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Unraveling the Mystery of Personal and Family Recovery: An Interview with Stephanie Brown, PhD

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In recent years, there have been growing calls to shift the organizing center of the addiction and mental health fields from pathology and intervention paradigms to a recovery paradigm and to begin this evolution with a recovery-focused research agenda. One of the pioneers who has most influenced this interest in resilience and recovery is Dr. Stephanie Brown. I consider her developmental models of personal and family recovery as among the most important in the modern era of addiction treatment. The implications of some research are so profound and far-reaching that it takes decades to fully appreciate their import. I think we as a professional field will be mining the implications of Stephanie Brown's work for decades to come. In this very personal interview conducted in late 2010, Dr. Brown talks about her life, her work, and her legacy.

Bill White: Stephanie, your Master's thesis at California State University and your doctoral dissertation at the California School of Professional Psychology both focused on alcoholism. How and when did you decide on this focus of study?

Stephanie Brown: I entered graduate school for my Master's within a month of recognizing my own alcoholism and beginning my recovery in March, 1971. I was steeped in the beginnings of my own deep self-exploration, as I had already been in psychotherapy for the previous year. So, I brought to my Master's program a combination of traditional psychotherapy, peer-supported recovery, and a desire to be fully credentialed at the Master's and Doctorate levels. There was no academic addiction studies field at that time, so my focus had to be on Mental Health Training. I was in my mid-twenties and starting recovery with the big question: "What happens to me now?" All the research I've undertaken in these nearly 40 years relates to important questions about myself, including what lies ahead. I knew that my childhood and young adult development had been shaped

dramatically by my parents' alcoholism, so I intuitively knew I would have to grow up again with this new life focus of recovery.

My own childhood experiences and childhood development under the influence of parental alcoholism, along with the shock and relief of recognizing my own alcoholism, made the question "what happens to me now?" deeply important and immediate. It prompted my Master's thesis, a study of the teenage daughters of male alcoholics, and led to the larger question that has guided my work: "What happens to people when they stop drinking?" I sought to define recovery as a process rather than an event and move beyond existing knowledge and practice that focused only on active addiction with abstinence as the end point.

Bill White: In 1977, you founded and directed the Stanford Alcohol Clinic. How did this opportunity come about, and how did your work at SAC influence your later work?

Stephanie Brown: I was young and inexperienced, but very passionate, in my first internship placement for my Master's degree. Out of the blue came a call from Irvin Yalom, a name well-known to many mental health professionals as the father of modern interactional group psychotherapy. Stanford Psychiatry had received a number of large grants to study aspects of alcoholism, and he'd been told I could be helpful. Would I like to work with him? I knew that this was "heaven calling," so the only answer was "yes." I began a three-year project studying group psychotherapy with alcoholics. He and I co-led groups and I began writing about our discoveries, which was the beginning of my theory building about addiction and recovery.

That research project ended in 1974, and I began my doctorate, studying traditional psychology with a dissertation focus on defining a developmental model of alcoholism and recovery. By then, I was firmly convinced, personally and professionally, that addiction and recovery are a continual process and not a singular event. Developmental psychology was very helpful, then and now, in understanding change processes.

When I completed my doctorate, I asked Dr. Yalom for advice about my next steps. "Why don't you start an alcohol clinic here at Stanford?" Once, again, I knew that the only answer was "yes." Through the support of wonderful donors, we opened The Stanford Alcohol Clinic in the fall of 1977. I was so blessed through all of this with fabulous emotional and monetary support?"

I decided to apply the new model I'd just developed in my research to the new clinic. Here was the beginning of the integration of addiction and mental health theory and practice as we worked within a once-a-week traditional psychotherapy model that had never been widely used in the addictions field. We also integrated clinical research, training, and education into the clinic model.

These professional origins continue to this day. In 1988, I transferred the applied, developmental model to establish an outpatient, private practice setting, called The Addictions Institute, which I am still directing.

Bill White: In 1985, you published the book, *Treating the Alcoholic: A Developmental Model of Recovery*. This book set forth the developmental perspective that has informed much of your work. Could you briefly describe this perspective?

Stephanie Brown: *Treating the Alcoholic* was a translation of my doctoral dissertation, now further confirmed by our patient work at Stanford. It outlined the stages in a developmental process and the tasks of treatment for the patient and the therapist at each stage, a radical way of thinking about alcoholics and alcoholism at that time for both the addictions and the mental health worlds.

I suggested that alcoholism, and alcoholism recovery, is an ongoing process, not an event, and outlined four general stages in this continuum. These are now widely known as active drinking, transition, early recovery, and ongoing recovery. Today, we say active addiction; drinking/using transition and abstinent transition, the move from active use to abstinence; early recovery, which centers on new development of self; and ongoing recovery, which is the stabilization of new behaviors, a new identity, and a whole new self.

From the beginning, I used child development theories, especially attachment, to illuminate the recovery process. The attachment theorists were new in the '70s and '80s and offered an astounding and valuable perspective about human development as an interpersonal process. I likened recovery to the transitions from infancy through childhood—the simultaneous development of senses, behaviors, and cognition, language and emotion all growing into an integrated whole.

Bill White: I recall when first reading this work being struck with the simple but profound idea that when people shifted from one stage of

recovery to the next, their needs dramatically shifted; treatment approaches need to dramatically shift in tandem with these transitions.

Stephanie Brown: That's right. In my view, mental health professionals at that time did not understand addiction, and in fact, were often doing more harm than good in their approach to treating alcoholics. Mental health theories worked against an understanding of the developmental process of healthy growth. Even today, many difficult experiences of recovery can be misinterpreted as "pathology" instead of a normal part of healthy recovery development.

During active drinking and the transition to abstinence, the individual is dominated by impulsive, out-of-control behavior combined with an identity that says, "I am not an alcoholic; I have not lost control." These behavioral and cognitive dimensions combine with emotional needs to keep the person locked in active addiction. When the individual hits bottom and "surrenders," a cognitive and emotional shift occurs ("I am an alcoholic. I have lost control") that allows the person to initiate recovery by asking for and accepting help. This is an action moment of recognizing one's powerlessness and helplessness, breaking the attachment to the drug, and forming a new attachment to sobriety. That bond is represented by AA, a sponsor, and new objects such as books, pamphlets, coins, and meeting places. The dependency on alcohol is transferred, rather than stopped, so the individual often continues impulsive, out of control behavior, but directs it to new recovery objects and relationships. It's a move from an unhealthy dependence to a healthy dependence.

Developmentally, most people are not cognitively clear enough at new abstinence to absorb much, although people will acquire and understand new basic learning—what to do, what actions to take—and recovery vocabulary. This is just like the toddler who's been getting ready to speak new words. Language facilitates mastery of behavior (which is NOT the same thing as control!) for children. Language is the great mediator for impulse in normal child development. In recovery, the potential for out-of-control behavior remains. The new language strengthens a stable base of recovery and provides distance from the dominance of impulse. It is the growth in recovery language and reduction in the dominance of impulse that moves people up a developmental ladder away from feeling like a vulnerable infant for years on end just trying to control your behavior. This is a state that many people live with for years when they don't have a recovery program—white knuckle sobriety.

Affective development varies widely. Emotion drives some people into recovery, and their feelings don't subside with abstinence and security in a recovery program. Instead, the emotions of the past—childhood trauma, the experiences of the trauma of their own loss of control—dominate initially. People are filled with intense emotional flashbacks, intrusive memories, and insomnia. At this point, they have to hang on tightly to recovery. They may need professional support to help them contain the emotions and direct their impulses to recovery actions instead of using.

For others, lucky at this point, the affect subsides or goes underground, making possible a smoother transition to new behaviors of abstinence and the beginnings of cognitive development. These people may not feel anything, or, they're thrilled with recovery and what they're learning. At some point, often towards the end of the first year, emotion peeks through. People may have disturbing dreams, or they're suddenly aware of feelings they can't even name. They were using so long that feeling is a whole new experience.

I call them lucky because time in recovery gives them a strong attachment, as well as new tools to deal with their emotions through the Steps and perhaps therapy. They can accept and face their emotions from a higher developmental level of recovery growth, which is incredibly helpful. The 12 Steps provide people a framework from which to experience and respond to such feelings.

The end of active addiction involves transformation. Transformation has been more understood within the field of religion than the field of mental health, and from religion, it is understood as a conversion experience. What I was describing in my work was a type of transformation experience that involved this process of hitting bottom and reaching out for help. It was transformational in the sense that the individual's locus of power shifted from the self to something greater than self, a relationship that develops over time in recovery.

Bill White: Is this when the paradoxes of recovery that you have described begin?

Stephanie Brown: Paradox begins at the point of hitting bottom and surrendering. The acceptance of powerlessness and defeat lead to a new kind of paradoxical power. The paradox emerges with acceptance, which occurs at a deep emotional level. People accept that they are powerless. Their next steps must come on faith, which many people don't believe they have.

People see deeply that they can't do it anymore, which makes hitting bottom such a profoundly spiritual, but not necessarily religious experience. It's about accepting one's fundamental vulnerability. That's what makes it such an infant experience because you feel utterly helpless, vulnerable, you can't do this anymore, and if you are operating under cultural or social standards of maturity, you will immediately invoke your belief that you ought to be able to fix this. What can you do to get control? The paradox comes in releasing all of your efforts to control, abandoning all your beliefs in your own power. And, in that moment of yielding and surrender, you experience release. You ask for help. This is the moment of clarity that so many people describe. You don't know the paradox yet. You live in the point of surrender, knowing or believing that you might very well die. You might evaporate; you might be annihilated, but you cannot do this yourself. And then, if you reach out for help, you have the touchstone for a new attachment. You may feel "carried" because you are not deciding in an adult sense. You are "swept up," guided by the slogans that are conveyed in concrete, toddler language. Quickly, you settle in and begin to experience a feeling of safety and relief. This is the experience we believe the infant feels in a secure attachment with a loving parent, that "I'm actually safe here." I liken the experience of sitting in a meeting in new recovery to the feeling of being rocked and held.

Let me illustrate with a story. In 1991, I was invited to Poland to teach at the time the Soviet empire was collapsing. It was an amazing time to teach about children of alcoholics and of being held captive by addiction. Many of these professional addiction counselors had also been held captive to other political powers, and some remembered painfully the trauma of growing up in concentration camps. It was an intense experience of emotional connection between us with great sorrow for the traumas of addiction and war rising to the surface.

They dedicated a Catholic mass to us (my husband, daughter, and me) and throughout the service, I could hear our names sung out in the context of the Polish language. The feeling of safety and security was profound.

Next, they dedicated a combined AA – Al-Anon meeting—still fairly new in Poland—to us. Eighty people in the room from both programs said their names in an almost musical overture. "I am Jarek, alcoholico" said one person after another, or "I am Maria, Al-Anon." Once again, it could have been a lullaby as I felt rocked by the Polish language and the music of the words. I felt very, very young—pre-language—throughout that meeting and the 18 days in Poland. I think one can feel more vulnerable and young when you don't speak the language.

One of our hosts was my interpreter, who stood side by side with me throughout the trainings. I would speak in English, looking out at the faces looking back and listening to me and then she would interpret in Polish. As her Polish words streamed out, faces smiled in recognition and identification or people began to cry. They were especially moved by their own comparisons of the trauma of helplessness children of alcoholics live with and their imprisonment (or their families') in concentration camps. They had also lived under a totalitarian regime for decades, giving them yet another experience of vulnerability and helplessness. People cried and cried. Their identification and response to my words focused on their own recovery experiences as individuals, families, and as a country.

We left Warsaw and traveled with our male host Wiktor, to Czestochowa, where Pope John Paul was coming for a young people's conference. Suddenly joining two million people in a spiritual procession, we jammed together with the millions, all facing a huge screen. Wiktor suddenly saw his friend Antony. As he heard my name and we shook hands, he reached out to hug me. "Thank you. Thank you. I've been walking for three days on a pilgrimage from Warsaw to see the Pope, and I have been reading your book," which had been translated into Polish. "I am studying the transition from alcohol to surrender and spirituality." Antony told me he'd been a founder of Overeaters Anonymous in Poland. This was one of the most emotional and meaningful moments of my life.

Bill White: Speaking of impact, you wrote a book called *A Place Called Self: Women, Sobriety and Radical Transformation* that has deeply touched many people. Could you share some of what you infused into that book?

Stephanie Brown: At the time I wrote *A Place Called Self*, I was deepening my understanding of paradox. Hazelden asked me to explore some of these paradoxes from the perspective of recovering women, although much of what I eventually wrote also applies to men. I reviewed the stages of development and reviewed the significance of surrender—of hitting bottom, of powerlessness. Then I addressed the question, "How can women accept their powerlessness when the culture is pushing them to claim their power?" Throughout the '80s and '90s, I found that a very thorny issue for women in recovery. I believe that's where the paradox comes in: that women, just like men, come to understand their fundamental humanity in the powerlessness, in the realization that we are all ultimately dependent—we find the power in powerlessness. We are not self-sufficient. We cannot go it alone. The dependence is the very beginning of that discovery and comes in reaching

out, acknowledging our powerlessness, and coming to believe in and connect with something greater than ourselves.

The initial dependency is the transfer of dependence from the drug to people within AA or other recovery support meetings, which then expands as the individual grows developmentally. That attachment becomes a belief in a Higher Power, which each individual defines. You externalize your dependence – you place it outside yourself in the books, meetings, or people of AA and recovery. Paradoxically, you will come to believe in a power greater than yourself, which you define, and in accepting your powerlessness, you experience a new kind of power.

The second paradox I defined was the wholeness of a divided self: accepting internal conflict. This is really vital to understanding the integration of mental health models with addiction and a 12-Step recovery developmental process. Some mental health theories, particularly psychodynamic, psychoanalytic, and developmental perspectives, see conflict as part of the human condition, which is also a theme in religion and philosophy. But some people in mental health treatments and some who are new to recovery stand by the notion that you shouldn't experience conflict—that conflict means you're not doing something right. This has been difficult for me through all the years of my own recovery: to hear people suggest that if you're not feeling good in recovery, you must be doing something wrong. This view is detrimental to people who come face to face with all kinds of emotion, pain, and conflict as a result of recovery. This pain is progress. At times, you're going to feel worse as you open up to feelings and memories and make sense of your life. You're likely to experience inner conflict as you work the steps. Conflict is part of human nature and of being human. So, the paradox of the "wholeness of a divided self" is in accepting conflicting parts of ourselves—even a war inside—as "normal" and ongoing as part of a healthy life. Many people stay active in 12–Step life because it is so rich in opening up the paradoxes and the conflicts that we all experience but usually try to deny or think we should deny or fix.

The third paradox is independence built on dependence—becoming separate through connection. Most people believe you shouldn't be dependent—especially in American culture—that dependency is such a bad thing. It means you're weak. But dependency is part of being human. We are all dependent. We can't go it alone. There is healthy dependence and unhealthy dependence. Addiction is an unhealthy dependence, but in recovery, people grow into healthy dependencies by becoming attached to AA and the people in AA. You have a new experience of growing up. First, you are dependent. Then you grow into separation and independence and

autonomy as a result of having had a healthy dependence. Nobody gets to independence without that experience of healthy dependence. The 12 Steps are all about acknowledging dependence and growing into a healthy relationship with it.

The final paradox is standing alone with the help of others, which is connected to the last one but is more specific. We are all alone in essence—come in and go out absolutely alone. We can accept that state of total aloneness by virtue of the attachments we form and by standing alone with the help of others, which is the healthy dependency that is the essence of the AA model. AA is an apprentice model of learning. Psychotherapy is hierarchical. The therapist is a professional authority with specialized expertise. In the AA model, the person from whom you seek guidance is an authority through personal experience and what that individual learned from others who had also experienced addiction and recovery. Knowledge is passed on from one person to another. Each person has had the experience of being in the dependent position and then almost immediately becomes one who passes it on. You are always the dependent person in relation to another, and you are also the person who is helping, the one who passes on to another. It creates a paradoxical equality. This paradox and the model of apprentice learning may be unique to the 12 Steps.

Bill White: After you left Stanford in 1987, you assumed the position of Director of Family Research at Merritt Peralta Institute in Oakland. Could you describe your work during this period?

Stephanie Brown: Merritt Peralta, now Summit, was a "granddaddy" residential treatment center that had been around a long time. I had asked the question in my dissertation, "What happens to the individual who stops drinking?" and I had followed that in the 1980s with "Who are the children of alcoholics and what is the process of recovery for them?" My next research question was "What happens to families when an adult partner, male or female and maybe also a parent, stops drinking?"

I brought that research question to M.P.I. as their Director of Family Research, a new position to reflect a new idea. Like the field as a whole, they had little programming for families. It was a challenge because nobody in the addictions field had any understanding of how to integrate a focus on family with the always dominant central focus on the addicted person. Everything was organized around the addict, the alcoholic, with family members viewed as secondary.

I began to look at family recovery from a family systems organizing perspective and asked the question: What happens to the family as a system during active addiction and recovery? I stayed at M.P.I. long enough to formulate the questions, but left to start the Addictions Institute, where I could begin to answer them. The Addictions Institute allowed me to integrate my academic and clinical interests through a private practice model. Psychologists, social workers, and marriage and family therapists joined with me to work in the psychotherapy framework with alcoholics, addicts and their families. Following the same model I built at Stanford, we saw individuals, couples, and families, including adult children of alcoholics, within this family-informed model. Whoever calls for help is the identified patient. The Addictions Institute continues to this day, with the same focus and the integration of the best of addiction theory and practice and with the best of mental health, working with people at all stages of recovery, new and established.

In 1990, I joined Dr. Virginia Lewis at the Mental Research Institute in Palo Alto to design and complete the formal Family Recovery Research Project. We spent ten years studying the process of recovery for the family and the individuals within, publishing two books and a curriculum for families. It was a powerful, gratifying experience to work so closely with couples and families who were as young as 79 days in recovery and as old as 18 years. My belief in the stages and complexity of the recovery process were validated and reinforced.

Bill White: About ten years earlier, you were involved in the early Adult Children of Alcoholics (ACOA) movement and offered guidance to that movement as it unfolded and was birthed. How do you look back on that movement today?

Stephanie Brown: With great warmth and affection. We came together as a group of individuals who had all begun to focus our professional work on the needs of children of alcoholics or adult children of alcoholics. We became NACoA, the National Association for Children of Alcoholics. There were initially about 15 of us, all professionals, and all, or most, self-identified adult children. It was a personal “coming home” for those of us who needed this movement ourselves, so we formed a strong bond. I believe we were all responding to our own emotional children of alcoholic selves in desperate need to “make real” and to name the truths of our lives—the reality of growing up with alcoholic/addicted parents.

We began writing about what we had seen clinically, in our professional roles, and for some, in our personal lives. The founding of this movement, I believe, was a combination of profound emotional need, which I call a "coming home," with our professional experiences, abilities, and credentials to tell the story to a wider group. Symbolically, the kids came together to form a family in which we were going to tell the truth about what is real. What we did carried over to the culture as a massive social movement.

This movement and the organization and work of NACoA were criticized by almost every professional domain. The alcohol and drug addiction treatment world was scared of it, I think, overwhelmed by the emotion the idea "children and adult children of alcoholics" was eliciting from the culture. The professions of mental health and psychology were critical of this grassroots movement as it was forming. Even though we were all well-trained professionals, we were most criticized within the mental health field, which, I believe, couldn't understand what we were saying and doing. The social movement lasted a good ten years, and then its major themes were picked up by academic research, which, in the next decade of the '90s, validated our original findings.

The social movement quieted, as social movements do, waiting until their "cause" is integrated and institutionalized in the culture or forgotten. Fortunately, this social movement has survived and is now well-integrated in mental health and addiction. Twelve-step groups sprang up like wildfire in the beginning, but most disbanded as the wave passed. They are forming again.

Bill White: What do you think are some of the most important contributions of that movement through its ten-year surge and aftermath?

Stephanie Brown: Most important was the naming of reality, the power of the label—children of alcoholics, adult children of alcoholics—because that label identifies parental alcoholism as a key source of a child or adult's development. It says that living with parental addiction will have an influence. The label was uniquely interpersonal when mental health and addiction theory and practice had been limited to a focus on the individual. America is still a nation where the individual is all powerful. The COA and ACOA movement highlighted the interpersonal nature of individual development and the difficulties adults brought from their childhood into their adult experience. The movement forged new theories of development to understand and explain the impact on children and adults of growing up

within the context of addicted parents. It also provided a clear link to the emerging broader mental health field of trauma. Twenty-five years later, all of these contributions are part of theory and practice in both mental health and addiction.

Bill White: Do you see any signs of resurgence of this movement?

Stephanie Brown: I do see it and am relieved and grateful. As I noted, research in the ’90s validated what we had described in the ’80s. Today, there is an established research base to support the return of this movement in a much quieter form. Back then, we were emotionally intense; today, we are thoughtful and mature, or more so. The re-emerging movement today has more wisdom, but even more importantly, it has the scaffolding and the bones. There’s a structure now, coming from the wide acceptance of the idea “ACOA” and the label.

When we first said it, we knew it was true to our experiences. It was a new idea based on our experiential truth, which was rejected by many in positions of authority. This rejection was exactly what children of alcoholics had grown up with. You didn’t dare speak about it or you would really be rejected, criticized, or punished. But now, it’s accepted. You can say “I’m an ACOA,” and people will nod. Or people will seek therapy, identifying themselves as “ACOA,” and expect to receive help from a professional who knows what that means. Plus, a Big Book for ACOAs was published, and 12-step groups for ACOA are starting up again, as I mentioned earlier.

Bill White: In 1999, you published a book with Virginia Lewis that virtually transformed my own understanding about family recovery from alcoholism. Could you share with our readers how the book came to be written and some of its major conclusions?

Stephanie Brown: The book came at the end of a ten-year research project that Virginia and I undertook in 1990 to study the process of recovery for the family. I had always wanted to know what happens to the whole family when the drinking of one or both parents stops. We asked the same main question I had asked previously: is the process of recovery for the family similar to the process for the individual, and do the stages of active addiction and recovery I identified for the individual hold true for the family? We discovered pretty quickly that these stages do hold true and that they are a good guideline for understanding what happens with recovery growth following abstinence.

We realized we needed a different kind of model to understand the processes involved for the family. So, we developed a matrix in addition to the linear, sequential stage model. Through the matrix, we included domains of experience along with the stages of family change in the academic book that was published in January, 1999. The domains of experience allowed us to look at the environment and family system in addition to individual experience. The environment includes the context and atmosphere of family life in which we all live every day, but rarely think about or acknowledge. We looked at the atmosphere, the mood, the tone, the feeling, the emotional experience of living within the addicted family as it transitioned into recovery and beyond. We quickly identified trauma as an organizing theme for the change process.

Bill White: Yes, you used the phrase "trauma of recovery" that just stunned me when I first read it.

Stephanie Brown: By 1994/95, we were well into analyzing family data and clearly saw that the experience of trauma, so starkly evident during active addiction, continues in the beginnings of recovery. Most people expect that when the drinking stops, everything is going to be fine, and it isn't. It isn't for the individual, and it definitely isn't for the family. New kinds of problems actually emerge with recovery, totally unexpected because no one knows what to expect with abstinence, and the family members do not know how to operate without the drinking.

The family system in active addiction achieves homeostasis by adapting to the pathology of addiction. The family system works during active addiction to maintain the status quo, but when you enter active recovery, those mechanisms no longer work. And, there are no family system mechanisms yet developed to support healthy living or healthy relationships. That leaves the family in the beginnings of recovery without structure to nurture and support the health of family members or the family as a whole. There's a vacuum in the system, which often creates more trauma—new trauma—which we labeled the "trauma of recovery." Clearly, this vacuum is a time when the family needs much greater external support to help "hold" them in their new recovery process. The transition from exiting formal treatment to achieving stable family functioning is still a huge vacuum for many families.

We found, sadly, shockingly, that children are often more traumatized in the beginnings of recovery than they were during active addiction. The traumas of new recovery often involve abandonment by both parents as the

parents are told to focus on their own recoveries. It used to be, in the ’80s and ’90s, that both parents might be instructed to go to meetings to focus on their own recoveries, and, in essence, not to worry about their children, which is a huge problem. We’re seeing corrections in that model as parenting and the importance of continuing, or starting, a new focus on your children is now a part of treatment programs. Our research families—the adults and many of their children—told us that the children felt initially abandoned and lost with recovery for their parents. They didn’t understand what was happening, and many were frightened. They knew their parents were supposed to be doing something that was healthy and good for the parents, but many kids were left to fend for themselves. One young adult told us he felt guilty having needs as an 11-year-old with newly recovering parents because they were working so hard to be sober, and he didn’t want to be a burden to them.

Continuing our summary of the research design, we explored the environment, the family system, and individual development as three domains of experience. To assess changes in these over time, we did a three-hour live, videotaped interview with families, and a number of paper-pencil tests of family system function. We analyzed the interviews word-by-word to determine the stages, key issues, and themes that occur for the family and family members in recovery. We also tracked developmental process in each domain. The data and the books describe what is “normal” in family recovery and how to assess family movement, process, and points in each domain where a family or individual can get stuck.

Bill White: You’ve proposed that the roles, rules, rituals, and other homeostatic mechanisms that allow the addicted family to function must collapse and be replaced in the recovery process, and you’ve recently talked about the need for what you call scaffolding that can support the rise of a new family process. What happens if families don’t have that kind of scaffolding?

Stephanie Brown: Most families in recovery have not had that scaffolding, which means external structures of support. In the early days, family members were viewed as “support people” for the addicted person, an extension of “codependent” family dynamics. In essence, they were expected to become the “scaffolding” for the newly recovering addicted person. It’s only recently been recognized that family members need their own separate recoveries as individuals, and that they must “detach” from their unhealthy involvement with the addicted person. This is of course what

Al-Anon teaches. But this is tricky to understand. It's easy to think that family members are not supposed to care about others in the family. It's another paradox: family members can be supportive of others' recovery as long as they have their own, and that their own individual recovery comes first. What needed to change was the expectation that family members would continue to abdicate their own needs, as they had done during the active addiction, to watch out for the needs of the recovering addict.

Families who participated in "family programs" during the '80s and '90s were provided some degree of "scaffolding" during the course of that treatment, but not much because they were not the "identified patient." As many told us in the research, they felt important before the addicted person entered treatment, and unseen as soon as the addicted person was in treatment. Structural supports, including education, recovery planning, and support people, were only available to the addicted person post-treatment.

There were some pioneer programs, such as the children of alcoholics services provided at the Betty Ford Center in Palm Springs and a few family programs that provided education and support for family members' recovery. But there is a vacuum in understanding the need for continuing focus and services to address the primary needs of all family members in transition and early recovery.

The 12-step programs of AA, NA, and Al-Anon have always provided the "scaffolding" of individual support. These programs help people tolerate and survive the vacuum in the family system that occurs when the pathology of the addiction-organized family system collapses with the onset of recovery.

Bill White: It poses the question of what the ideal scaffolding would be like that could support recovery.

Stephanie Brown: I think we understand much better today that the family encounters a vacuum on entering recovery with or without formal treatment or outpatient therapy. This vacuum within the family, and the same kind of vacuum in the community—the neighborhood, town, city, work, school, and social environments—is a significant problem. Current treatment ideas and formats could be extended into something quite wonderful. The treatment center could expand its focus to include the care of families and extend their responsibility beyond what is now included in treatment into a process of sustained continuing care for the families they serve. As people leave treatment, there would be a much stronger "hand-off" to professional and peer-based supports, including alumni groups and mutual aid groups. The

idea of a recovery coach is growing now, which I think will be a tremendous help to individuals and families. The notion of a recovery coach emphasizes the necessity for continuing care and reduces the "dropping off the cliff" experience that has previously characterized family experience. I hope treatment centers will become more active in support of their patients in the months and years following the first treatment experience.

Bill White: You see part of that support coming from the treatment center, but a great deal of that support also coming from the larger community itself.

Stephanie Brown: I would like to be able to see family support resources developed in the larger community by treatment centers, and I think this could begin by mobilizing their alumni as a family-focused recovery support resource.

Bill White: There's been a recent rise of new grassroots recovery community organizations and recovery community centers. Might these be a source for long-term family support?

Stephanie Brown: Yes. What is necessary is a "holding" environment for the family—one that is active rather than passive—a support network for people post-treatment and for people who haven't been in treatment. The recovery community is beginning to organize supports for individuals and families beyond 12-step meetings that can support recovery as part of broader life in the community.

Bill White: From your studies, Stephanie, how long does that support need to be provided to families?

Stephanie Brown: I would say a minimum of a year. What I envision is the apprentice model we discussed earlier—that people who use the supports will pass on their experience to newcomers leaving treatment centers, on referral from a therapy experience, or simply entering recovery on their own. It's probably the case that most people who find recovery have not been in formal treatment programs or even any kind of therapy. Thus we need to conceive of "community supports" as a loosely organized network separate from any one treatment center or person. Ultimately, community supports could be part of community medical centers or other kinds of local

educational and support services that currently exist, such as the widely available community support networks for cancer patients.

Bill White: If those sanctuaries of support were embedded in the community, there wouldn't have to be a finite time period attached to it; families could be supported almost across the family life cycle.

Stephanie Brown: You are correct, and I wouldn't want to put a timeline on such support. The developmental model functions according to need and process, not time. Individuals and families have varying needs for support and professional help at varying times throughout their recoveries; people with 12, 15, 40, or more years of recovery may find a need for new or renewed support. Basically, the need for recovery support never ends.

Bill White: When I first read the book you and Virginia Lewis co-authored, what struck me was you talked about family recovery following treatment, not in terms of days or months, but in terms of years. None of us in the field at that time had that kind of vision.

Stephanie Brown: I think that's correct. That's where the developmental perspective is helpful. The normal process of recovery for the individual and family is not all forward progress. Normal development is back and forth, not always just straight ahead growth. Periodic problems, or even ongoing struggles, are normal and expected as part of healthy growth, so they should not automatically be interpreted as a problem with recovery. Not only do individuals and families look and feel worse at the beginning of recovery and as they move forward, but the process itself—a deepening of memory and emotional understanding—will often create pain and conflict that can be misinterpreted as pathology rather than part of a growth process. The signs of potential relapse and the signs of significant growth are not always easy to distinguish. The same difficulties that can lead someone to relapse can also lead to a deepening of the recovery experience, just as the emergence of pain, conflict, and struggle in recovery can be a sign of progress as often as it can be a sign or warning of relapse potential. Years of recovery growth will hopefully provide a healthy foundation to enable people to tolerate deeper emotional work—often dealing with traumas from the past.

Bill White: Over the years, you've had an opportunity to consult with treatment programs in the development of family programs. How would you describe the state of family treatment and recovery support today?

Stephanie Brown: Treatment centers are still primarily focused on the addicted individual. They have not been able to add a family focus that allows family members to also be viewed as identified patients. They still are looking at the family as appendages to the addicted person, which is a huge problem in my perspective.

Bill White: Your work has enhanced understanding of the intergenerational nature of alcohol and other drug problems. Have you envisioned how such intergenerational cycles might finally be broken?

Stephanie Brown: I think we've started to name and describe what happens in addicted families across generations, which is helping us understand family addiction and the complexities of family recovery. And I think we are poised to move beyond our current focus on the genetic and neurobiological influence on intergenerational transmission of addiction to include exploration of the larger psychological and social processes involved. We need more family research to understand the transmission process and the kinds of family and community support processes that can influence these cycles and positively disrupt them. We need to help families who have intergenerational vulnerabilities understand family addiction processes and integrate recovery as an integral part of the family lifestyle and identity. We will not always prevent addiction because we don't know how to prevent it. But by intervening and supporting healthy family systems, we may someday be able to have an earlier, bigger impact on prevention.

Bill White: Have you found any evidence that children in recovering families who go on to develop a problem themselves have a better prognosis for recovery?

Stephanie Brown: Yes. We were so lucky to interview a number of families in which the adult children were already in their own recoveries. Their parents had entered their recoveries when these young people were still children and adolescents; we could see and hear the impact on them of experiencing recovery while they were still young and living at home. They told us they saw the path ahead. They lived out their own addictions and entered recovery at a young age. Some told us they wanted to join the recovering family now established by their parents, and they had to pursue their own individual recoveries to do so. It's important to remember that we're talking about small numbers of research subjects. We did see

generational recovery, but we need more research and more subjects to confirm our findings.

Bill White: Treatment administrators lament that they can't provide family programming because no one's paying for it at the present time. I'm wondering what kind of supports could be provided to families that wouldn't be contingent upon either public or private funding?

Stephanie Brown: We need to move toward community models to support families—the use of alumni on-site during active treatment, the use of alums and volunteers after treatment. The idea of volunteers is not new, but it needs to be valued, promoted, updated, and organized. I also think it would help if treatment centers could deeply understand the concept of the family as patient and build volunteer networks from this basis.

Bill White: There is a lot of talk today about peer-based recovery support services, but we haven't fully developed the idea that the peers could be families.

Stephanie Brown: That's beautifully stated, and I think it is vital. I don't think there's any other way for us to proceed. Therapists, such as myself and others, who are schooled in understanding recovery and understanding addiction and mental health—the integration that I represent—can come in at various points over time and as trauma issues surface that create the need for professional services, but this is a minor role in the greater scheme of looking at family recovery support over time.

Bill White: That's fascinating. You're describing the role of the treatment professional as not the first line of support, but as the safety net. That's a radically different view of the role of the treatment center and the private therapist.

Stephanie Brown: I don't think we're going to proceed otherwise. For treatment centers to lead the provision of family support, they must move beyond a fixation on money and billable services and look to how family support can be mobilized in the larger community. The fee-for-service system cannot provide an adequate level of family support over the course of the family recovery process. Some of the centers now charge a modest fee for family programs, for children's programs. I think that's a very important

and valid idea, but ways have to be found to also extend that support into the community itself.

These professionals are vitally important at key points in an ongoing process. But they are parts of a bigger picture. We need to raise the value we give to peer-based and other no-fee supports. It might be helpful to think about "global recovery" in addition to local, community, and treatment center support. The internet offers enormous potential for constant support 24 hours a day anywhere in the world. I don't advocate that online recovery support ever replace personal human contact, but the internet is a fantastic resource for broad, quick coverage—filling the vacuum that people feel at various points in their treatments and recovery.

The treatment world cannot bear the costs of providing fee-for-service support over time in recovery for the individual or the family. Some centers charge a fee for family and children's programs, which is important and necessary, but we need to think beyond fee-for-service to the notion of community recovery if we hope to understand and facilitate a long-term view of family recovery.

Bill White: Stephanie, let me take you to another area of recent interest for you, and that's recovery support services for people in prison or who are re-entering communities from prison. How did your interest in this develop?

Stephanie Brown: This has been a wonderful gift to me. A few years ago, I received a letter from a woman telling me how helpful my book *A Place Called Self* had been to her in prison. Months later, I received another letter from a different woman who was still in prison, also thanking me for that book. I was touched deeply and wondered "what's going on here," because I had never been active in the prison world. A colleague and his wife, with whom I'd consulted, developed a treatment/recovery center for the homeless and ex-prisoners from the California State Prison System. In 2009, he received a large grant to train incarcerated felons to become credentialed addiction counselors within the prison system. What an idea! Many of these prisoners have life sentences without eligibility for parole, so they will be working inside the prison.

I was fortunate to be part of that training program, working with 50 male prisoners on the developmental model and children and adult children of alcoholics. The room literally vibrated when I started talking about COAs and ACOAs as these men recounted their own childhood experiences, which they then connected to their lives of crime. There was an intense emotional bonding in the room as I described the painful, traumatic experience of

living with parents and family who are out of control, abusive, and violent. Many made instant connections in the context of my naming and validating the trauma and its devastating impact on children. It was clear from their faces and input that the idea "children of alcoholics" had opened something deep within and they felt understood, many for the first time.

Like the experience I told you about in Poland, this was another of the most powerful emotional experiences of my life. Most of these men went on to take and to pass the licensing exam a few months later.

Over the last year, I've worked with Dr. Ross Ziegler, the founder of Escalade Recovery Foundation. His Empowerment Services Project, within the broader organization, is providing financial support to bring *A Place Called Self* and other recovery materials to people around the country, or world, who are coming back to their local communities from prison. Here you see the value of support that enables safety and self-reflection within the context of peer-based or professional services. We've got a very exciting project with Rediscover in Kansas City, an outpatient agency that provides therapy to female ex-prisoners and parolees. It's been thrilling to talk with them about their experiences and to receive their warm letters of gratitude for *A Place Called Self*. This is such a marvelous linking between a community agency, a foundation, and women in recovery.

Bill White: Stephanie, in addition to this thread of trauma that permeates so much of your work is the role of spirituality in addiction recovery. How have your views on this role changed over the course of your career?

Stephanie Brown: Now, this is not an easy topic. My views have changed over time as I've increased the depth of my personal and professional understanding of spirituality and worked to maintain my commitment to be open to new learning and experience. I have come to look at spirituality within the developmental frame, the integration with mental health theory, and my theoretical interpretations of AA experience as I have come to understand AA over many years. I see spirituality as an acceptance of fundamental human dependence. All human beings need a key attachment, which is usually parents. The addict forms a similar attachment—a core dependence—to alcohol, other drugs, food, spending, or even the internet now. That is addiction, a faulty attachment. With abstinence and recovery, the addict ideally transfers this faulty dependence to AA, a treatment program, or simply objects that represent recovery, such as the Big Book or meetings. This new dependence, formed within the context of 12-step recovery, is usually concrete. Soon, as recovery development proceeds,

individuals begin to define their own personal concept of a Higher Power, which may become more abstract over time. Of course this is paradoxical. You create the Higher Power to which you will relinquish control!

In our Family Recovery Research project, we found that people who had grown up with positive religious experiences, or who embraced positive religious experience in recovery, had the same kind of process in the development of their dependence on something greater than the self. We found that other people, who did not have prior positive religious experience, also came to an understanding of something higher than the self. Their concept of spirituality evolved in the transfer of the source of power out of the self onto something greater, even if it remained undefined.

Mostly, we saw that people were able to find something positive in their definitions of something greater. We also found that some people shifted their dependencies on substances to an addiction to something else, which is common and certainly part of the beginnings of recovery. People may turn to food, TV, or a problematic substitute for the original addiction, which temporarily holds them as they stabilize in solid recovery and contemplate the need for a Higher Power.

We determined that change was hardest for people who didn't have a new healthy dependence, including a power greater than the self, because their source of power remained within the self. That reinforced their old beliefs in individual power and will and made "letting go" extremely difficult.

Bill White: You've been recently applying the concept of recovery to our whole culture, suggesting among other things that we as a culture are out of control, have lost our sense of limitation, and are prone to all manner of excess. Could you provide any highlights of what we could anticipate from your next book?

Stephanie Brown: American culture was formed in the 1600s with a basic belief in the power and entitlement of the individual. American identity and American character were formed on a sense of privilege. Americans saw themselves as the chosen people, entitled to this new land and to the rest of the continent. This identity is similar to the kind of personal identity and beliefs that form with addiction—grandiosity and entitlement without limit. The addict believes "I am not an addict; I can control my use, and I can have what I want." In essence, "limits don't apply to me."

Westward expansion proceeded through the 1700s and 1800s and the beginnings of the 20th century. But by the 1950s, the end of territorial

expansion occurred, and colonialism became unpopular. The United States was faced with the reality of geographical limits for the first time, but we did not have a national or cultural identity that accepted limits.

Then along came cyberspace. By the 1970s, ’80s and ’90s, cyberspace provided a new territory without limits. Cyberspace became the new “frontier,” the new focus of expansion. As far as we know, cyberspace is indeed unlimited, but human beings quickly had to face human limits: we cannot go as fast or as endlessly as cyberspace and technology. Human beings must come face-to-face with human limits.

But instead, in the last 20 years, our culture has become out of control. The beliefs in entitlement, the grandiosity of no limits, and the realities of loss of control now characterize American cultural identity and behavior. I’m writing about a culture addicted to speed—going fast—driven by its denial of limits and a belief that we are always moving forward. There must be only progress and only success. We need to slow down, but slowing down is failure. This is just the tip of the story.

Bill White: From what you have described, it seems like there might be a real appetite for this recovery concept within the larger culture in the coming decades.

Stephanie Brown: Absolutely. In the last three months, the *New York Times* and other news sources are full of articles describing the out of control culture. The popular press is picking up on this “new idea” and it will soon be, I hope, a serious subject of concern. I see that the principles of addiction apply to the whole culture, and an understanding of recovery can help us face it and deal with it. The “American way” is to slow down temporarily, to get control, and then jump back on board to ride the wave of “the next big thing.” This is the same dynamic that occurs with addiction: try to get control until you can be out of control again.

Bill White: Let me ask a few final questions. At a professional level, you’ve received many very distinguished awards for your work in the addictions field—the Bronze Key Award from NCADD, the Norman Zinberg Memorial Award from Harvard, and others. I know you also received a special award a few years ago from Health Communications for your contributions to the understanding of adult children of alcoholics. Could I ask what it has meant to you at a personal level to be recognized in that way?

Stephanie Brown: Oh, the words for this. I would say deep gratitude. I have functioned professionally for these nearly 40 years as an observer, standing in two fields—addiction and mental health—belonging to both, but always having one foot on the perimeter, or even radically outside, as I've been in psychology—watching and thinking. I have needed to ask "why" and I've needed to be able to explain—not all things, but many.

It's a feeling of deep gratitude for the acknowledgement. It's been reinforcement for me that the path I've been forging over these years is valid. The validation has helped me accept the loneliness I've sometimes felt trying to integrate what are often conflicting and opposing fields. The awards tell me that people understand and value what I'm doing, and for that, I am extremely grateful

Bill White: Given that isolation, how have you sustained yourself over these decades? This is a field that can devour people emotionally. To what would you attribute your ability to both sustain yourself and the quality of work you've sustained over these years?

Stephanie Brown: I love that question and it's tricky. I think that seeing myself as an outsider has been enormously helpful. It allowed me very early on to set limits and to say no so that I could maintain my focus. The traumas I experienced growing up in an alcoholic family have plagued me as well as helped me stay outside of things because I have always been wary of joining anything. I wanted to preserve my observer status for my own protection. I wanted to be the one who comments on the process rather than being lost in it, and that has helped me immensely. The outsider status helps with boundaries, which people have appreciated and respected even when they were also upset with me for what I wouldn't do or couldn't join. I see that I've had a personal need for several degrees of distance from the fields I have tried to interpret, sometimes challenge, and influence. But I do hope I've achieved a middle ground, more as a "participant-observer" than a pure outsider. I have been deeply involved with my own recovery, and in that sense, I am an insider.

Bill White: You've been a very prolific writer over the years, and I'm wondering if you have any advice for aspiring writers in the field, either in terms of the writing process or the process of getting published?

Stephanie Brown: My writing, since the beginning of my own recovery and professional career, has been about addiction, recovery, and trauma, with

both an academic and popular focus. Although my writing comes from a research base, both formal and clinical, I have shaped my questions from my own experiences and my own deep need to know. I have had a deep need to understand myself, particularly my childhood experiences, in order to heal and to become healthy. This need to know has been my "mission," which I feel as a gift. A lot of writers feel they have to write, and I am one of those. I have had to write.

I don't think you can advise people to go out and get a mission. It comes from within. It has been important to write what I know or what I've experienced for the kind of writing I do, the questions I've asked, and for seeking deep within for answers or direction.

Another key to good writing is being a good listener, cultivating the ability to listen to what others are saying concretely and at deeper, symbolic levels. As a therapist and a researcher, I've gained immensely in my capacity to listen to others and to listen to myself.

Getting published seems to be harder than ever. I cannot write to the audience, to what I think people want to hear. I cannot write formulas that will supposedly sell, which is what some publishers want. I have to write what I believe, though I still dream that my books will show up on the *New York Times* Bestsellers list. Hasn't happened, but I haven't been sorry about anything I've written, and that's a good place for me to be. If you've got a good idea, talk to other writers and look closely at publishers in your field. You may be able to submit a proposal directly, though many authors and publishers today suggest an agent. It's a complicated process to find and work with a publisher, but your good idea and good writing will get you started.

Bill White: You and I are both at a stage in our careers where it is natural for us to think about legacy and what we want to do with the time we've got remaining to serve the field. I'm wondering what that list would look like for you, the things that are your top priorities to get done?

Stephanie Brown: The book on speed, which has been very difficult to write, is still in process. It is very important to me, so I plug along. I am more naturally an academic writer, so I have struggled with this book to find the voice and the central threads to translate complicated theory into an accessible, popular work. Once I do finish, I may complete the academic version, which expands on the developmental model and its application to culture.

I don’t have an agenda beyond finishing this book, although I do hope to continue to contribute to the greater integration of mental health and addiction theory and practice over time. Ideas come to me, and I’m open to what might emerge over time. Often, a new book idea or a new direction of work, such as the prison projects or consulting on family recovery, comes out of the blue. I try to stay open so I don’t miss a meaningful opportunity and a chance to contribute. I see myself, as you say, in service: speaking, training within the apprentice model of passing on knowledge that I have developed, taught, and continued to learn through my own personal and professional experiences. I am sometimes chagrined by my sense of continuing vulnerability—what I don’t know and what I don’t know I don’t know. But this reality has also given me my most deeply meaningful experiences. When I think about what has been the greatest gift I’ve received professionally, I think it has to be how moved I feel when I hear people’s stories of surrender—what it was like and what happened. I am full of awe.

I have always worked with patients in my own private practice, which is one of the most privileged and special relationships I can imagine. I plan to continue my direct work with people in this capacity as well as consulting and teaching. I have no desire or plans to “retire.” What could be better than what I’m doing? I have long considered myself the luckiest person in the world, given the personal opportunity to “see what I couldn’t see” and “know what I couldn’t know.” I hope I can continue on this life-affirming path.

Sometimes, facetiously, I say that one of my greatest achievements of these last 40 years is to have passed the point when I could die young. That really says it. I am one of those fortunate people who got to recovery, and it has blessed me ever since.

We haven’t touched too much on my personal life, but I’d love to say how much I’ve been blessed by my long relationship with my husband, our daughter, and now, our son-in-law and two new adorable granddaughters! I am immersed in this utterly loving and wondrous experience and see that family life will also continue to nurture and inspire me and to top my “list” of what’s ahead.

Bill White: Stephanie, thank you for all you’ve done for the field, and thank you for this very engaging interview.

Stephanie Brown: Thank you so much, Bill. It’s been absolutely wonderful.