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

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

Before AA

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

The AA Standard

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

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

Threats to Early AA and Other Recovery Societies

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

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

Why AA Survived

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

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

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

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

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

The Importance of Context

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

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

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

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

The Future

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

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

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

The Growing Varieties of Recovery Experience

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Cultural and Political Awakening of Communities of Recovery

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

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

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

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

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

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

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

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

The Commercialization of Recovery Support

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

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

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

Technological Innovation and Recovery Support

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

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

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

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

An Emerging Science of Recovery

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

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

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

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

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

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

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

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

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

Summary

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

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

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References

Alcoholics Anonymous. (1953/1989). *Twelve steps and twelve traditions*. New York: Alcoholics Anonymous World Services, Inc.

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

Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press.

Kaskutas, L. A., Ammon, L. N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research, 29*(11), 1983-1990.

Kurtz, E. (1991). *Not-God: A history of Alcoholics Anonymous, expanded edition*. Center City, MN: Hazelden Educational Materials, Inc.

Kurtz, E. (1999). Spirituality and recovery: The historical journey. In *The collected Ernie Kurtz* (pp. 109-144). Wheeling, WV: The Bishop of Books.

Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. *Alcoholism Treatment Quarterly*, *20*(3/4), 5-40.

Kurtz, E. (1999). *The collected Ernie Kurtz*. Wheeling, WV: Bishop of Books.

Room, R. (1993). Alcoholics Anonymous as a social movement. In B. McCrady, & W. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives.* New Brunswick, New Jersey: Rutgers Center of Alcohol Studies.

SAMHSA. (2008). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2007. Data on Substance Abuse Treatment Facilities* (OAS Series # S-44, DHHS Publiction No. (SMA) 08-4343). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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

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

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

White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

White, W. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

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

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

Wilson, B. (1954) Letter to Betty T., Habit Forming Drug Group, March 30.