to the development of dual relationships (where the psychologist attempts to be both clinician and spiritual guide to patients).

I hope you find the articles in this special issue to be stimulating and informative. You may have noticed the subtitle of this column: "Spirituality and Addiction Treatment: Is it

Really a Match Made in Heaven?" Please give this question some thought and drop me a note. I would be delighted to publish your response in the next issue of *TAN*.

McCrady (continued from page 6)

Can we and should we conduct research on spirituality? Research suggests that religious/spiritual involvement is predictive of less alcohol use and less alcohol-related problems. We also have data that demonstrate a statistically significant, though not overpowering correlation (*r*'s in the range of .20-.40) between AA involvement/attendance and positive outcomes of treatment. However, the fact that we can conduct research on aspects of spirituality or religious beliefs and practices does not mean that we should conduct research on these topics. Why, as a scientist, should I make such an assertion? An observation by John Allen at a meeting on research on spirituality had a profound impact on my thinking. He posed the question (this is my rough recall of his comment): "What if God does not play by our rules?" What did John mean by this comment? Essentially, he was suggesting that the fundamental assumptions of empirical research may not apply in the area of spirituality. If, for example (John's example), we designed a randomized clinical trial of the impact of intercessory prayer on recovery (half our participants had others who prayed for their recovery; half had no one assigned to pray for them), we might think that we had a good design that would allow us to conclude that intercessory prayer did or did not impact on recovery. But... what if there is a personal God, looking out for each of us? God might decide that those in the no-prayer group were particularly lost and bereft of spiritual support, and might intercede to help them with their recovery. If the no prayer group did better than the prayer group, the psychologists running the study might conclude that prayer interferes with recovery and would probably develop an elaborate set of post-hoc explanations for why prayer was bad (perhaps related to internal versus external attributions, powerlessness, or the like). In fact, of course, they would be completely wrong. The difficulty, though, is that there would be no way for the researchers or participants to know that God had made a decision that went against our rules for empirical research. Consideration of the inherent contradiction between ordered empirical inquiry and belief in the miraculous have made me wary of our ability to actually conduct meaningful research on core issues related to spirituality and recovery. If we cannot be reasonably sure that our experimental designs and controls will lead to interpretable results, conducting such research may be lead to erroneous conclusions, with perhaps serious and untoward implications. Returning to the hypothetical study described above, would we then counsel our clients and their loved ones away from prayer? Using scientific knowledge to guide practice is one of the ultimate goals of our research, but if we end up with wrong knowledge and use that wrong knowledge in our practices, our practice could then be harmful to our clients.

Can we intervene in spirituality? A moral and ethical concern I have relates to the use of research findings suggesting that religious involvement or spiritual practices are associated positively with recovery. Our current knowledge base is correlational, and to my knowledge, there are no data suggesting that the manipulation of religious involvement or spirituality results in better recovery. However, even if such data existed, how, as psychologists, should we use such knowledge? Is it within the role and expertise of a clinical psychologist to try to impact on spirituality or religious practices? If so, what type of spirituality or religious practices should we promote? Those that are most familiar to us as individuals? Those that are familiar and acceptable to the client? What if research focused on only one type of spirituality, such as that associated with fundamental Christianity. Is it then appropriate for us to promote fundamental Christianity to our clients? Respect for the individual beliefs and autonomy of our clients is central to the practice of psychology; I worry that promoting particular or any religious beliefs or practices may be inappropriate and disrespectful. The line that we cross when we move from the use of psychological knowledge and principles to promote changes in affect, cognition, and behavior, to the use of religious and spiritual practices is one that we should examine carefully before stepping across it.

Some other concerns. An important concern I have relates to sources of funding for research on spirituality. Research on tobacco sponsored by the tobacco industry, research on the environmental impact of oil spills funded by Exxon, or research on the health benefits of alcohol supported by the alcoholic beverage industry are all tainted by the possibility of biasing of research designs and questions or the possibility of withholding of negative findings by the funding agency. It is not impossible to conduct excellent and independent research with such funding, but the firewall between the funding agency and the scientist must be remarkably secure. In the field of spirituality, substantial funds from private foundations are being made available to support the development of research and a research agenda. It is crucial that the nature of these foundations, the sources of their funds, and the other types of activities they support be known and examined carefully, and that researchers are aware of the overall purposes and aims of the foundations supporting such work. A foundation, for example, that funds work related to the agenda of the "Christian Coalition" might, in fact, be most interested in research that *demonstrates* the *value* of Christian practices in addiction treatment rather than research that *explores* the *possible role* of a variety of spiritual practices.

As a corollary to this concern, I also worry that some professionals interested in conducting research on spirituality and health may have a specific agenda that they are promoting. The "neutral scientist" is probably a myth, and certainly each of us conducts research on topics that we care about (couples therapy, AA, methadone maintenance, etc.). A good scientist, however, builds in experimental controls to make it more difficult for his or her prejudices and predilections to determine the outcome of a study, and the good scientist is willing to let the data lead to conclusions different that those intended. Science is also subjected to peer review, both in design and in the reporting of results. The variety of external controls on scientists is designed to decrease bias in designing studies and

interpreting results. In research on spirituality, clearly the same scientific standards

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McCrady (continued from previous page)

should apply. Some of my experiences, however, have left me concerned about devotion to devotion rather than devotion to science. When participating in group discussions about research on spirituality, I have had the uncomfortable experience of hearing "scientists" make assertions such as: we cannot withhold prayer from anyone in an experiment because we know that prayer works, or we need to do research to prove what we know. I should emphasize that these comments were not made by addictions researchers, but hearing such comments from professionals supposedly interested in science has given me pause.

Finally, I have asked myself and pose this question to members of Division 50--should we be here? When we are working as psychologists, we are not theologians, clergy of any persuasion, or persons working the spiritual program of recovery of AA. Should spirituality be their domain, not ours? The answer to this ultimate question, as should be clear from my comments, is unclear and fraught with potential pitfalls and temptations.

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LaPierre (continued from page 8)

human intimacy is destroyed by our self-centered pursuit of what alcohol offers.

A sequel to the loss of interest in human intimacy is our resistance to attaining the developmental stage of interdependency. We fail to move from a state of some independence to recognizing our interdependence in the human, the environmental, and the overall spiritual dimensions of our lives. We retreat into an inwardly focused dependency on alcohol and the resources it purports to offer our weakened sense of self. Ultimately, we allow ourselves to depend so much on the alcohol that it effectively becomes our "Higher Power."

On a more physical level, the spiritual journey, even in its most ascetic forms wherein we fast and otherwise limit our access to normal human pleasures, will not generally make us ill. The abuse of alcohol, however, will destroy our minds, our overall health, and eventually our lives. To put it differently, misuse of alcohol will prevent us from being the kinds of spiritual people that many of us believe that our Higher Power meant for us to be.

Alcohol will even lead us away from some of the social opportunities that it seems to offer--namely, a sense of camaraderie, of friendship, of being really connected. The ebullience, excitement, or even charm of the moment that is built on a foundation of shared drinking can evaporate almost as quickly as alcohol itself will. Spiritual growth, on the other hand, can equip us to see the goodness in another person and even allow the other person to see the goodness in us. That mutual perception of goodness, grounded in a sense of the Higher Power as the source of the goodness we see in each other, will promote trust, love, and the risk-taking that is so necessary for spiritually healthy relationships.

The "spirits" in alcohol do not offer peace--not even temporarily. While the attainment of inner peace is at least one of the goals of every religion and healthy form of spirituality with which I am familiar, the reality is that alcohol does not offer or otherwise lead to the experience of inner peace. It offers excitement, disinhibition, a drugged form of sleep, temporary relief from some forms of pain, an impaired memory, and so on, but it does not offer peace! Healthy forms of spirituality encourage their followers to seek peace and to help others to attain it.

Finally, healthy spirituality is an integrative experience. Abuse of alcohol becomes a disintegrative experience. Healthy spirituality promotes the desire to do what is good for self and others. Overuse of alcohol leads in exactly the opposite direction. Healthy spirituality leads to a belief that there is reason to hope for the future and to give thanks for the present. Excessive consumption of alcohol leads to cynicism, despair about the future, or even emptiness in the present. Truly, the "neutral spirits" are neither neutral nor spiritual, and healthy spirituality is, well, healthy!

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Congratulations to

Tom Brandon!

New Editor of our journal

Psychology of Addictive Behaviors

Thanks go to members of the Search Committee: Bob Zucker, Sandy Brown, Ken Leonard, Jerry Platt, and Jalie Tucker.

Hart (continued from page 9)

Unfortunately, alcohol researchers have given virtually no empirical attention to the study of psychospiritual means and mechanisms of recovery among alcoholics in treatment who adhere to the 12-Step program of spiritual growth outlined in the Big Book of AA. Theoretical writings far outstrip empirical investigation. Of the few data-based studies that have been reported with this particular focus (Carroll, 1993; Corrington, 1989), most tend to consist of methodologically inadequate correlational investigations. A major exception to this general trend is the Project MATCH study (Project MATCH Research Group, 1997), a multi-site randomized clinical trial which tested the efficacy of a standardized AA-like treatment condition called Twelve-Step Facilitation. One-year follow-up results of this important study revealed TSF resulted in significant and sustained reductions in drinking. More impressively, results showed that the magnitude of therapeutic gains for TSF equaled that of cognitive-behavioral coping skills therapy and motivational enhancement therapy. This finding provides a remarkably strong endorsement for a spiritual approach to alcoholism treatment. Moreover, other Project MATCH results showed that the efficacy of the 12-Step intervention was particularly strong among clients who had a positive attitude toward spiritual growth ("meaning seekers"). Thus, clients who were meaning seekers benefited most from the AA-like intervention. This effect, however, was rather weak.

Although the 12-Step treatment condition only addressed the first five steps of AA, Project MATCH results nevertheless provide the strongest evidence to date that there may be a causal link between involvement in the AA Steps and sobriety. In addition, the study also suggested that it is possible to operationalize aspects of the 12-Step program in the form of a treatment manual (Nowinski et al., 1992) and that therapists in different locations can be trained to deliver a standardized AA-based treatment protocol. This final contribution has direct implications for the present study, which seeks to develop a standardized treatment manual based primarily on facilitating appreciation of and involvement in Steps 8 and 9. To summarize, scientific evidence indicates that the psychospiritual mechanisms which underlie the 12-Steps of AA may contribute to successful outcomes for alcoholics seeking relief from their drinking problems (Mathew et al., 1995). These outcomes include both physical abstinence from alcohol (Montgomery et al., 1995) and spiritual growth (Brown & Peterson, 1990; Waisberg & Porter, 1994).

The present study seeks to examine the unique therapeutic effects of practicing steps that specifically involve forgiveness (i.e., Steps 8 and 9). In addition, this investigation will give attention to the analysis of spiritually-related "process variables" that might account for long term drinking outcomes. Although anecdotal observations support the effectiveness of the forgiveness steps (e.g., Kaplan, 1993), solid research is lacking. However, preliminary research (Brown & Peterson, 1990) has compared value priorities of alcoholics in 12-Step recovery (i.e., AA members) to the value priorities of actively drinking alcoholics and non-alcoholics in general. Results showed that, relative to comparison groups, AA members give higher priority to the importance of forgiveness. While interesting, these data clearly shed no light on the question of whether or not forgiveness--in the context of a spiritual program of recovery from alcoholism--has therapeutic benefits or what these benefits might be.

Spirituality of the forgiveness steps. Literature published by AA (e.g., The Big Book and the "Twelve and Twelve") reveals that the main purpose of "doing" Steps 8 and 9 is to be in a better position to carry out the 3rd Step decision, which consists of the choice to become willing to let "God" (or some "Higher Power") direct one's thinking and actions. Completion of Steps 8 and 9 facilitates the realization of the 3rd Step decision because the process of making amends rids the self of guilt, shame, & remorse (unforgiveness of self) as well as bitterness, resentment and the desire for revenge (unforgiveness of others). All of these block a richer experience in awareness and fuller expression in behavior of the "Grace of God." Thus, according to the Big Book of AA, unforgiveness separates people from experiencing the Healing Power of Grace. In terms of the actual practice of these steps, Step 8 requires the recovering alcoholic to make a list of all persons they have harmed and to become willing to make restitution (amends) to them all. Step 9 follows by asking the AA member to make direct amends to these people, wherever possible, except when to attempt to do so would injure them or others.

Importantly, in the vast majority of cases, names that appear on an AA member's 8th Step list also appear on the member's 4th Step "grudge" list, which is an inventory of others who are targets of unresolved animosity and resentment (i.e., people who the AA member has not forgiven). Because of this overlap between the 4th and 8th Step lists, the alcoholic who earnestly pursues the behavioral actions required by Step 9 is faced with the difficult task of summoning and exhibiting true humility and forgiveness. Members of AA who balk at the prospect of engaging in confession, contrition, and reparation (i.e., making a 9th Step amends) with those whom they resent are encouraged to pray to their Higher Power (or a "God" of their own understanding) for the needed willingness.

Through the power of prayer, members seek the Grace needed to transcend their egocentricity (i.e., their focus on their own hurts). Thus, according to AA, prayer gives the

recovering alcoholic the courage and humility needed to reach out and make reparations to those they dislike, or even hate. Clearly, during the evolutionary process of precontemplation, contemplation, and action regarding carrying out Steps 8 and 9, different alcoholics will experience and express different degrees of forgiveness, with different degrees of benefit.

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Nominate a colleague to be an officer of our Division (see page 34)

Hart (continued from previous page)

In the present study, participants in both the spiritual and secular interventions will be encouraged to forgive others for harms that they may have perpetrated. However, in marked contrast to the secular intervention, the spiritual intervention also seeks to promote self-forgiveness as well as forgiveness-from-others for harm done to them. This focus on self-forgiveness and on showing penitence and making reparations for how one's own actions caused another to suffer clearly distinguishes the spiritual intervention from the secular intervention. Given that this is the case, we expect that, relative to the secular intervention, clients exposed to Step 8 and 9 facilitation will experience a greater sense of self-forgiveness, a greater sense of "forgiveness from God," and a greater sense that others have forgiven them for their trespasses. We also expect that participants in the spiritual condition will experience relatively greater degrees of "spiritual growth."

A personal view: Love is letting go of anger. My personal view of AA is not a secular one. I see authentic AA as one of many sacred paths to "God" (whatever that is), and I see the 12-Steps as a set of spiritual principles and spiritual practices that helps some people "spiritually self-actualize." Some people who attend AA meetings, probably a minority, use the 12-Step program and the supporting human fellowship to enable them to actualize in their awareness and experience the true spiritual essence of their being. A number of personality defects serve to block "conscious contact" with this immanent yet transcendent dimension of reality. However, none does a better job at masking the presence of the "Higher Self" than unresolved interpersonal anger, what AA calls "resentment." Resentment is the number one block to spiritual awareness and awakening. Popular writers, like Wayne Dwyer, call this Higher Self the "Sacred Self." I have come to the conclusion that, regardless of what it is called, it is nothing other than a ray of pure Divine Sunlight that is sometimes expressed in and through people (e.g., Jesus, Buddha, Mohammed, Confucius, etc).

The expression of Divine Energy that I refer to is sometimes called spiritual love, or agape. And this type of love is the opposite of resentment. They are mutually exclusive, and as one diminishes the other expands. If resentment is defined as bearing ill will toward others and desiring to harm them, then spiritual love is the just the reverse. Spiritual love is bearing good will to others and desiring that good come to them. This form of Agape Love, as taught in many world scriptures, and not just Christian scripture, comprises a "spirit" (an "attitude" if you like) of good will, kindness and the desire to alleviate suffering (compassion). Although this special type of love is "of God," it cannot be experienced or expressed in our normal mode of consciousness, mostly because awareness is so often consumed with bitterness and resentment. Resentment truly is the "cancer of the Soul." Thus, if the truth were to be told, I do not really see our study of AA's 12-Steps as a study of "forgiveness" and letting go of resentments. Rather, I think we are studying a possible way in which behavioral science might help cultivate the realization of agape (spiritual) love. When viewed from this perspective, the 12-Steps of AA become the 12-Steps to love-in-action.

End note. Alcohol researchers interested in exploring the possibility of obtaining funding for studies promoting the "education of the Soul" are referred to the John Templeton Foundation website at http://www.templeton.org. Further information on the present study can be found at: http://www.psyc.leeds.ac.uk/staff/kenh.html.

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Most addiction work is based on faith. When one realizes that Alcoholics Anonymous (AA) began in 1935, professional and para-professional programs began in the 1950s, and federal funding for treatment and prevention did not take off until the 1970s and has been reduced in the 1980s and 1990s, we are compelled to think that addiction work is a young science indeed. Cohen and Levy (1992) trace the history of the alcoholism, drug abuse, and mental health movements in America. These are still three fields, often separate and apart with certain real mutual antagonisms. So a great deal of what has evolved so far in addiction work has been based more on faith in what works (or might work) than on empirical evidence of the same. Treatment technology can only improve as the different fields and disciplines begin to share knowledge and experience. Well-controlled empirical studies add to our knowledge base but do not brush aside a different kind of knowing borne of personal experience and based on faith. Psychologists like Stanton Peele and Howard Shaffer have been right to admonish us for our failure to communicate and have been swift to point out how rigid ideologies may prevent this. On the other hand, when people have been brought to the depths of suffering by both antecedents and sequelae of addictive behavior, beliefs that seem simplistic or rigid may be very compelling to the client. Over 12 million people in the United States belong to self-help groups. AA has 1.5 million members worldwide. Their membership relies on personal experience as data.

Faith may be defined as confident belief in the truth, value, or trustworthiness of a person or idea. Faith does not rest on logical proof or material evidence and involves loyalty to a person or idea. For the religious person, faith involves belief and trust in God and the doctrines or scriptures of their particular religion. Recovery from addiction often begins with the client or member placing faith in treatment personnel, recovering peers, and for some, a higher power or power greater than themselves. Pain is the human motive behind seeking treatment: physical, psychological, and spiritual pain. Most addicts and alcoholics have tried numerous times to stop on their own, often with short-lived success. Self-efficacy is usually at an all-time low once the person comes into the orbit of a treatment program or self-help (actually mutual-help) program like AA. Faith in others can lead to faith in oneself. It has occurred to us that when faith is borne out in reality a deeper spiritual awakening often occurs. People who report a profound spiritual awakening, such as Bill W. (co-founder of AA), have their backs to the wall. Their lives have become desperate and riddled with pain and suffering. Psychology is not particularly comfortable with such spiritual notions. Bergin and Jensen (1990) found that "therapists were less committed to traditional values, beliefs, and religious affiliations than the normal population at large." Their survey found that only 33% of clinical psychologists described religious faith as the most important influence in their lives, as compared with 72% of the general population. The proportion of the population who profess a belief in God has remained at around 95% ever since the question was first asked in public opinion polls (Hoge, 1996). According to Hoge, "The American experience calls the universality of the secularization model into serious question." Stanton Jones (1996) speaks of the "potency of mental health professionals" who "stepped in to fill the cultural niche vacated by the institutional church and have been in the business of answering questions of ultimacy with the powerful mantle of modern science cast about their shoulders." Jones also points out that "therapy and religion each services the function of establishing a "deep structure" for understanding life through the enactment of myths and ritual, which are given their power through the personal empathy and institutional settings in which they are administered."

What is the best in religion is also best in psychology: unconditional love, positive regard, acceptance, forgiveness, and a connection to the human community. All these endeavors involve the use of positive human values and the application of faith. Most of the addicts and alcoholics that the authors have known well who were able to achieve long-term abstinence and improved lives have acknowledged spiritual development as essential to their recovery. This includes persons who stopped on their own, participated in long and short-term care, belonged to 12-Step programs or not, were on methadone maintenance or in drug-free modalities, suffered from other mental and physical disorders, and used traditional psychotherapy services. Stanton Peele (1989) summarizes the change process quite nicely when he states:

> In the final analysis, what works in all these effective therapies is identical to what works for people who improve their own lives without therapy: a strong desire to change; learning to accept and cope with negative feelings and experiences; development of enough life resources to facilitate change; improved work, personal and family dealings; a changed view of the attractiveness of the addiction brought on by a combination of maturity, feedback from others, and negative associations with the addiction in terms of the person's larger values.

Among the values that Peele (1989) sees as clear antidotes to addiction are achievement and competence, consciousness and self-awareness, energy and activity, health, responsibility and self-regulation, self-respect, intimacy, and community. The dialogue is needed to bring psychologists working in addiction closer to other addiction clinicians is of a spiritual nature. As indicated earlier, psychologists tend to shy away from traditional values. Sometimes, we become hermetically sealed inside our academic towers or our clinical practices. We think Dr. George Albee was right when he said we have to turn psychology over to the "unwashed." What is best about psychology needs to be shared. It is not ours to jealousy guard nor selfishly inflate. As our friends in the therapeutic community programs like to say, "You can't keep it unless you give it away!"

The role of addiction counselors, paraprofessionals, and the special case of recovering people as clinicians deserves mention.

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Robyn Dawes (1994) forces us to consider the following: while psychotherapy works in reducing psychologically painful and often debilitating symptoms, the reasons it works are unclear. We know clinicians should be empathetic. We also know that the credentials and experiences of the psychotherapists are unrelated to patient outcomes, based on well over five hundred scientific studies of psychotherapy outcome. Studies of addiction show that: (1) treatment and prevention work, (2) the longer one stays in treatment the better the outcomes, (3) empirical findings do not favor one modality over another, (4) some findings are supportive of non-traditional approaches such as community reinforcement models. Well-controlled studies with appropriate control and comparison groups are few in number. In the meantime, three related treatment movements are struggling for maturity, parity, and the hearts and minds of the American people: the alcoholism, drug addiction, and mental health movements.

It has been our experience that lives are enriched by a spiritual quest. It has been our particular experience that the quest of addicts and alcoholics for a healthier, happier and more meaningful life is enhanced by spiritual pursuits. It may begin with a shift in values-in-action. A liar begins to tell the truth and finds honesty can be rewarding. Shame-based secrets that propel relapse are revealed and the threat to recovery lessens. You cannot know another person's basis in faith or religion unless you ask them. Working with a broken spirit and providing spiritual comfort begins with knowing oneself and then one's client. We believe that the therapist's ability to empathize is spirituality-in-action and that it is a vital part of what Liese (1998) calls "therapist talent." We hope that more psychologists and clergy will join in the growing collaboration between science and religion. There really is very little new under the sun. We seek modern interpretations of ancient wisdom. So do our clients.

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with strong spiritual components such as AA and NA, but I did not see myself as someone who could impart pearls of wisdom to our Division members. Although I have taken (and taught) graduate level courses on addictive behaviors, very little of this content focused on spirituality or religion.

As I reflected on this discrepancy between my more extensive clinical exposure to spiritual aspects of many individuals' efforts to change their addictive lifestyle and my lack of research based knowledge in this area, it became evident to me that this dilemma is similar to what many psychologists face when first treating addictive disorders. We may have a wealth of clinical experience but feel ill-prepared to proceed clinically or make recommendations based on solid empirical research for domains that are professionally foreign to us. Consequently, I began for myself the education process in this domain which I have advocated so often in the past to reduce the clinical-research knowledge gap.

Why is knowledge about spirituality important to psychologists specializing in addictive disorders? Spirituality is one dimension of the cultural context of our lives, and as such it influences external resources and risks, phenomenological experience, and overt behavior. Social and cultural factors are intricately involved in the etiology, progression, and remission of addictive disorders, and consequently spirituality may play a role in this process.

Further, as services expand to better accommodate under-served populations (e.g., minorities, pregnant women, HIV populations, youth and the elderly), it increasingly behooves us to become educated about all aspects of cultural diversity. It is from the perspective of cultural diversity education I have sought to approach my focus in this special edition of *TAN*.

While perhaps insufficiently appreciated by researchers and academicians, spirituality is a prevalent, if not pervasive,

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component of treatment programs for substance use and other addictive disorders in the United States. Longitudinal studies indicate that some people attribute success in efforts to change these difficult behaviors to spiritual aspects of their lives or spiritual features of their treatment. Yet, how many of us know what is meant by "spirituality" or how spiritual or religious factors may be involved in facilitation of addictive behavior change or protection against engagement in these types of behaviors to begin with?

Spirituality, loosely defined, is central to most societies and cultures around the world. As reflected in religion or religious beliefs, 75% of American adults say their approach to life is partly based on religious beliefs. About half of adults in the United States report daily prayer and over 40% report regular attendance at religious services. Of note, rates of such activities are remarkably lower among mental health professionals. David Myers' (1996) recent research indicates that adults with religious commitment and involvement report more personal satisfaction in their lives than adults without such involvement. While spirituality is more than just religion or religious beliefs, it is clear that this is a central issue in our society and culture.

What exactly is spirituality? It is evident from the various articles in this Newsletter that diverse perspectives exist with regard to the definition and composition of spirituality as well as the extent to which psychologists should focus on this topic (see McCrady, this issue). While the concept of spirituality has been debated throughout history, a recent consensus report of the National Institute for Healthcare Research (Larson, Swyers, and McCullough, 1997) provides a working definition of spirituality to include "the feelings, thoughts, experiences and behaviors that arise from a search for the sacred" (p. 21), where sacred refers to a "divine being or ultimate reality/truth." This broad definition, while difficult to operationalize, includes religion/religiosity and encompasses domains of: (1) Religious affiliation and history, (2) social and private participation in activities, (3) support and coping, (4) beliefs and values, (5) commitment, (6) motivation and (7) specific experiences. Instruments for the assessment of each domain of spirituality are available, although they vary markedly in psychometric quality, process and stage of development (e.g., MacDonald et al., 1995; VanderCreek, 1995), and sensitivity and specificity to these various domains.

What has research shown regarding spirituality and addictive disorders? Knowledge of the associations between spirituality and addictive disorders is based primarily on behavioral measures of religious involvement. For several decades measures related to religion, religious orientation, and attendance at religious activities have been consistently associated with lower rates of involvement in deviant behaviors including alcohol and drug involvement. The association between religion or religiosity and substance involvement is evident across the life span and for diverse deviant behaviors particularly during adolescence (e.g. illegal activity, sexual involvement). More general measures of conventionality, with religious involvement included, buffer (i.e., moderate) the impact of risks for the development of substance use disorders for youth and young adults. As noted in the Bennett article in this issue of *TAN*, there are differences in substance use rates across denominations with religions that take a strict stand against substance involvement having lower rates of such problems. However, while a number of studies have found associations between religions/religiousness and lower rates of mental health problems such as depressive symptoms, suicide and delinquency, other research has indicated that certain religious content and very high levels of religiosity are associated with poorer emotional functioning. The latter is a potentially important caveat given the high rates of psychiatric comorbidity with addictive disorders.

Finally, two interventions which have spirituality as a component have been associated with better substance use disorder outcomes: AA and meditation. Of note, meditation has also been shown independently and in combination with other interventions to produce better outcomes for both mental health and physical problems. At this point, it is not clear whether the spiritual component is the mechanism through which better outcomes are produced or whether some other process (e.g., neurophysiological conditioning is the facilitating agent.)

What is needed to better understand the relationship between spirituality and addictive behavior? Unfortunately, measures of spirituality or religion are not routinely employed when considering cultural factors influencing development, maintenance or remission of addictive disorders. Common definitions and psychometrically sound measures which would allow for comparisons across studies are not yet the norm. Consequently, it is not clear whether spirituality should be considered as one facet of conventionality or a distinct cultural feature. It is also not clear whether specific spiritual content or some unique aspects of the "spiritual search" process is even operational in the moderating effects of spirituality on the risk-addiction relationship. Many religious activities, for example, include positive structured social activities, reinforcement for positive cognitions, opportunities for social network restructuring, and "safe" (e.g. drug-free) environments with learning opportunities to improve self-esteem and self-efficacy, and develop both cognitive and behavioral coping skills. It is assumed in the literature on spirituality that it is through a common process that AA and meditation may influence outcomes but different mechanisms may lead to improvements such as the unconditional positive regard and genuineness promoted within 12-Step programs or the neurocognitive or physiological conditioning of meditation.

Many more questions remain than have been answered regarding spirituality. What are the models of change for spiritual interventions? With the exception of meditation, the efficacy and effectiveness of religiously focused interventions have not been systematically evaluated either as independent

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mechanisms of change or components of effective change agents for addictive behaviors. Since non-spiritual/non-religious interventions have demonstrated efficacy for addictive behaviors, do spiritual interventions share common processes which promote behavior change or do they offer unique avenues to success?

Clearly, robust associations have been demonstrated between religious activity and addictive behaviors. Spirituality, although not consistently defined or measured, is a common component to several approaches to treatment and it would be useful to have answers to many of the above questions and issues so that we can continue to reduce the clinical-research gap, be more well-educated regarding the cultural aspects of spirituality and addictive behaviors, and ultimately improve any efforts to prevent and effectively treat addictive disorders.

Where can you get more information? Several venues are available to become more educated consumers regarding this topic. The most general place to start may be the Psychology of Religion Home Page (www.psywww.com/psyrelig) which includes resources, journal indices, notable people, and links to related sites. The 1998 consensus report of the conference on Scientific Research on Spirituality and Health (Larson, Swyers, & McCullogh, 1998) sponsored by the John Templeton Foundation is a good reference source of substance use disorder specific information and is available at dlarson@nihr.org.

Also, the National Institute of Alcohol Abuse and Alcoholism is sponsoring a two-day Conference on Studying Spirituality in Alcohol Research February 1-2, 1999, in Bethesda, MD. This conference will focus on the study of spirituality in the epidemiology, initiation, maintenance and recovery of alcohol use disorders and those interested may contact Faye Calhoun (301-443-1269) for information.

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Please assign your votes to Division 50 when you receive your apportionment ballot from APA!

Congratulations to our New Division 50 Fellows!

Fellow Status in the Division acknowledges the important nature of a member's contributions to the field and profession. The Fellows and Awards Committee recommended two members of the Division who had Fellow status in another APA Division. This member was:

Donald Calsyn
Kenneth Sher

The Committee also submitted four Division members for New Fellow status. At the Council meeting in August, all were approved (effective January 1, 1999). The new Fellows are:

Robert J. Craig
Patrick M. Flynn
Arthur "Mac" Horton, Jr.
Barbara C. Wallace

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Call for Nominations
Division 50 Officers

Division 50 is soliciting nominations for the offices of President-Elect and Member-at-Large (3-year term). Division by-laws state that a nomination "must be supported by the signatures of at least two and one-half percent" of the members. Thus, your nomination should be supported by at least 32 members of the Division. You may obtain signatures for your nominees or have members submit similar nominations to the Elections Supervisor. Nominations of women and ethnic minority members are especially encouraged.

In addition to duties as described in the Division by-laws, officers are expected to attend the annual APA convention and the winter Board of Directors Meeting (some funding for travel is available). Candidate biographies will appear in the spring issue of *The Addictions Newsletter*. The ballot for officers will be included in the mid-April APA election mailing.

Make your nominations by indicating nominee and office. Nominations may be sent by e-mail but must be followed by a signed nominations form or letter. Please provide signature, home address, and phone number for all nominators to permit verification. **THE DEADLINE FOR NOMINATIONS IS FEBRUARY 1, 1999**.

I nominate _____ for _____ of Division 50.

I nominate _____ for _____ of Division 50.

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THE DEADLINE FOR NOMINATIONS IS FEBRUARY 1, 1999.

Announcements

Program Manager Position for the Research Institute on Addictions

The Research Institute on Addictions in Buffalo, NY announces an opening for a Program Manager (Project Director). Will manage day-to-day operations of a research project focused on brief motivational interventions as a means of encouraging drinking reduction and HIV risk reduction among college students. Responsibilities include staff training and coordination, oversight of project operations, database management, statistical analyses, and writing research reports. Will be assigned to the "Enhancing HIV Prevention through Drinking Reduction" project. Salary is $41,898 annually. Minimum qualifications: Doctoral degree or ABD in clinical psychology or related field preferred. Strong clinical, organizational, and verbal/written communications skills essential. Submit a cover letter mentioning position title and item # RFMH #908-1088A, along with c.v. and 3 letters of reference, to Lora L. Gartee, Personnel, 1021 Main Street, Buffalo, NY 14203-1016, or respond to gartee@ria.org. Deadline: December 11, 1998.

Brown Post-Doc Fellowships Alcohol Abuse Treatment and Intervention Research

Brown University Center for Alcohol and Addiction Studies is training pharmacologic, behavioral, social and health care scientists for a career in alcohol abuse/alcoholism research. Focus is treatment and early intervention. Emphasizes the need to test more sophisticated theories of treatment/intervention; the importance of the biological, social and cultural environment in which intervention occurs; and refining methods for measuring person, intervention and impact variables. NIAAA supported stipends range from $21,000 to $33,012 per year. Center training faculty from specialty areas of psychology, anthropology, sociology, psychiatry, public health, social work, and internal medicine. Applications received by February 15, 1999. Women and minorities are encouraged to apply. Training initiated between July and September 1999. For further information/application write Richard Longabaugh, Ed.D., Director, Brown University, Center for Alcohol and Addiction Studies, Box G-BH, Providence, RI 02912. Brown University is an affirmative action/equal opportunity employer.

Post-Doc Research Fellowships in Substance Abuse Treatment University of Vermont

Minorities are encouraged to apply. Competitive stipends. Two to three year appointments. Applicants must be US citizens. Send letters of interest, vita, and letters of reference. **Position #1:** Participate in the development, conduct, and publication of studies on behavioral treatments for cocaine dependence. Participation in laboratory studies examining factors influencing human drug self-administration is also possible. Contact: Stephen T. Higgins, Ph.D., UVM, Dept. of Psychiatry-Human Behavioral Pharmacology Laboratory, 38 Fletcher Place, Burlington, VT 05401-1419. **Position #2:** Research fellowship in Substance Abuse Treatment and Computer Technology. Responsibilities include conducting and publishing studies on innovative application of computer technology to the treatment of opioid and heroin dependence. Research includes using the new pharmacotherapy, buprenorphine, and behavioral treatment. Contact: Warren K. Bickel, Ph.D., UVM, Dept. of Psychiatry-Human Behavioral Pharmacology Laboratory, 38 Fletcher Place, Burlington, VT 05401-1419

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