2020

An Analysis of the Spiritual Narratives of Formerly Observant Jews in Recovery

Matthew Milstein
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Matthew Milstein

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Susan Marcus, Committee Chairperson, Psychology Faculty
Dr. Sandra Rasmussen, Committee Member, Psychology Faculty
Dr. Barbara Chappell, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

An Analysis of the Spiritual Narratives of Formerly Observant Jews in Recovery

by

Matthew Milstein

MS, Walden University, 2011

BTL, Ohr Somayach Tanenbaum College, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

February 2020

Abstract

Addiction is a world-wide problem, and 12-step recovery programs are the most popular intervention, which incorporate a spiritual message in the recovery process. However, little research has explored how spirituality is experienced, and the meaning it has for individuals leading up to addiction, during active addiction, and in recovery using the 12-step model. Thus, this qualitative research study was conducted to explore the spiritual narratives of formerly observant individuals raised in the Orthodox Jewish community, who used a 12-step recovery program to recover from addiction and maintain sobriety. Cognitive dissonance theory and faith development theory were used to identify the stages and conflicts of spiritual development along with semistructured interviews of 8 participants. Thematic analysis revealed turning points in the spiritual narratives (childhood trauma, rebellion/downward spiral, addiction, early recovery and sustained recovery), and 6 themes emerged using in vivo coding: religious not spiritual (childhood education), pretending (loss of interest and trust), rebelling (delinquent behaviors), darkness (active addiction), rebirth (early recovery), and harmony (sustained recovery). The narratives revealed that spirituality was lacking in their rigid religious upbringings, and that spirituality in recovery is perceived as dynamic and positive. The findings of this study may be used to develop preventative measures and intervention strategies (e.g., community-awareness seminars, educational workshops) for practitioners, educators, and the families of individuals raised in the Orthodox Jewish community who are struggling with addiction, or potentially heading toward active addiction.

An Analysis of the Spiritual Narratives of Formerly Observant Jews in Recovery

by

Matthew Milstein

MS, Walden University, 2011

BTL, Ohr Somayach Tanenbaum College, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

February 2020

Dedication

I would like to dedicate this work to my wife, the love of my life, Shani Milstein. You have been by my side through this entire journey, and my success is a direct result of your constant encouragement and sacrifices over the years. I am truly blessed to have you in my life and hope to always appreciate your role as my wife, best friend, and awesome mother of our children. May G-d continue to bless every aspect of your life, and may you continue to be a blessing for all the lives you have touched with your smile, warmth, sincerity, compassion, and boundless love.

Acknowledgments

I would like to take this opportunity to acknowledge Hashem as my Higher Power in helping/guiding me along this journey, and all other journeys that have, and will continue to make up my life. I sincerely acknowledge the continued love and encouragement from my wife Shani, my two daughters Racheli and Yaeli, my parents, family, and friends have made it possible for me to complete this dissertation. I gratefully acknowledge my chair, Dr. Susan Marcus for her ardent support, patience, advice, and feedback from the beginning of this dissertation journey. I thankfully acknowledge Dr. Sandra Rasmussen, Dr. Barbara Chappell, the IRB, and the Form and Style department for their reviewing my work and providing valuable feedback.

I am grateful for all the participants who joined this study, and for individuals who distributed flyers. I'm also grateful for peers who offered advice for collecting and analyzing data.

Finally, I sincerely acknowledge the creators of good music, good food, and technology who provided me with energy, comfort, and peace of mind – that I desperately needed throughout this study.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Only in the past 200 years has the problem of substance abuse and addiction become recognized as a social issue in need of effective interventions. Currently, the most popular intervention is a combination of 12-step work and fellowship (Ferri, Amato, & Davoli, 2009; Megura, Cleland, & Tonigan, 2013). The 12 steps focus on personal spiritual growth and character modification, and the structure of the recovery path provides a social format for fellowship, support, and accountability (Alcoholics Anonymous [AA], 2001; Kelly, Stout, Magill, Tonigan, & Pegano, 2011). Additionally, research has identified spirituality as a key element in recovery, as it produces positive mental health outcomes and works as a protective barrier against relapse (Galanter, 2006; Pardini et al. 2000; Zemore, 2007). Spirituality significantly helps with addiction prevention and recovery efforts (Kelly, Stout, Magill, & Tonigan, 2011; Laudet, Morgen, & White, 2006).

This study involved a narrative approach to examine the lives of addicts in recovery in a narrative arc of three temporal sections: life before addiction, life in active addiction, and recovery (Reissman, 2008). This study explored the narratives of addicts, across all three sections, focusing on their experiences with spiritualty and the meaning or meanings they attributed to those experiences. The specific target group for this study was individuals who were raised in Orthodox Jewish communities.

This study adds to what is currently known about addiction risks, and protective elements, through documenting the successive spiritual journey of individuals with substance use disorders. The findings of this study can be used to develop educational

workshops, and intervention strategies, for increasing spirituality and/or identifying resistance to spiritual growth. These applications will be discussed in further detail in Chapter 5. Major sections of this chapter include the background of the problem (a summary of existing literature with identified gaps), followed by the purpose of the study, research questions, identifying the theoretical frameworks, and the nature of the study. Definitions, assumptions, scope of delimitations, limitations, and significance of the study are reviewed.

Background

Results from the 2015 National Survey on Drug Use and Health showed that 21.7 million Americans (8.1% of the U.S. population) ages 12 and older needed treatment for problems relating to drugs or alcohol (Substance Abuse and Mental Health Services Administration, 2016). Additionally, comparison of data over 2002-2015 revealed an increase in illicit drug use. Although this is largely due to spikes in marijuana use, both heroin and methamphetamine abuse have been increasing as well. Prescription drug abuse has plateaued and cocaine (including crack) abuse has been decreasing. Alcohol and illicit drug abuse cost the United States over $400 billion annually due to crime, lost work productivity, and health care (National Institute on Drug Abuse [NIDA], 2017).

Currently, there are several interventions used for addiction recovery including self-help groups, cognitive behavioral therapy, and motivational interviewing (Carroll et al. 1998; Longabaugh & Magill, 2011). Locations where recovery services are offered include residential treatment, partial hospitalization, intensive outpatient, outpatient, and group meetings. The most popular and longest running self-help groups, known as

anonymous groups (e.g., AA and Narcotics Anonymous), focus on 12-step work and fellowship. They are identified as spiritually-based recovery programs that can be found throughout the world (AA, 2015), with several meetings offered every day of the year. An Internet search of "meetings near me" will list several sites (e.g., addiction.com) where one can find information on meetings worldwide.

Along with these programs, spiritual beliefs and practice can act as a buffer against substance abuse and high-risk behavior (Bonelli & Koenig, 2013). Research continues to provide evidence that spiritualty has a causal link to recovery from addiction (Schoenthaler, et.al. 2015). Spiritual growth generates stronger commitment to fellowship, greater perceived support, optimism, and increased coping for daily stressors (Pardini et al. 2000; Zemore, 2007). Recovery and spirituality have a reciprocal relationship; where spiritual growth enhances the recovery process, the length of time in recovery leads to increased spiritual growth (Laudet, Morgen, & White, 2006). However, the actual mechanics of religious/faith development and the meaning these have for addicts in recovery has not been fully understood (Blakeney, Blakeney, & Reich, 2005).

The founders of AA were Christians and members of the Oxford Group (Grapevine Writings, 1953; Mullins, 2010). Several aspects of 12-step work were based on Oxford Group teachings (e.g., surrendering to a Higher Power). The founders considered spirituality to be the essential element of 12-step work and wanted the program to be available for all individuals (religious and secular) struggling with alcoholism. This led to the use of ambiguous language as the 12 steps were developed—"Higher Power" and "G-d of our Understanding." The success and popularity of the 12-

step program has been attributed to its avoidance of promoting organized religion in favor of individualized spiritual growth (Rudy & Greil, 1988). Individuals in recovery will describe themselves as spiritual with little discussion on religiousness or religious faith, but the operational definition of spirituality remains vague and elusive (Pardini, Plante, Sherman, & Stump, 2000). Recovering individuals have a variety of definitions for spirituality including connecting with G-d (or a Power that guides the universe), spending time in nature, improving health, and relationships with others. Some view spirituality as an umbrella for constructs such as religion and personal growth. Others view spirituality and religion as polarized, where spirituality is identified as highly individualized (i.e., coming from within the individual, and religion is an organized system of beliefs and practices to which the individual must conform). In modern times the term of *spirituality* is applied more broadly to incorporate nondenominational and no-Theist spiritual perspectives (Moreira-Almeida, Koenig, & Lucchetti, 2014).

Another important aspect to consider in addiction recovery and spirituality is that negative life experiences (e.g., trauma, suffering, or long-term sickness) can affect an individual's core belief system and religious/spiritual affiliation (Exline, Yali, & Lobel, 1999; Gall, Basque, Damasceno-Scott, & Vardy, 2007). Negative beliefs about G-d can lead to guilt and doubts about religious teachings, predicting high rates of emotional distress with symptoms of depression, anxiety, suicidal ideation, paranoia, obsession, and compulsion (Weber & Pargament, 2014). Negative religious coping due to conflicts with G-d (e.g., feelings of getting punished by G-d) or the religious community are strongly associated with worse quality of life (Stroppa & Moreira-Almeida, 2013).

Although there is existing research on the benefits of spirituality in addiction prevention and recovery, along with the effects of spiritual experiences on quality of life, what is missing is the role of spirituality leading up to addiction, during active addiction, and the recovery process. Researchers have encouraged further investigation into social and motivational processes connecting religiousness/spirituality with substance-use disorders (Johnson, Sheets, & Kristeller, 2006) and mediators (e.g., social support or religious skepticism) between spiritual struggles and addiction (Faigin, Pargament, & Abu-Raiya, 2014). If spirituality is the core component of 12-step work, then negative experiences with spirituality prior to the recovery process may hinder the recovery process. Religious/spiritual struggles (e.g. feeling abandoned by G-d) have a direct negative affect on alcohol use and alcohol problems (through impacting motives for drinking; Johnson et al., 2006). For example, Abu-Raiya, Pargament, Mahoney, and Stein (2008) found that religious struggles among Muslims predicted higher rates of depression, angry mood, alcohol abuse, and poor physical health. Psychological, emotional, and physical pain are also strong predicators for relapse (Harris, Smock, & Tabor Wilkes, 2011). Individuals may use destructive methods (e.g., self-medicating) for coping with the alienation and loneliness caused by personal beliefs that are not accepted in their culture. This is speculation, and research is needed to more systematically examine the exact mechanisms in the relationship between religious struggles and recovery outcomes (Abu-Raiya, 2013).

Although research has found that spirituality, religion, and faith aid in the recovery process (and better mental health outcomes in general), these three constructs

have historically been lumped together, making it difficult to identify the mechanisms and effectiveness of each as a standalone construct (Carrico, Gifford, & Moos, 2007; Laudet, Morgen, & White, 2006). Therefore, this study was conducted to examine spirituality and recovery among Jews who were raised in Orthodox communities. The results may help address challenges with incorporating spirituality into recovery programs.

Problem Statement

Research is lacking in understanding the role of spirituality in addiction and recovery such as whether there is a reciprocal relationship and whether struggles with spirituality hinder the recovery process. There is also a lack of research on how recovering addicts perceive experiences with spirituality in their recovery, compared to experiences with spirituality in their childhoods and in active addiction. To address this lack of research, I explored the narratives of those from the Orthodox Jewish community in recovery.

Purpose of the Study

The purpose of this study was to explore the spiritual narratives of formerly observant Jewish addicts who maintained sobriety through the 12-step recovery program. The Orthodox Jewish community was chosen as the target group of interest for several reasons. Although significantly lower rates of substance abuse and addiction are reported in the Orthodox Jewish communities, as with the secular world, the rates are rising (Baruch, Benaroroch, & Rockman, 2015). The 12 steps have been adopted by treatment programs specifically developed for individuals from these communities (Loewenthal,

2014). Second, individuals who were raised in an Orthodox Jewish community have been immersed in a spiritual lifestyle, making it possible to examine the narrative of their spiritual histories before, during, and after recovery. Orthodox Judaism revolves around a strong commitment to spiritual growth through daily practice and study of Jewish law and literature (i.e., the Torah). These laws govern everyday behavior, setting life goals, and ideology. An individual who breaks from the system may be shunned, and left with little to no support, as the community has limited tolerance for individuals who do not keep Torah observance (Berger, 2015).

Through documenting the spiritual narratives of formerly observant addicts in recovery, themes emerged that identified their experiences with spirituality and what it means to them (Riessman, 2008). The findings of this study are presented in Chapter 4. Interpretation and application to the scholarly and professional literature is presented in Chapter 5.

Research Questions

The primary research question for this study was "What do the spiritual narratives of formerly observant Jewish addicts reveal about their experience in a 12-step recovery model?" The following subquestions were explored:

- How does the narrative begin?
- What are the turning points in the spiritual experience?
- What is the meaning of spirituality?
- How is spirituality experienced in the 12-step program?
- What is the present moment of the narrative?

Theoretical Frameworks

The theory of cognitive dissonance was used to clarify and understand the history of struggles, behavior, and decisions of individuals leading to addiction and through the recovery process (Festinger, 1957; Rodriguez, Neighbors, & Foster, 2014). Additionally, faith development theory was used to identify turning points in the spiritual narratives of the participants (Fowler, 1981). Turning points included experiences, behaviors, shifts in attitudes or beliefs, and knowledge gained.

Festinger's theory of cognitive dissonance (1957) postulated that there is a human drive for cognitive consistency (i.e., experiencing harmony in attitudes and beliefs). When inconsistent cognitions are presented, the drive for consistency causes feelings of discomfort, arousing the human mind to reduce the inconsistency (i.e., dissonance). The individual responds in one of three ways: changing an attitude, belief, or behavior; acquiring new information that overpowers the dissonance; or reducing the importance of an attitude or belief. Due to the nature of addiction and recovery, addicts are constantly struggling with inconsistencies between their behavior and what they want (or do not want) in life (Harrawood, McClure, & Nelson, 2011; Narimani & Sadeghieh, 2008). The life journey from being raised in an Orthodox Jewish community, dissociating with the community during addiction, and working through 12-step recovery is ripe with potential instances of cognitive dissonance and responses. The narrative method provided participants an opportunity to describe these inconsistencies.

Fowler's (1981; Fowler & Dell, 2006) faith development theory was strongly influenced by Erikson's stages of psychological development and Kohlberg's stages of

moral development. Fowler proposed that an individual's belief system evolves through six developmental stages. Life experience combined with gaining and implementing knowledge affects how individuals conceptualize a Higher Being and the role of this Being in their lives. Faith development theory aided in identifying the development of beliefs and attitudes toward spirituality of participants in their upbringing, during active addiction, and in recovery.

Nature of the Study

This qualitative study involved narrative analysis given that the complexity of the subject is "cloaked" and scholarly research is lacking (Reissman, 2008). Qualitative narrative analysis creates a context where the narrator (the interviewee) relates a story to an audience (i.e., the researcher). This format presented the opportunity to collect rich, thick descriptions of participants on their recovery journey. Narrative analyses have been used to explore different kinds of transcendental processes. For example, several researchers have found that the narratives of individuals suffering from chronic illness contained two tiers: on an individual level (the individual's personal experience with the illness) and on a global level (connecting this experience with the individual's identity and late modernity; Bury, 2001; Coats, Crist, Berger, Sternber & Rosenfeld, 2015).

Meanings that individuals attribute to their experiences are also comprised of several factors: multiple life experiences, physical and psychological development, relationships, and gaining knowledge (Riessman, 2008). The story telling process connects a chain of events, which helps to identify thought processes while minimizing assumptions (which are stumbling blocks for credibility). The life stories of addicts in

recovery are often full of extreme experiences, conflict, drama, and confusion. Relating their experiences in narrative form helped to clarify the nature of participant experiences, actual logistics, along with contributing to their self-awareness. The format of the narrative approach carried an additional benefit in that participants already had experience with telling their life stories at meetings and working through the 12 steps.

Spirituality was the key concept in this study. Individuals related their spiritual narratives (i.e., personal experiences with spirituality) and what spirituality meant to them through their upbringing in the Orthodox Jewish community, during their active substance abuse (addiction), and in recovery using the 12-step model. Invitation flyers posted at meetings and snowball sampling were used to develop a participant base. Potential participants went through a screening procedure and consent process. Finally, a semistructured interview was conducted, and the data were coded and analyzed through thematic analysis and in vivo coding.

Definitions

12-steps (12-step facilitation): An addiction recovery program created in 1935 by the founders of AA. Individuals work through 12 steps that focus on spiritual growth and character modification.

Addiction: A primary, chronic disease of brain reward, motivation, memory and related circuitry, characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with an individual's behaviors and interpersonal relationships, and a dysfunctional emotional response (American Society of Addiction Medicine, 2011).

Faith: The interrelated dimensions of human knowing, valuing, committing, and acting in order to find or give meaning to the conditions of our lives (Fowler, 1995). Faith is expressed through symbols, rituals, and ethical patterns.

Fellowship: A support network for addicts in recovery, usually in the format of self-help groups/meetings.

Formerly observant: Individuals who practiced Orthodox Judaism during their upbringing in the community.

Frum: Adherence to Orthodox Jewish law and customs.

Hashem: G-d, literally translated as "The Name" in Hebrew.

Judaism: Monotheistic religion that was founded in the Middle-East over 3500 years ago.

Orthodox Judaism: Sect of Judaism that demands strict adherence to Jewish law as interpreted by a historical chain of rabbinical scholars.

Rabbi: An authority who teaches and counsels members of Jewish communities. This individual is sometimes referred to as "Rav" or "Rebbi" (Rabbanim plural form).

Relapse: In the context of addiction, this is the reinstatement of the active addiction. Twelve-step groups define relapse as ending a period of sobriety/abstinence, except for a medical intervention (e.g., given a sedative during a surgical procedure).

Recovery: A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential (Substance Abuse and Mental Health Services Administration, 2015).

Slip: In the context of addiction, whereas a relapse is the complete reinstatement of active substance abuse, a slip is considered after having a period of sobriety, abusing a substance for a short interval and stopping.

Sobriety: Abstinence from alcohol and all other nonprescribed drugs.

Spirituality: The personal quest for understanding answers to ultimate questions about life, about meaning, and about relationships to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community (Moreira-Almeida, Koenig, & Lucchetti, 2014).

Spiritual narrative: An individual's reported history of beliefs, rituals, sense of transcendental connection, views of G-d, ethical implications, mystical experiences, and community or private religious practices (Moreira-Almeida, Koenig, & Lucchetti, 2014).

Substance use disorder: Current diagnosis listed in the Diagnostic Statistical Manual (DSM) 5, defined as continuing the use of a substance despite significant substance-related problems (American Psychological Association, 2013).

Torah: Divided into two parts—written and oral. The written Torah is comprised of 24 books (commonly known as the Old Testament), that document historical accounts, Jewish law, and ideology. The oral Torah expands on the written Torah through providing an in-depth review and clarification of the historical accounts, along with Jewish law and ethics that govern everyday life.

Yeshiva: School setting with a primary focus on Judaic studies.

Yetzer Harah: Hebrew translated as "the evil inclination."

Assumptions

I assumed that starting the narratives from participant upbringings significantly enhanced the understanding of their experiences with spirituality in recovery. I also assumed that current knowledge in the field of addiction and recovery (e.g., causes of addiction, common physical and psychological factors, relapse prevention issues, etc.) could be applied to participants in this study. Several assumptions also revolved around the integrity of the participants for the study. I assumed that participants accurately reported their narratives to the best of their knowledge and did not purposely distort their story. It was also assumed that the participants honestly reported that they engaged in 12-step work and maintained sobriety for the past year. Further, I assumed that individuals who engaged in the 12-steps and maintained sobriety for the past year were able to accurately report their experiences and meanings of those experiences more than someone who did not maintain sobriety over the past year.

Scope and Delimitations

Research has shown that spirituality is a positive component in resilience to addiction as well as aiding in the recovery process. Orthodox Jews are involved in religious practices daily, which means that individuals raised in these communities have a high probability of having experiences with spirituality. This study was focused on the timeline of experiences with spirituality throughout the lives of these individuals. Investigating participant experiences with spirituality contributed to existing literature on identifying precursors for substance abuse, resistance to 12-step work, and reasons for relapse. Participation was limited to individuals who were raised in an Orthodox Jewish

community and between 18-65 years old. Participants met the requirement of having a substance abuse in full remission DSM 5 diagnosis. Full remission was understood as complete abstinence for the past year (12 months).

Additionally, other theories were considered for this study but were excluded. Transformative learning theory, developed by Jack Merizow, proposes that individuals are involved in a continuous learning process that moves them through stages of development. Although transformative learning theory has been used to identify factors that aid in addiction recovery (Fair, 2006), it is focused on adult learning whereas this study includes childhood thoughts and experiences. Additionally, general systems theory, proposed by Ludwig von Bertalanffy in 1928, has been popularly used in studies on addiction and recovery, family/community relations, and spirituality. This study contains these components; however, the purpose was not on how these systems function but on identifying experiences and meanings attributed to these experiences.

Transferability is the ability to apply (transfer) research findings to other settings. Although individuals in this study have a unique upbringing, these individuals share several similarities with other populations including: negative experiences (e.g., history of being bullied, abuse, and/or neglect), addiction behavior (e.g., types of drugs abused, high-risk situations), biological factors, relapse factors, and ability to maintain sobriety through fellowship and successfully engaging in 12-step work (Baruch et al. 2015; Lowenthal, 2014; Vex & Blume, 2001). This study was intended to have a level of detail that would allow the findings to be applied to different populations.

Limitations

Narrative analysis carries the potential for several pitfalls that can limit its credibility. For example, narrative analyses involve positionality and subjectivity rather than objectivity (Reissman, 2000, p. 19). This means that this type of research puts aside "objectionable truth" in favor of perceived experiences and meanings the narrator attributes to those experiences. Another methodological question is how the researcher chooses when the narrative begins or ends, which means that boundaries in narrative analysis are influenced by researcher preference, research questions, and evolving theories (Reissman, 2000). Avoiding these potential pitfalls will be addressed in detail in Chapters 3 and 5.

Several aspects of the population used for this study also limited transferability. First, an individual's cultural upbringing plays a significant role in developing attitudes and life experiences. An Orthodox Jewish upbringing is different from other religious/spiritual contexts. This study was limited for individuals who were raised in an Orthodox Jewish community but used another recovery intervention other than fellowship and the 12-steps to maintain sobriety. Limitations in transferability were also due to other exclusion factors (i.e., younger than 18, older than 65, less than 1 year sober).

Further, several potential areas for bias were checked. First, I was raised in a secular home and became an Orthodox Jew as a young adult. As such, I did not have the positive and negative experiences shared by the participants in this study. Second, although I do not have a personal history of addiction, I have experienced the damage it

has done to my family. My experience working in a residential treatment center allowed for bias when interviewing the participants and analyzing the data. Several measures to minimize any such bias included member checking, triangulation of data, and creating an audit trail. These will be discussed further in Chapter 3.

Significance

Substance abuse and addiction have carried severe negative effects. Despite having several options for interventions and therapeutic environments, relapse rates continue to be high (Narimani & Sadeghieh, 2008, NIDA, 2012). This study contributed to what is currently known about addiction and recovery related to the role of spirituality leading up to active addiction, during active addiction, and recovery. There is a statement often said at the end of 12-step meetings, "Keep coming back, it works if you work it!" But it is important to consider what factors stop a person from "working it". The addict admits that substance abuse comes with severe negative repercussions, but there is still resistance to the recovery process.

Research has identified spirituality as a preventative measure to substance abuse, along with it aiding in the recovery process (Kelly, Stout, Magill, & Tonigan, 2011; Laudet, Morgen, & White, 2006). Thus, research is needed to identify which factors promote spiritual change, and determining when the change occurs (Zenmore, 2007). It is currently unknown why spiritual change in 12-step work is related to better outcomes. The role of negative experiences with spirituality in addiction and recovery is unknown as well. The findings of this study provide some clarity to these issues.

Over the past 25 years spirituality has become a popular subject addressed in research (Moreira-Almeida, Koenig, & Lucchetti, 2014; Bonelli & Koenig, 2013). In a meta-analysis of research published between 1990 and 2010 on religion, spirituality, and mental illness, Bonelli and Koenig (2013) found that only 41% of psychiatry journals focused on religion or spirituality even though 72% of articles over the past 40 years reported significant associations between religious/spiritual involvement and positive mental health outcomes. Further, AA has promoted spirituality as the key factor in maintaining sobriety since its creation in the 1930s. Yet there is still a need for further research on spirituality in psychiatry. Though this was not the scope of the study, the narratives of participants and findings in this study contribute to global research on spirituality beyond addiction and recovery.

Summary

This chapter introduced the global problem of addiction, 12-step work as an effective intervention, and spirituality as a key factor in addiction and recovery. The purpose of this study was to explore the role of spirituality in addiction and recovery. This was achieved through analyzing the narratives of participants who were raised in Orthodox Jewish communities, developed addictions, and used the 12 steps to maintain sobriety for more than 1 year. Two theories, cognitive dissonance and faith development, were used to guide interview questions and clarify aspects of participant narratives.

Chapter 2 identifies the literature search strategy and provides a literature review. Chapter 3 explains all aspects of the research design and methodology. Chapter 4 reports

the actual data collection and analysis process. Chapter 5 includes an interpretation of the findings and implications for future research.

Chapter 2: Literature Review

Introduction

The purpose of this narrative analysis was to explore the role of spirituality in the addiction and recovery of individuals who were raised in the Orthodox Jewish community. According to the NIDA (2012), addiction continues to be a growing global problem with high rates of relapse reported across current intervention programs. Spirituality can help avoid substance abuse and aid in the recovery process (Kelly, Stout, Magill, & Tonigan, 2011; Laudet, Morgen, & White, 2006). However, research is lacking on identifying the role of spirituality leading up to addiction and the role of negative experiences with spirituality in the recovery process.

Chapter 2 provides a review of the relevant literature. The database search strategy is presented and followed by a review of what was found. Major sections of the literature review include the history of addiction and treatment, the 12-step program (how it was developed, effectiveness, and proposed mechanisms of change), spirituality, and addiction in the Jewish community.

Literature Search Strategy

Peer-reviewed journals on quantitative and qualitative studies were searched electronically in Google Scholar, Academic Search Complete, Thoreau Multi-Database Search, PsycARTICLES, and PsycINFO. Key terms for the search included *addiction and Judaism, addiction in the Orthodox Jewish community, alcohol drug abuse and Jews, addiction and spirituality, spirituality and recovery from addiction, spirituality and 12 steps, spirituality and relapse, Judaism and 12 steps, effectiveness of 12 steps,*

effectiveness of Alcoholics Anonymous, effective interventions for addiction, history of addiction and recovery, causes of addiction or relapse, adolescent substance abuse, addiction and religion, negative experiences with spirituality, anger toward God, cognitive dissonance addiction spirituality, stages of faith development, and *narrative analysis in qualitative research*. Three government sponsored sites were searched: American Society of Addiction Medicine, NIDA, and Substance Abuse and Mental Health Services Administration. In addition to online searches, articles in Jewish magazines (Jewish Action and Mishpacha), and four books were reviewed: *A Theory of Cognitive Dissonance* (Festinger, 1957), *Narrative Methods for the Human Sciences* (Riessman, 2008), *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (White, 2014), and *Stages of Faith: The Psychology of Human Development and the Quest for Meaning* (Fowler, 1995).

Theoretical Frameworks

Cognitive Dissonance Theory

The theory of cognitive dissonance was developed in the 1950s by Leon Festinger. He proposed that there is a human drive to maintain a state of consonance (i.e., harmony between attitudes and actions; Festinger, 1957). Dissonance occurs when a decision is needed between multiple cognitive elements, each carrying attractive (or unattractive) characteristics. The two most common situations where dissonance is formed are experiencing a new event and exposure to new information. When dissonance is experienced, it is a signal that there is an error in the individual's system of beliefs, and the drive to alleviate the inconsistent cognitions commences (Gawronski, 2012). Three

possible actions relieve the dissonance: the individual can change an attitude, belief, or behavior to make the two opposing elements consistent; reducing the dissonance through acquiring new information that overpowers and relieves the dissonance; or reducing the importance of an attitude or belief. Festinger also identified three possible actions for reducing dissonance that is created specifically through social influences: changing a personal opinion, attempting to influence others, and attributing incomparability to others.

Research has used the theory of cognitive dissonance to explain attitudes and behaviors of individuals who engage in substance abuse and struggle with addiction. For example, Rodriguez, Neighbors, and Foster (2014) found that individuals who think about their religiosity experience cognitive dissonance, resulting in underreporting their drinking behavior. Self-help groups also recognize denial as a stumbling block and that admitting to having an addiction is crucial for recovery. Cognitive dissonance plays a role in both the denial and admittance stage. Feeling responsible for behavioral consequences acts as a catalyst for alleviating cognitive dissonance (Chiou & Wan, 2007).

This study included the theory of cognitive dissonance to guide interview questions, along with understanding the decisions and behaviors in the narratives of participants. Participants for this study were raised in Orthodox Jewish communities and had experiences that led them through active addiction and recovery. Their history of personal struggles, changing attitudes and behavior, and ability to maintain sobriety are clear indicators that they have experienced cognitive dissonance at several points throughout their lives.

Faith Development Theory

Faith development theory was developed by James Fowler in the 1970s. The theory postulates that an individual advances through six stages of spiritual development based on structural-psychosocial events (Fowler, 1995). The foundation and developmental aspects of this theory were influenced by Piaget's theory of cognitive development, Erikson's stages of psychological development, and Kohlberg's stages of moral development. Fowler placed newborns in a "pre-stage" called Infancy and Undifferentiated Faith (Primal Faith). In this pre-stage, the relational experience with a person's primary caretaker and environment influence trust, love, sensed threats of abandonment, and inconsistencies. Fowler used Piaget's "object permanence" to propose that a newborn's first pre-images (i.e., formed prior to language and concepts) of G-d are formed through awareness of self as separate from powerful others.

The six stages of spiritual development.

Intuitive: Projective faith (early childhood, toddler). The imaginative process underlying fantasy is unrestrained and uninhibited by logical thought. Children in Stage 1 rely on rich stories to provide images and symbols for their construction of self. Therefore, primary caregivers are immensely responsible for the quality of images and stories as guides for the child's imagination. Children should be encouraged to freely express images that are forming to promote positive images or help deal with distorted/destructive images. There is a danger in this stage of exploiting the child's imagination to reinforce taboos and religious expectations (Fowler, 1995).

Mythical: Literal faith (middle-childhood and beyond). Individuals in Stage 2 begin sorting out the real from the make-believe, seeking proof for claims of fact. Observances and beliefs that symbolize belonging to the community are undertaken. In this stage self-generated stories emerge to communicate experiences and meanings. But individuals in Stage 2 cannot step back from the stories and communicate their meanings in abstract statements. Fowler (1995) describes Stage 2 as being in the midst of a river, and unable to step out onto the bank (i.e., to reflect on the composite meanings of stories). There is a danger in this stage of developing over-controlling/perfectionist behaviors or a demeaning sense of badness, caused by mistreatment (e.g., abuse or neglect).

Synthetic: Conventional faith (adolescence and beyond). In Stage 3 the individual starts to think abstractly and has deep emotional investments in values and normative images. The individual observes certain patterns of meaning from life events and develops an ideology (a cluster of values and beliefs), which aid in forming personal identity and faith. Individuals in this stage have a perspective that is highly dependent on expectations and judgments of significant others. This leads to mirroring the responses and evaluations of significant others. Personal relationships are viewed on a deeper level and grow stronger. The individual's relationship with G-d becomes more important and there is a yearning for a G-d - Who knows and accepts the mysterious depths of self. The dangers in this stage are jeopardizing the autonomy of judgment and action due to enmeshment and/or overreliance, and the creation of nihilistic despair from interpersonal betrayals (Fowler, 1995).

Individuative: Reflective Faith (young adulthood and beyond). Through critical reflection and questioning, Stage 4 is considered a "demythologizing" stage. The individual forms a new identity marked by choosing personal/group affiliations and distancing from the previous value system. Questions that represent this stage include, "Who am I beyond my circle of friends or community?" and "What do these symbols/rituals mean?" There is a relocation of authority to making it within the self, where the individual will decide how important the values and judgments of others are. This leads to accepting the burden of responsibility for personal commitments, lifestyle, beliefs, and attitudes. The dangers in this stage are excessive confidence and narcissism (Fowler, 1995).

Conjunctive faith (unusual before mid-life). Having developed the ability to hold multiple perspectives instead of "either/or" logic, individuals in this stage break out of the strict constructs that were developed in Stage 4. There is a radical openness in recognizing that there are other "truths" while using learned tools to avoid self-deception. There is an appreciation for symbols, myths, and rituals in other faiths. This places the individual in a state of conflict: loyalty to the present order (institutions and groups) versus loyalty to the self. The danger in this stage is in becoming complacent due to its paradoxical understanding of truth.

Universalizing faith (very rare). In Stage 6 the individual overcomes the Stage 5 fear of sacrificing the self for what's perceived as the greater good. The goal is to promote an ultimate environment of an inclusive and fulfilled human community. Current social, political, and economic ideologies are considered shackles that prevent universal

peace and justice. Individuals in this stage exhibit a relentless fight for universalizing compassion. Driven by their transcendent moral and religious actuality, they are seen as extraordinary and inspirational. Fowler listed Gandhi and Mother Teresa as people who reached this stage (Fowler, 1995).

Summary of stages. The stages represent most of the population; however, there are adolescents and adults who exhibit the structural characteristics of earlier stages (Fowler, 1995). For example, adults can exhibit the "magical thinking" found in Stage 1, or the importance of reciprocity in fairness and justice, which governs human-divine relations found in Stage 2. Narrative analysis is an effective methodology for identifying and exploring an individual's trajectory in faith development (Streib, 2001). Through reconstructing and relating a narrative, the interviewee revisits traumatic/exciting experiences and reflects on conscious statements, which allows the interpreter to conduct a contrasting comparison with other narratives. Thus, faith development theory was used to identify and explain turning points in the spiritual narratives of the participants.

Literature Review Related to Key Concepts

Defining Addiction, Recovery, and Spirituality

Addiction is a disease of reward, motivation, and memory characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with behaviors and interpersonal relationships, and a dysfunctional emotional response (American Society of Addiction Medicine, 2011). Other terms historically used for addiction include alcohol/drug dependence, inebriety, having an "allergy" to a particular substance, narcotic addiction, and Jellinek's disease

(White, 2014). Individuals struggling with addiction have been labeled addicts, drunkards, hard cases, inebriates, alcoholics (alcohol), having "barrel fever," dope fiends (heroin), junkies (heroin), meth heads (crystal meth), cokeheads (cocaine), and crackheads (crack cocaine; White, 2014). Recently, addictions outside of substance use have been identified as "process addictions" (e.g., gambling and pornography addictions). The DSM 5 currently identifies alcohol and drug addiction as substance use disorder (e.g., opioid use disorder). The DSM lists several criteria for use disorders including compulsive use, cravings, problematic patterns, tolerance, and withdrawal (American Psychological Association, 2013). The strength of the disorder (mild, moderate, or severe) is based on the number of diagnostic criteria met. The DSM defines sustained remission as the absence of all criteria for a period of 12 months or longer, except for having cravings. Substance use disorder is different from substance abuse in that the former refers to compulsive use and the latter refers to the irresponsible use of a substance (Inaba & Cohen, 2014). Individuals working through the 12 steps and attending meetings use the term addiction and refer to themselves as addicts. Therefore, DSM criteria were used for inclusion participant selection, but the terms *addiction* and *addicts* are used throughout this narrative study.

In terms of prevalence of addiction and substance use, in 2015, the Substance Abuse and Mental Health Services Administration conducted a national survey on drug use and reported that 10.1% of Americans aged 12 and older used an illicit substance in the past 30 days. Primary substances abused were marijuana and prescription pain killers.

The survey also found that an estimated 20.8 million Americans aged 12 and older had a substance use disorder.

Causes for substance use disorder are categorized under biological or environmental factors. Biological factors include genetics, physiology, and the presence of comorbid psychopathologies (NIDA, 2014). For example, externalizing factors (e.g., drug abuse, mental illness, and antisocial behavior) are highly heritable (McGue, Irons, & Iacono, 2014). From a physiological perspective, continuous use of a substance reinforces the constant drive for reward (pleasure) through causing molecular changes in the brain. Further, there are two brain responses to addictive drugs: neuronal adaptations (homeostatic responses to excessive stimulation) and synaptic plasticity (connects drug-related stimuli with specific learned behaviors; Berke & Hyman, 2000). Research has also linked high rates of substance use disorder and co-occurring disorders including conduct disorder, antisocial behavior, and disinhibitory personality traits among adolescents (Krueger et al. 2002; Trezza, Baarendse, & Vanderschuren, 2014). Individuals suffering with serious mental illness (e.g., schizophrenia-spectrum disorder, bipolar disorder) predict high rates of substance abuse and relapse (Bahorik, Newhill, & Eack, 2013).

Environmental factors include familial and communal relationships, observations, and experiences (NIDA, 2014). There is a developmental course of substance abuse to substance use disorder caused by learned maladaptive thought patterns and behaviors. Children observe and learn family/peer attitudes and behaviors (e.g., parental/sibling smoking), which is described through social learning theory. Children raised in an

environment that promotes drug abuse (or where drug abuse is prevalent) are at high risk for developing substance use disorders (McGue, Irons, & Iacono, 2014). Other learned maladaptive thought patterns include impulsivity and hopelessness, which have been identified as strong risk factors for alcohol and substance abuse (Mackinnon, Kehayes, Clark, Sherry, & Stewart, 2014).

Child abuse is also prevalent among individuals struggling with substance use disorders, and the type of abuse is associated with other adverse behaviors as well. Childhood sexual abuse is associated with risky sexual behavior, physical abuse is associated with violent/aggressive behavior, and emotional abuse is associated with emotional dysregulation (Banducci, Hoffman, Lejuez, & Koenen, 2014). Child maltreatment (i.e., neglect and abuse) is associated with engaging in antisocial behavior at a younger age, which predicts higher rates of criminal activity, high risk sexual encounters, and substance abuse in middle adulthood (Horan & Widom, 2015). Research has shown a causal link between adolescent delinquent behavior (e.g., substance abuse and criminal activity) because of the inability of individuals to achieve positively valued goals (Kerig & Becker, 2015).

In addition to factors that lead to substance use, relapse is also a component of addiction, as the NIDA (2014) defines addiction as a chronic relapsing brain disease based on a reported high rate of relapse (40-60%) across all currently known treatment models. Relapse is caused by several factors including physical and emotional pain from withdrawal symptoms, social factors (unemployment, friends who are actively using, long stretches of leisure time, and high risk situations), psychological factors (high levels

of anxiety and depression, lacking healthy coping to daily stressors, impulsivity, low self-esteem, and learned helplessness), and familial factors (lacking family support, and conflict with family members; Narimani & Sadeghieh, 2008). A popular understanding of relapse is that is it triggered by "people, places, things, and moods" (i.e., associative learning or conditioned responses to drug-associated cues; NIDA, 2014).

SAMSHA defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential (2015). Addicts are considered to start the recovery process when they make an effort to maintain sobriety. Anonymous meetings give a 1-day sobriety chip to individuals who have maintained sobriety for the past 24 hours.

In a meta-analysis of research published between 1990 and 2010 on religion, spirituality, and mental illness, Bonelli and Koenig (2013) found a general lack of precision in defining differences between religion and spirituality. To avoid confusing the terms, this study will define religion, spirituality, and spiritual narratives according to Moreira-Almeida, Koenig, and Lucchetti (2014). Religion is defined as an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, Higher Power, or ultimate truth/reality). Spirituality is defined as the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationships to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community. Spiritual narratives (histories) are defined as beliefs, rituals, sense of

transcendental connection, views of G-d, ethical implications, mystical experiences, and community or private religious practices.

History of Addiction and Treatment

Alcohol and substance abuse have plagued mankind since antiquity. The use and abuse of mind-altering substances throughout history can be categorized into three areas: spiritual/religion, medicinal/therapeutic, and feeling good (Rosso, 2012). Beer and wine were thought to be elixirs of life, having supernatural properties (e.g., containing the spirit of a god). Within the realm of medicine, alcohol was considered a "cure all" remedy, used as anesthetics, sedatives, antiseptics, analgesics, digestives, antidotes, and purifiers. Historically, the most popular use of alcohol has been as a stimulant for feeling good (e.g., the ancient Greeks would have a symposium – a gathering for feasting, drinking, and entertainment). The Bible discusses Noah's inebriation upon exiting the ark after the flood. Other early civilizations used alcohol in pagan rituals and payment for services (e.g., patients paid for medical services with beer in ancient Egypt; 2012).

Opium was cultivated by the Sumerians, at the end of the third millennium B.C. (Brownstein, 1993). While opium was primarily used in spiritual rituals, it was also used medically as a pain reliever and sleep inducer, financially in trade, and recreationally (Hamarneh, 1972). Arab traders in the early 8th century A.D. brought opium to India and China, which eventually spread across Asia Minor and Europe. The 19th century witnessed the development of morphine and heroin - both highly abused in Europe and the United States, while opium abuse was still prominent in Asia. Cocaine was created

during this period as well, and its use/abuse was popularized through its ability to anesthetize, reduce fatigue, elevate spirits, and increase sexual desire (Allen, 1987).

While substance abuse has historically been recognized, only the past 200 years have witnessed the development of treatment models (Levine, 1978). Before this time, drug and alcohol abuse were frowned upon, and considered irresponsible behavior. The concept of addiction (i.e., the inability to control substance use) was unheard of before the 18th century. The word "addiction" comes from the Latin word *addico* translated as "giving over" (Alexander & Schweighofer, 1988). Historically it had a positive connotation as well (i.e., understood as devotion). The temperance and anti-opium movements in the early 19th century restricted the term "addiction" to an illness or vice.

The earliest known enacted preventative measure against alcohol abuse was in Egypt around 1500 B.C., where taxes were raised for individuals who were found excessively drinking (Rosso, 2012). The first known government sanction against both wine and hashish, was enforced by Egyptian King al-Zahir Baybars (1266-79) through the closure of taverns and brothels (Hamarneh, 1972). From the colonial period, up until the 18th century, the United States experienced a major increase in the consumption of alcohol.

Benjamin Rush, prominent physician who served as Physician General of the Continental Army, witnessed the birth of the United States as an independent nation. He recognized alcohol abuse among soldiers in the Continental Army (White, 2014). In 1784, Rush published the disease concept of alcoholism in a pamphlet titled *An Enquiry into the Effects of Spirituous Liquors Upon the Human Body, and Their Influence Upon*

the Happiness of Society (Rush, 1791). At that time, treatment for alcoholism included: substituting beer, wine, or cider for distilled spirits, using opium instead of alcohol, sweating, blood-letting, blistering the skin, purging (using laxatives and emetics), and inducing fright (White, 2014). Rush believed that success in maintaining sobriety would happen through religious, metaphysical, and medical influences (e.g., conversion to Christianity, witnessing the death of a drunkard, and cold baths).

Habitual drinking was popular, and it was believed that people drank because they wanted to, not because they had to (Hamarneh, 1978). During those times alcoholics filled courthouses and jails upon being arrested for public intoxication (White, 2014). Throughout the 19th century alcoholics and drug addicts were stripped of their freedom through incarceration, mandated to almshouses, or placed in inebriate homes/asylums (2014; Hall & Appelbaum, 2002).

Inebriate homes and asylums opened in the mid-1800s, with strong financial backing from state legislatures, religious and temperance groups, philanthropists, and patient fees (Hall & Appelbaum, 2002; White, 2014). These facilities housed drunkards and individuals with drug-related problems. Inebriate homes provided non-medical detoxification, engagement in fellowships, and moral development sessions. Most of the staff members were “wounded healers” (i.e., addicts in recovery). While the homes only provided short-term voluntary stay, the asylums often institutionalized patients from 1 to 3 years with moderate success rates. Boston’s Washingtonian Home reported a 35% success rate for patients sober a minimum of 8 years after they left the facility and the

New York State Inebriate Asylum received reports from families that patients were temperate well past 5 years of leaving the facility (2002).

The American Association for the Cure of Inebriates was formed in 1870 under the leadership of Dr. Joseph Parrish (White, 2014). The American Association for the Cure of Inebriates promoted the disease concept model of addiction and called for the development of inebriate homes/asylums throughout the country. During this time, proprietary addiction cure institutes arose, surrounded by controversy due to their promotion of miracle cures and promises to cure addiction (White, 1999). The most popular were Keeley Institutes (started by Dr. Leslie Keeley in 1879), that advertised a 95% success rate. Patients engaged in a 6-week treatment program where they enjoyed good food, exercise, a warm atmosphere, and fellowship. The Keeley Institutes witnessed explosive growth in the 1890s but swiftly closed as they were pulled into the collapse of all other addiction treatment programs by the start of the twentieth century. With no government restrictions, unrestrained advertising, and virtually no treatment programs, drug abuse/addiction rapidly spread across the United States (White, 2014; Musto, 1991).

The first 20 years of the 1900s witnessed several interventions by the U.S. government to control drug distribution (White, 2014). In 1905 Congress restricted the use of opium to medicinal purposes (this same year China started a campaign against opium use). While the Pure Food and Drug Act of 1906 did not restrict distribution of drugs, it did require accurate labeling of all patent remedies (Musto, 1991). In 1911 and 1912 multiple countries entered agreement to enact legislation that would control narcotics trade. The Harrison Act of 1914 placed a tax on manufacturing and distributing

opiates and coca products, and in 1919 the Supreme Court prohibited the prescription of these products for indefinite maintenance of addiction. Currently, the United States considers the possession of illegal drugs against the law. The charge is either a misdemeanor or felony, depending on the type of drug, amount, and circumstances of the crime.

The formation of AA and the 12 steps. Outside of government interventions, self-help groups and programs promoting abstinence from alcohol were created in the nineteenth century. In the early 1800s a Congregational minister by the name of Lyman Beecher sought to create a program to combat intemperance (Maxwell, 1950). Beecher gave a famous speech in 1825 where he defined intemperance as, "the daily use of ardent spirits." The American Temperance Society was born the following year, and by 1829 it had close to 100,000 members (1950; White, 2014). In 1836, the movement started to lose ground because it promoted complete abstinence from all drinks that could cause intoxication. Close to 2000 societies and several wealthy contributors were not willing to take this step.

The Washington Temperance Society was formed in 1840 by six drinking buddies who often met every night in a tavern in Baltimore (Maxwell, 1950). The founders believed that total abstinence could be obtained through signing a pledge to never drink again. Becoming a member included signing this pledge, paying membership fees, and bringing more men to the meetings. The founders of the movement quickly learned that telling over their stories of alcohol abuse, and freedom from the bottle found in sobriety, were effective in increasing membership. The movement rapidly spread across the United

States. Public meetings were set in churches that were packed with curious crowds. Peak activity is estimated around 1843, but the movement started to deflate in 1846. The last society (in Boston) ended in 1860 leaving the prevailing belief that nothing could be done to help alcoholics.

The Oxford group (also known as Buchmanism), was started by Frank Buchman, who was a former Lutheran minister from Pennsylvania (Cantril, 1941; Kurtz, 1991). In 1908 Buchman reported that he received a vision while visiting a small church in England. The vision made him a "changed man", which set him on a path of confessing and asking forgiveness for carrying resentments, and dishonest and/or selfish acts towards past recipients of such behavior. Buchman believed that his mission in life was to teach others to follow in his footsteps, and he recruited members, who he thought would be highly influential, from prestigious universities (one of which was Oxford – hence the name The Oxford Group).

Post-World War I the progress of civilization was in doubt, and the Depression mocked the popular belief that hard work brought success (McCrady & Miller, 1993). In 1933, the 21st amendment repealed Prohibition, which brought alcohol back to its former state of popular use and abuse across the United States. During that time women were becoming more empowered with the rise of the feminist movement. With divorce becoming a thinkable option, coupled with unemployed men who were drinking away their sorrows, the air was ripe for a social movement. This movement would have men search beyond alcohol to find the real root or roots of their problems. Factors such as ego and self-will, with the absence of spirituality became the culprits.

The idea of seeking sobriety through spiritual/religious experiences was reported to have started with Carl Jung's documentation of his work in the 1920's with Rowland Hazard, a patient he was treating for alcoholism (Kurtz, 1991; White & Kurtz, 2008). After relapsing, Jung advised Hazard that sobriety might be found through a powerful spiritual or religious experience. The patient became a member of the Christian evangelical Oxford Group, "found" sobriety, and carried his message of hope to other alcoholics.

In November 1934, Edwin (Ebby) Thacher, another alcoholic, was released into Hazard's custody instead of being sentenced to prison (Kurtz, 1991; White & Kurtz, 2008). Thacher joined the Oxford Group, and several months later he was sitting across from Bill Wilson, discussing his newfound freedom from the bottle. Wilson recalled that Thacher used several catching phrases such as, "I had to pray to G-d for guidance and strength" and, "I had to get honest with myself and somebody else" (Grapevine Writings, 1953). While Wilson did not become sober overnight, the message from Thacher created an internal dialogue that eventually helped Wilson to see the transformative power of spirituality as a key ingredient for maintaining sobriety (AA, 2001).

The following month (December 1934), Wilson had a profound spiritual experience as he was detoxing in Towns Hospital. Thinking he was losing his sanity he described his experience to his physician, Dr. William Silkworth who instead of diagnosing Wilson with psychosis told him, "No. Bill, you are not hallucinating. Whatever you got, you had better hang on to; it is so much better than what you had only an hour ago" (AACA, 1957, p. 13).

Cravings for alcohol revisited Bill Wilson at the end of a failed business trip in May 1935 (AA, 2001). Instead of reaching out to a professional in the medical/mental health field, he found Dr. Robert Smith (Dr. Bob), who was struggling with alcoholism as well. They soon realized that sobriety could be maintained through communicating shared experiences, mutual vulnerability, and keeping it personal (i.e., nonprofessional and free). Dr. Bob's last drink was June 10, 1935, which is considered the birthdate of AA (2001).

In Wilson's grapevine writings, he provided a history of the very shaky beginning of AA. Unlike the Temperance Movement and Washingtonians, AA avoided destructive choices only seen in hindsight (Grapevine Writings, 1945). For the first 3 years there were two groups, one in Akron and one in New York (Kurtz, 1991). Dr. Bob and Wilson yearned to spread the message of their success to the suspected millions of alcoholics across the world. The two believed that this would require hospitals for alcoholics, paid workers, and a book – ultimately the need for a large amount of money (Grapevine Writings, 1955; White & Kurtz, 2008). To their dismay, after extensively seeking America's wealthy businessmen, who fully backed the program, these businessmen felt AA would be destroyed by too much money. Wilson recalled how John D. Rockefeller feared professionalizing AA and only gave small donations. Finding investors for the book production failed as well, forcing the founders of AA to borrow from different sources for its publication. Hopes were shattered when Readers Digest decided not to run a story on AA which would have coincided with the book's appearance (April 1939) on the market. Book sales were extremely slow the first few months but started increasing

(September 1939) when Liberty Magazine wrote a piece called “Alcoholics and God” (1955). As sales increased, AA could expand its workforce and pay its debts. Wilson expressed gratitude to Rockefeller in saving AA from, “the perils of property management and professionalism” (Grapevine Writings, p. 147).

Bill Wilson attributed the success of AA in learning from the mistakes of the Washingtonian movement (Grapevine Writings, 1945). Several mistakes that he listed were: personal ambition, members becoming competitive, unclear purpose which lead to fighting among leaders (e.g., clamoring for legislation to outlaw alcohol), no editorial or public relations policy, over-zealousness to acquire members (where many social drinkers who were not alcoholics pledged), and no tradition (p. 5). Maxwell (1950) added AA avoidance of theological or religious controversies, which plagued the Washingtonian movement. While AA is linked to Christianity (through its creators and the early years), the program uses the term “Higher Power” and “G-d as we understood Him”, to initiate the importance of spirituality but not limit the alcoholic to a certain belief system.

AA focused on relations between the medical field and religion. Realizing that they would be shunned by the medical community if promoted as a medical treatment, as well as by religious groups if promoted as a new religious sect, AA was proposed as a “way of life” (Grapevine Writings, 1955). Wilson stated that AA would leave the practice of medicine for the doctors and religion for the clergymen, and instead it would supply the much-needed link.

During the mid-1940s, AA was struggling with many of the same issues the failed Washingtonian Movement had witnessed 100 years earlier (White & Kurtz, 2008; Kurtz, 1991). The main issue was lack of unity (i.e., besides trying to sober up alcoholics, there was nothing binding the groups together). To combat this issue, the 12 Traditions were created in 1946. The traditions revolve around a core concept – maximum openness and acceptance of any individual through avoiding affiliations, endorsements, and personal use of the program (Grapevine Writings, 1946). Bill Wilson set out to promote them, though he was met with little interest among the groups (Grapevine Writings, 1955). Support of the traditions grew, and they were formally adopted by AA at its first national convention in 1950.

The 12 Traditions of AA are largely attributed to its successful survival, and these traditions have become a standard for 12-step groups. Unlike the Women's Christian Temperance Union (its founding generations aged and died), AA has survived beyond the thought that it was geared towards a particular age cohort (McCrady & Miller 1993). Throughout the years it has continued to expand (in membership and locations) regardless of the development of private/public treatment institutions.

AA has historically avoided the political stage. In terms of religion, the program is spiritual but not affiliated to any one religion and leaves the term "Higher Power" open to individual interpretation. Personal anonymity is at the forefront, and individuals are barred from using the program for personal monetary gain. Profits from literature sales sustain the structure (e.g., paying salaries for service workers, and copyrights/registered trademarks are in place to prevent personal property ownership). While AA has a central

office, national conferences, and literature, the meeting rooms where groups take place are considered the real power behind the program (McCrady & Miller 1993). Groups are autonomous, fully self-supporting, and leadership/committees for the groups are rotating and chosen by local group members. While external anonymity is promoted, information on members is usually available for two reasons: as an aid to the 12th step, and to keep leadership/committee positions transparent. There are no exclusive territories or franchises, and there is no hierarchy among the groups.

Balanced power and the avoidance of personal gain helped AA to avoid the disastrous results of becoming a cult like Synanon (McCrady & Miller 1993). Started in 1958 by Charles Dederich, Synanon was a peer-based recovery program that promoted an aggressive, confrontational intervention strategy (e.g., forced confessions, demands to change physical appearance, group therapy that utilized verbal attacks; White & Miller, 2007). AA views addiction as a life-long disease, but members are not required to pay towards membership, families are not split up, and while anonymity is promoted, there are no rules for avoiding nonmembers. With no official handouts or specific order for proceedings, meetings operate through more of an oral tradition. For example, sponsorship is not listed in the 12 steps/traditions but is considered a crucial component to recovery. Group membership is open with only one qualification: the alcoholic's sincere desire to stop drinking (AA, 2001). The openness of group membership came to light in 1937 when a man who yearned to break free of alcohol was accepted into the Akron group, despite stating he was a homosexual (White & Kurtz, 2008).

The evolution of the modern AA program. The publicized belief that the AA program could help the alcoholic, initiated the development of self-help groups across the world that catered to different populations (e.g., Cocaine Anonymous, Overeaters Anonymous). As of 2015, there are approximately 115,326 groups and 2,040,629 members worldwide (AA, 2015). AA activity can be found in approximately 175 countries, making it the most popular intervention strategy for addiction (especially when including all self-help groups that practice fellowship and 12-step work).

In the July 1953 Grapevine writing, Bill Wilson wrote on the creation of the 12 steps. He stated that it was a combination of three channels of inspiration: The Oxford Group, Dr. William Silkworth, and William James. Several ideas from the Oxford Group helped to form the 12 steps (Grapevine Writings, 1953). The group was anti-intellectualistic and non-sectarian (i.e., not interfering with personal religious views). Oxford Group members known as Groupers have been changed and must change others, seeking four absolutes: absolute purity, absolute honesty, absolute love, and absolute unselfishness (Cantril, 1941). The first procedure in obtaining these absolutes is that the individual must give in to G-d and seek His guidance. The concept of confessing one's sins and resentments (called sharing) and making amends was a requirement for members as well.

Besides being a pillar of support for Bill Wilson through his detoxing, Dr. William Silkworth promoted two key concepts for understanding addiction. He called alcoholism an illness (an obsession of the mind) and paired this with calling alcohol an allergy of the body (for alcoholics) (Grapevine Writings, 1953). These proclamations of

Dr. Silkworth helped Bill Wilson to accept that he had hit rock bottom with no hope that he could ever again control his consumption of alcohol. Wilson called it a verdict of science and stated, “The obsession that condemned me to drink and the allergy that condemned me to die” (Grapevine Writings, 1953).

During his stay at Townes Hospital, Bill Wilson picked up the book *Varieties of Religious Experience* by William James (Grapevine Writings, 1953). Wilson learned that appealing to a Higher Power, when one has hit rock bottom, initiates a powerful transformation. The individual is filled with hope and that the unimaginable can be obtained. For the alcoholic, this means he could be freed from the shackles of the bottle.

With these newfound realizations, Bill Wilson joined the Oxford Group in hopes of reaching alcoholics in the pits of their addiction (Grapevine Writings, 1953). To his dismay, Groupers were pessimistic that he would succeed in his quest. After 6 months with no success, Wilson himself had thoughts that his plight was futile. In confiding with his wife that he was giving up because he could not keep others sober, she said, “but, you’re sober” (Clancy, 1988). This brought about the idea that helping alcoholics recover is one of the most powerful tools for maintaining one’s own sobriety. At this time Dr. Silkworth was of great help as well, through pointing out that Wilson had lost sight of his role. Instead of relating the destructiveness of alcoholism as an illness and an allergy of the body, Wilson preached about his spiritual experience. A short time after the conversation with Dr. Silkworth, Wilson found himself visited by alcohol cravings, alone in a hotel in Akron, Ohio (1953; AA, 2001). This is when he reached out to Dr. Bob, which ultimately helped them to realize that alcoholics need each other to stay sober.

The following 3 years Bill Wilson and Dr. Bob focused on growing groups in Akron, Cleveland, and New York (Grapevine Writings, 1953). They decided to create a society separate from the Oxford Group and developed six principles based on the Oxford Group's four absolutes. In 1939, four chapters of the Big Book were complete, and it was decided that the 5th chapter would be about the program. Within an estimated 30 minutes, Bill Wilson created a draft of the 12 steps. Over the course of several days and nights, members debated regarding the religious content of Wilson's proposal. Agnostics wanted this content to be more open to individual interpretation. The conclusion was to incorporate the ideas of these members, and the 12 steps were born. Wilson attributed the success of the steps to the ability of every individual to integrate his personal belief system into step work. This ultimately led to the steps being accepted by clergymen of all denominations and psychiatrists alike.

Mechanisms of Change in 12-Step and Self-Help Groups

The AA perspective. The pioneers of AA proposed that the mechanism of change occurs through having a spiritual experience (awakening) and changing attitudes/behaviors through working the steps (AA, 2001). AA views spirituality as striving for a relationship with G-d or connecting to something greater than one's self (e.g., an ideal). Interestingly, the principle of separating spirituality from religion has helped 12-step work to be accepted across different societies, cultures, and religions.

There is evidence that spirituality and religion are beneficial to addicts in recovery. Spiritual/religious practices facilitate schematic cognitive restructuring, leading to healthy/adaptive responses to stressors (Kelly, Stout, Magill, & Tonigan, 2011). From

a psychological standpoint, addicts engage in substance abuse as a coping mechanism against stress and uncomfortable feelings/emotions. Tonigan, Rynes, and McCrady (2013) conducted a meta-analysis followed by a longitudinal study to examine the relationship between AA attendance, spirituality, and drinking. They found that AA participation predicted increased abstinence, where paths between AA participation and spirituality and between spirituality and abstinence were significant. The meta-analysis found that spiritual/religious beliefs and practices helped individuals to develop and implement healthy responses to stressful cues, instead of turning to substance abuse. The longitudinal study found that spiritual practices benefit recovery within 4 and 6 months of 12-step affiliation. However, the mechanism or mechanisms within spirituality that affected recovery, and why there was an association between spirituality and abstinence was unclear. The study also found that initial 12-step intensity predicted spiritual beliefs and practices over a 9-month period (i.e., if initial meeting attendance was infrequent, there was a steady decline in spiritual beliefs and practices). Tonigan et al. suggested that research is needed to identify causal linkages between changes in spiritual practices, cognitive and behavioral coping skills, and negative emotional arousal that contribute to drinking outcomes, along with the need to evaluate the effects of spiritual growth and practice on meeting attendance and perceived group cohesion.

The 12-step perspective views the addict as self-centered, selfish, and self-absorbed. The intent of the program is on “ego reduction” and expanding the addict’s attention towards others (AA, 2001). The first three steps focus on breaking the ego (i.e., admitting powerlessness, and building hope/reliance on a Higher Power). Steps four

through ten focus on building positive traits: courage, humility, and discipline, while reducing negative traits through making an inventory of character defects – asking Higher Power to remove the defects, and a list of people harmed – making amends wherever possible. Step 11 refocuses on spirituality and humility. Step 12 involves giving back through carrying the message and guiding others through the 12-steps (i.e., service).

If the program is followed correctly, AA lists 12 outcomes (known as the 12 promises) towards experiencing a better quality of life understood as: being free from regret, selfishness, worry, and feelings of uselessness while increasing positive thoughts, having a more positive outlook on life, and building competence (Kelly & Greene, 2013). Greater 12-step participation and meeting attendance leads to members' decreased urges, cravings, thoughts, and compulsions to use alcohol and other drugs, which is consistent with AA's 12 promises (2013; McKellar, Stewart, & Humphreys, 2003).

A self-sustaining upward dynamic is created through the interconnection of positive emotions, positive social connections, and physical health (Kok et al. 2013). The 12-steps promote positive emotions (love and joy), aiding in the recovery process (Valliant, 2014). The first three steps focus on attaching one's self to an outside (higher) Power, allowing the addict to feel loved. The final steps promote joy through helping others who are struggling with addiction. AA calls these positive emotions the "language of the heart".

Social psychology perspective. A common belief carried over from the pioneers of AA is that putting two or more people together, who have the desire to become sober, greatly enhances the recovery process. As an alcoholic in recovery once stated, "If you

put a bunch of cancer patients in a room together, would they get better? So, it's truly amazing that a room full of addicts, trying to stay sober, get better." AA and all other self-help groups view meeting attendance as a crucial component to the recovery process. Meetings are social gatherings where support and advice help addicts maintain sobriety, similarly, compared to a life-support system. Continuous meeting attendance helps newcomers identify with the testimonies of other addicts who have more recovery time (Sandoz, 2014). The newcomer will start to believe that his path of recovery will follow a similar path as he gains a sponsor and starts 12-step work.

Moos (2008) described three dimensions of self-help groups: relationships, goal orientation, and system maintenance. Relationships include group cohesion and peer support. Goal orientation means encouraging personal growth, altruism, responsibility, and spirituality. System maintenance involves group monitoring of individual behavior. To explain how self-help group attendance is essential for recovery, Moos connected self-help group attendance to four theories.

First, self-help groups are consistent with social control theory, which posits that strong bonds created through support by family, peers, work, and religion all promote responsible behavior, goal setting, and refraining from substance misuse. Attending groups allows for growing relationships with individuals who provide abstinence-specific support. The friendships developed at group meetings can shield the individual from the negative influence of drug-using friends. The values of these types of bonds are consistent with biological markers found in the brain's nucleus accumbens (reward

center) when a secure attachment is present, as well as when good deeds are done (e.g. giving to a favorite charity; Valliant, 2014).

Second, self-help groups are consistent with social learning theory, which posits that an individual's attitude and expectations of substance use are formed through observing the attitudes and behaviors of family and peers. Group members model abstinence orientation, express negative attitudes towards their history of drug use, and relate stories of the negative repercussions of their drug use. This theory may also explain how individuals are at higher risk when other family members and peers use drugs.

Third, self-help groups are consistent with behavioral choice theory, which posits that involvement in healthy rewarding activities, protects individuals from temptation for substance misuse. As individuals engage in positive pursuits (e.g., educational, vocational, sports), they are less likely to pursue substance use as an alternative. Plus, they affiliate with others who are engaging in the same positive pursuits, leaving less desire to engage in something different.

Finally, fourth, self-help groups are consistent with stress and coping theory, which posits that group involvement promotes the development of healthy self-confidence and coping skills for managing high-risk situations and general stress, instead of self-medicating through substance abuse. Group members often carry a similar history of trauma, dysfunctional families, chaotic upbringings, and limited support to help build healthy coping mechanisms. Seasoned members can teach addicts early in their recovery how to develop such tools from a personal perspective.

Reports from individuals who participate in such meetings indicate that the positive feelings from 12-step work steadily increase and can continue over the course of the addict's life. It is suggested that the continued connection to others counteracts the effects of substances which tend to encourage the user to detach from people and reality. Twelve-step work explains that any individual can engage in addictive pleasure, but it takes a relationship to produce love and joy. Valliant stated, "Alcohol is the lonely human's religion" (p 219, 2014). Twelve-step groups create a community where addicts connect and feel like they belong.

Biological and neurological mechanisms. From a biological view, imaging researchers found increased activity in the nucleus accumbens (reward center) when a secure attachment is present, as well as when an individual gives to his favorite charity (Valliant, 2014). The 12-steps build secure attachment to one's Higher Power as well as other group members and one's sponsor, essentially stimulating the nucleus accumbens, acting as a substitute for good feelings caused by drug use. While one could argue that the good feelings from drugs are much more amplified, these feelings happen in an ever-shortening time as drug use continues.

Williams and Adinoff (2008) explained the mechanics of addiction that activate reward and memory circuitry in the brain. The rewards system revolves around basic survival functions (e.g. eating and sex), as these things produce subjective feelings of pleasure. Addictive drugs stimulate the reward pathway, producing feelings of pleasure that eventually alter the brain, becoming the survival function. This means that an addict will crave the drug over food, sex, and every pleasurable activity because this is now the

survival function. Intoxicants cause the release of dopamine, creating good feelings which the reward system views as “evolutionary success” (Giuffra, 2015). Intoxicants also affect the prefrontal lobes, where functions such as planning and morals occur. Addicts engage in selfish behavior, often using deception and manipulation to continue drug use. In his proposal on the mechanism of action for the 12 steps, Giuffra separated the 12 steps into 3 sections: as drugs inhibit prefrontal cortex functioning, steps 1-3 have the addict admit powerlessness and place trust in a Higher Power, steps 4-10 and 12 disarm the “instant gratification” reward system and avoid/minimize maladaptive traits through focusing on altruism, honesty, and selflessness, step 11 promotes meditation and prayer, which research has found, increases blood flow (increased functioning) to the frontal lobes (2015).

Bio-psycho-social-spiritual model. Successful recovery can be attributed to self-help group involvement and working through the 12 steps. As seen above, these aspects implement the different systems found in the bio-psycho-social-spiritual model, combating similar systems that lead to addiction. Individuals suffering with addiction often have issues within any one to all these systems. Research in biology and genetics has found evidence that the children of addicts are more predisposed to engage in substance abuse and have more incidences of addictive behaviors (Davis & Loxton, 2013). The Collaborative Study on the Genetics of Alcoholism was a study created to detect genes that increase risk for alcohol dependence and related Phenotypes. The study, which included 1440 families, found that children of alcoholics are more susceptible to alcohol dependence due to genetic factors (Reich, 1996).

Psychologically, addicts often lack self-awareness, have low self-esteem, and present several mental health issues (Valliant, 2014; Kelly & Greene, 2013). The 12-step approach espouses a system of personal values (e.g., helping other addicts). Plus, self-disclosure, through telling one's story, builds self-awareness as well as aiding in the shaping of schemas (Galanter, 2013).

From the social standpoint, drug use often starts with other people (Moos, 2008). This creates an opportunity for peer pressure or social acceptance to promote drug use, leading to abuse and trying several types of drugs. Social connection tends to weaken through isolating as abuse develops into addiction. Consistent meeting attendance and engaging in step work strengthens social connections along with building a support network.

There is a popular statement that the addict's drug becomes his god. In retrospect, as people engage in 12-step work, they realize the absence of spirituality in their life. While addicts share similar factors that brought them to alcohol and drug dependence, differences can be found in any one of the categories (e.g., a different social upbringing and/or biological factors). Prest and Robinson (2006) stated that viewing the bio-psycho-social-spiritual model as a pie, each piece is reciprocally connected (i.e., contributing more/less to addiction and recovery).

In sum, there are several theories on identifying the mechanisms of change within 12-step programs. Addiction research is a relatively new field, and as such, evidence backing these theories is continually being discovered (e.g., using genetics to find links between family members who are addicts). Due to differing views on how to define and

categorize mechanisms that facilitate the change from alcohol/substance abuse to addiction, several treatment models have been developed. Currently, research on identifying the mechanisms of change, across different treatment models, has yielded inconsistent results (Longabaugh & Magill, 2011). All models incorporate cognitive and behavioral changes, but steps towards these changes differ based on what are considered the underlying issues of addiction. The next section will discuss the effectiveness of the 12 steps and other treatment models.

Effectiveness of 12-Step Programs

The effectiveness of AA has been assessed through measuring length of sober time and comparing it to no-treatment groups or other treatment models (cognitive behavioral therapy and motivational enhancement therapy). Two key aspects of AA (and all other self-help groups that use 12-step facilitation) are 12-step work, and the fellowship which is created through participation in social gatherings, meetings, and sponsorship (Kelly, Magill, & Stout, 2009). Step work and fellowship create a reciprocal relationship towards relapse prevention, as such, one without the other greatly increases relapse potential. Therefore, in addition to examining the extent to which participants maintain sobriety, studies of 12-step program effectiveness have also examined which aspects are most predictive of success.

Evaluating "effectiveness" of an addiction intervention is extremely difficult. The stated goal of AA (as well as many other programs) is complete abstinence, which is very challenging to measure for two reasons. First, from a scientific perspective, reliable, confirmable reports of abstinence require measures beyond self-report (e.g., blood

alcohol content, urinalysis, or confirmation by another; Litten & Allen, 2012). This is beyond the scope of most studies and is difficult to achieve because of the nature of the population. Second, the frequency (how many times a year) and duration (how many years to assess) of assessing sobriety varies across studies (Hilton & Pilkonis, 2015). Additionally, there are scales and other assessment tools (e.g., structured interviews) that collect self-report data on social psychological and lifestyle variables that co-vary with changes in the extent and impact of alcohol use (Carroll, 1995).

Because of these and other methodological issues, the effectiveness of AA is a highly debated topic. Individual studies and meta-analyses provide mixed results: AA is very effective, moderately effective, or not effective. For example, Gaghainn (2003) found significant rates of success in maintaining sobriety, based on AA membership and meeting attendance in the United Kingdom. Mueller, Ptetitjean, Boening, and Wiesbeck (2007) found that AA is not effective, based on similar rates of relapse between individuals who attended AA meetings and individuals who did not seek treatment. Kaskutas (2009) provided a focused review of the literature including previous literature reviews and meta-analyses. She proposed using 6 criteria to establish the effectiveness of AA:

- Criterion 1 was assessing the strength of the relationship between exposure to AA and rate of abstinence. Results from a longitudinal study of male inpatients in VA programs showed that rates of abstinence were twice as high for individuals who attended AA.

- Criterion 2 was comparing level of involvement with AA with level of abstinence (i.e., dose-response relationship). Results from three studies (male inpatients in VA programs, male outpatients in VA programs, and a longitudinal study of previously untreated problem drinkers who entered the AA program) showed that individuals with longer duration of AA attendance had longer durations of abstinence.
- Criterion 3 was assessing the consistency of the association of criteria 2 based on studies in this area. Kaskutas (2009) found that comparing level of involvement with level of abstinence was consistent across studies. These studies included the three listed above, a longitudinal study of VA inpatients and previously untreated problem drinkers who attended AA but no other treatment, and a study of the general population that compared abstinence rates of alcohol dependent individuals who attended AA (with no formal treatment) and individuals who did nothing.
- Criterion 4 was that the timing of AA exposure be prior to the period of abstinence. While most studies considered concurrent AA attendance, Project MATCH showed a temporally correct association.
- Criterion 5 was the ability to rule out other explanations for abstinence other than AA exposure. Studies have compared 12-step facilitation with no treatment and other treatment models, while other studies have compared AA efficacy based on individual factors such as severity of drinking and legal

issues. While these studies have been unable to control for all individual factors, the studies found that AA exposure was the cause for abstinence.

- Criterion 6 was assessing if AA works in a way that is consistent with major theoretical perspectives on health behavior and behavior change. There is empirical support from several studies that the mechanisms of change found in other theories (e.g., Bandura's social learning theory) are also found in AA involvement and abstinence (2009).

Timko, Moos, Finney, and Lesar (2000) conducted a longitudinal study that compared drinking patterns between four groups: those who attended AA only, formal treatment only, AA and formal treatment, and no treatment. They found that similar to AA and formal treatment, untreated individuals improved on drinking related outcomes and functioning from baseline to first year. However, there was no more improvement in any of these areas from 1 to 8 years. Individuals who were treated for alcoholism were significantly more likely to be abstinent after 1 year of starting treatment than untreated individuals. After 8 years, 54% of treated individuals were abstinent whereas 26% of untreated individuals were abstinent. In comparing the success of treatment, AA only, formal treatment, and mixed AA and formal treatment groups were equivalent on drinking outcomes after 8 years. The only difference was within the 8 years, where formal treatment only groups were worse off at 1 and 3 years than formal treatment plus AA and AA alone.

Research has produced mixed results on the effectiveness of 12-step facilitation compared to cognitive-behavioral therapy, and motivational enhancement therapy. Ferri,

Amato, and Davoli (2009) performed a meta-analysis on the effectiveness of all three interventions and found that they had similar results in reducing alcohol consumption. The cognitive-behavioral model uses social learning theory to explain the formation of addiction. The individual has distorted thinking about substances (e.g., beliefs about the power of the substance). Using the substance to cope with stress reinforces its use (Ouimette, Finney, & Moos, 1997). Motivational enhancement therapy (also known as motivational interviewing) is a brief intervention for reducing health-risk behaviors. The goal is to increase motivation to change through empowerment methods, merged with the client feeling accepted and understood (O'Leary Tevyaw & Monti, 2004). Kelly et al. (2009) found that 12-step facilitation was significantly superior in increasing rates of continuous abstinence at a rate of 36%, compared to cognitive-behavioral therapy (24%) and motivational enhancement therapy (27%).

Factoring in cost-benefits effects, a study of the US Veteran Administration found that patients treated with cognitive-behavioral therapy received significantly more inpatient days, and twice as many outpatient visits than those treated with 12-step facilitation (2009). This resulted in 30% lower costs using 12-step facilitation, saving roughly $2440 per patient. Abstinence rates for patients treated with 12-step facilitation were substantially higher than those treated with cognitive-behavioral therapy. Higher rates of abstinence were also found in different ethnic groups, gender, youth, and dually-diagnosed individuals.

In another comparison between 12-step facilitation and cognitive-behavioral therapy, Ouimette, Finney, and Moos (1997) found that there were no significant

differences between cognitive-behavioral, 12-step, and mixed cognitive-behavioral 12-step programs. All were effective in reducing substance use and psychological symptoms, while increasing likelihood of being employed and avoiding legal problems. A closer look at the actual numbers shows that rates of abstinence were higher in 12-step programs (25%) than cognitive-behavioral programs (18%) (1997). Individuals from 12-step programs were 1.5 times more likely to be abstinent than from cognitive-behavioral programs. Including employment as a quality of life factor, individuals from cognitive-behavioral programs had slightly higher odds (1.53) of being employed than individuals from 12-step programs (1.42) respectively (1997).

Project MATCH was a large-scale, longitudinal study (8 years) that investigated the efficacy of 12-step facilitation, cognitive-behavioral therapy, and motivational enhancement therapy. A total of 1,726 individuals with alcohol use dependence disorders according to criteria from the DSM-III-R (excluding other substance addictions) engaged in 1 of the 3 treatments for 12 weeks. A questionable aspect of the study was its exclusion of AA meeting attendance, which AA considers a key factor in maintaining sobriety. Magura, Cleland, and Tonigan (2013) found that higher AA attendance predicts higher rates of abstinence and reduces drinking problems.

Based on the results of Project MATCH, Cutler and Fishbain (2005) concluded that none of the current psychosocial treatments for alcoholism are effective. They found that significant progress in recovery occurred within the first week of treatment (60% increase in abstinence) and maintained approximately the same level for the following 11 weeks of treatment (4% increase in abstinence). The minimal progress found from weeks

2 through 11 were like the untreated group. Miller (2005) stated that the conclusions (that treatments are ineffective) of Cutler and Fishbain were incorrect due to a lack of understanding the recovery process. Miller (2005) explained that short-term abstinence (within the first week) is not difficult to achieve, whereas maintaining long-term abstinence is very challenging. Plus, Cutler and Fishbain (2005) stated that many alcoholics often underreport drinking, while Miller (2005) pointed out that Project MATCH included objective measures and collateral reports to confirm self-reporting. Using the data from Project MATCH, Magura, Cleland, and Tonigan (2013) found that while AA is effective during primary outpatient treatment, it is less effective as an aftercare modality.

The famous statement at the end of every AA meeting is, “keep coming back; it works if you work it!” People who view the AA model as 100% effective, and if someone relapses, it must be that they were not seriously working the 12-steps, carry the name “12-steppers”. While research has compared the relatively low success rates of AA with other treatment models, there is evidence connecting relapse to not working the AA program as it has been defined. Mueller, Ptetitjean, Boening, and Wiesbeck (2007) found that while overall social functioning improved in people who attended AA meetings (once or twice a week) more the no-treatment group, there was no significant difference in rates of relapse. They proposed that meeting attendance alone is not enough to maintain sobriety.

Meeting attendance and 12-step work help to maintain sobriety, but engagement in both steadily declines over the years. The results from Project MATCH showed that

meeting attendance was at its peak during treatment but declined, while addicts helping other addicts (in recovery) and low levels of 12-step work were stable over the course of 10 years (Pegano, White, Kelly, Stout, & Tonigan, 2013). Pregano, Friend, Tonigan, and Stout (2004) found that individuals who were sponsoring others and/or engaging in 12-step work were significantly more successful with abstinence than those who were not helping other alcoholics. This falls in line with the core concept of AA that modifying one's character, through breaking selfish, self-absorbed thoughts and behaviors, is crucial to the recovery process. Pegano et al. (2004) also found that helping others is not limited to gender, level of education, socioeconomic status, race, or severity of drinking behavior.

Self-help groups are defined as non-professional, peer-operated organizations identified as a gathering of members who share similar experiences/problems and give/receive advice (Humphreys et al. 2004). AA is a self-help group that uses 12-step facilitation, as with other "anonymous" groups (e.g., Narcotics Anonymous and Overeaters Anonymous). Other self-help groups that do not use 12-step facilitation are Rational Recovery, SMART Recovery, Women for Sobriety, Secular Organizations for Sobriety, LifeRing, Celebrate Recovery, and Moderation Management. The term "effective" means more than survival of the group and member count, to include length of sobriety and reduction of alcohol/drug use. There is minimal research on the effectiveness of these self-help groups, though each has its strengths through catering toward the needs and desires of individuals. For addicts who disagree with the disease concept model and the strong focus on spirituality of 12-step facilitation, Rational

Recovery and SMART Recovery (both using cognitive-behavioral techniques) are a valid option. Rational Recovery allows for "slips" in substance use making it difficult to compare effectiveness against 12-step facilitation which demands complete abstinence. Galanter, Egelko, and Edwards (1993) found that members of Rational Recovery had a larger number of drinking days per month which may be a poor prognostic sign. Brooks and Penn (2003) found that SMART Recovery was less effective in reducing alcohol use, but more effective in improving employment status. Kaskutas (1996b) found that Women for Sobriety members had a similar rate of sobriety to members of AA, but the nature of the group (i.e., for women only) created a much smaller membership pool and far less available meetings. Secular Organizations for Sobriety is basically AA without the spiritual component. While the effectiveness of this group is lacking, Connors and Dermen (1996) found that a popular complaint of members was that meetings were not widely available, and meeting discussions were often disorganized. LifeRing was created as an alternative to 12-step facilitation, where the goal is empowerment of the Sober Self which leads to development of a personal recovery program. There is a strong focus on fellowship, as meetings are held face-to-face as well as online. Nicolaus (2012) stated that the effectiveness of LifeRing can be seen in the thousands of members who are currently sober, but empirical research is needed to clarify its effectiveness. Celebrate Recovery is a Christian-faith based self-help group that uses 12-step facilitation and defines the Higher Power using interpretations from the Christian Bible. Brown, Tonigan, Pavlik, Kosten, and Volk (2013) found that spirituality was a significant component in confidence levels of resisting substance use. They stated that spirituality assists members

of faith-based recovery programs, and that future research should focus on associations between changes in spirituality and other recovery variables. Moderation Management is different from all other self-help groups in that the goal is to moderate drinking instead of total abstinence. Research on the effectiveness of this group is lacking and having a group that tries to help problem drinkers moderate their drinking may present a stumbling block for alcoholics (Lembke & Humphreys, 2012).

Spirituality

Research has identified spiritualty as a significant component in increasing positive mental health (Bonelli & Koenig, 2013). Positive mental health is defined as an increase in feelings of joy, fulfillment in life, connection with others, and a decrease in negative emotions (e.g., anxiety and depression). Stroppa and Moreira-Almeida (2013) found that positive religious coping strategies were related to better quality of life.

Close to 50% of existing research over the past 40 years failed to clearly define differences between spirituality and religiosity (2013). Moreira-Almeida, Koenig, and Lucchetti (2014) addressed this issue through providing definitions for religion and spirituality. It is interesting to note that over 80 years ago, the founders of AA understood that the two are different and chose to avoid endorsing religion in favor of promoting the understanding of spirituality as a personal choice.

Spirituality plays a significant role in addiction and recovery. It acts as a buffer against substance abuse through promoting the desire to avoid potential risks of physical/emotional damage. Plus, spiritual practice can boost an individual's sense of purpose as well as avoiding feelings of loneliness through connecting to a Higher Power,

or with others in a social structure. Chambers (2015) found that Quakers involved in spiritual practice had lower rates of substance abuse.

Individuals suffering with chronic pain exhibit higher rates of feeling punished, abandoned, and find it difficult to forgive G-d (Rippentrop, Altmaier, Chen, Found, & Keffala, 2005). Anger at G-d and negative religious coping predict higher rates of depression, anxiety, limited coping outcomes, poor adjustment, and a reduced rate of recovery from illness (Exline, Yali, & Lobel, 1999; Fitchett, Rybarczyk, DeMarco, & Nicholas, 1999). People have greater spiritual needs during illness (Mueller, Plevak, & Rummans, 2001). This supports the focus on spiritual growth in 12-step recovery which views addiction as an illness. Schoenthaler et al. (2015) found that lower rates of spirituality predicted higher rates of relapse.

While research has provided evidence on the benefits of spirituality in preventing addiction and aiding in the recovery process, questions remain on identifying the relationship of different components between these constructs (e.g., identifying critical points where spiritualty aids in the recovery process). The role of negative experiences with spirituality, negative spiritual coping, and anger at G-d leading up to addiction and in the recovery process is unknown as well. If lower rates of spirituality predict relapse, then identifying why individuals do not increase spirituality in their recovery is crucial for boosting the effectiveness of treatment programs.

Addiction in the Jewish Community

Orthodox Judaism revolves around a strong commitment to spiritual growth through daily practice and study of Jewish law and literature (i.e., the Torah). These laws

govern everyday behavior, setting life goals, and ideology. Orthodox communities are insular, secretive, and highly avoidant of outside interactions especially with children and adolescents. The younger crowd attends private schooling, and the communities make efforts to avoid exposure to media and secular ideology in general. An individual who breaks from the system may be shunned, as the community has limited tolerance for individuals who do not keep Torah observance (Berger, 2015). These individuals are labeled as "off the *derech*" (path), *apikorsim* (deniers), and are sometimes excommunicated from their community or disowned by their family. They may be asked to leave their home to protect family members and/or to protect the family's name (in the community). In cases where these individuals can stay, the other family members may be told to dissociate in order to not be influenced. Organizations have recently been created to help these individuals, but historically they were left with little to no support which resulted in: completely breaking from the Orthodox Jewish community, suicide, severe substance abuse and engaging in high risk behavior, or trying to change and conform to community expectations (Davidman & Greil, 2007).

While the Orthodox Jewish community shares many of the same socially induced ills of secular society (e.g., abuse, divorce, addiction), historically this has been to a much lesser degree (Kelemen, 1996). Alcohol and substance abuse have been considered illnesses that did not affect the Jews (Loewenthal, 2014; Dynner, 2014; Vex & Blume, 2001). One exception was in the late 18th and early 19th centuries, where due to anti-Semitism, German and Russian medical texts blamed Jews for social, economic, and drug

problems, exaggerating the proportion of Jews among drug addicts and drug dealers (Vasilyev, 2012).

Unkovic, Adler, and Miller (1980) identified two factors that contributed to low rates of alcoholism among Jews: keeping cultural values (i.e., few taboos against moderate drinking, but strongly opposed to intoxication), and solidarity of the Jewish community (keeping distance from the socially induced ills). Orthodox Judaism frowns upon alcohol and substance abuse. This stems from both the written and oral laws that have discussed the repercussions of intoxication. For example, Aaron's (the high priest) sons died while performing a service in the Tabernacle. Immediately following the incident, the Bible discusses laws against the priests performing services while intoxicated. Jewish law promotes alcohol use on holidays, sanctifying the Sabbath, and for almost all celebrations (e.g., at weddings, circumcisions, and after the birth of a child). There is one holiday, Purim, where alcohol intoxication is promoted. Still, there are several laws in place to help avoid negative, damaging behavior during this time.

Genetics may be another factor for lower rates of substance abuse and addiction among Jews. ADH2 converts ethanol to acetaldehyde. ADH2*2 is a variant allele, found to be protective against heavy drinking and alcoholism (Chen et al. 1999; Thomasson et al. 1991). The prevalence of ADH2*2 is different across the world with a high prevalence in the Asian population (1999; 1991), and low prevalence in the European population (Borras et al. 2000). The Jewish population in Israel consists of Sephardic and Ashkenazi Jews. Hasin et al. (2002) attributed low rates of alcohol abuse and addiction amongst Israeli Jews to the high prevalence of ADH2*2.

In 2001, the Jewish Board of Family and Children's Services of New York conducted a study using data from the Jewish self-help program for addiction, commonly known as JACS (Jewish Alcoholics, Chemically Dependent Persons, and Significant Others). The research found that 35% of the 3000 individuals in its database were identified as having an addiction to alcohol and/or drugs (Vex & Blume, 2001). Jewish affiliations in the study were split into four groups: 10% Orthodox, 28% Conservative, 32% Reform, and 30% non-affiliated. The results indicated that alcohol was the most prevalent substance of dependence (54.7%), followed by other drugs: cocaine (11.8%), opiates (11.6%), marijuana (11.3%), tranquilizers (2.4%), amphetamines (2.4%), sedatives (1.8%), hallucinogens (0.3%), and other (3.7%). Approximately 71% of respondents reported dual addictions, with alcohol being the most prevalent secondary drug (24.5%), followed by sedatives (10.8%) and tranquilizers (8.4%). Ultra-Orthodox males reported three equally high primary addictions: alcohol, cocaine, and marijuana. Reported length of abstinence ranged from 1 month to 37 years, with a mean of 9.2 years. The most widely used intervention was self-help groups using 12-step facilitation. Approximately 83% of respondents who sought help from the Jewish community reported receiving little or no help at all.

A recent pilot study found evidence that rates of addiction are increasing in the Orthodox Jewish communities (Baruch, Benarroch, & Rockman, 2015). Actual numbers of individuals struggling with substance abuse and addiction are currently unknown because, as with most other social issues (e.g., abuse, mental/physical illness), these have not been openly discussed in the Jewish communities. Researchers have presented several

reasons for this including: stigma, denial, lacking education to identify such issues, competing priorities, fear, and praying to G-d instead of seeking professional help (Baruch et al. 2015; Tkatch et al. 2015; Lowenthal, 2014; Yashinsky, 2007). Only recently has substance abuse and addiction become a more popularly discussed issue, with recent articles published in several popular Jewish magazines (e.g., Jewish Action, Mispacha). Local lectures on the topic, facilitated by rabbis and mental health professionals can be found posted on community bulletins.

While there is evidence that social inequality is associated with alcohol related problems (Bloomfield, Grittner, Kramer, & Gmel, 2006), this was not found in Jewish communities. Vex and Blume (2001) found that the connection between addiction and social problems (i.e., low income, lack of education, alienation, or loss of religious conviction) was not significant. Even though substance abuse and addiction are less prevalent in Jewish communities, social advantages do not act as a buffer against such problems.

Child abuse predicts illicit drug use, and leads to lower levels of social support, resulting in high levels of anxiety and depression (Sperry & Widom, 2013; Anda et al. 2006). Survivors of abuse often exhibit feelings of betrayal, which coincide with feelings of shame and guilt – the latter leads to stigmatization (Finkelhor & Browne, 1985). Religiosity does not act as a buffer against childhood abuse. Feinson and Meir (2014) found that there was no significant difference in levels of psychological distress, for survivors of child abuse from religious and nonreligious backgrounds.

Historically, abuse in the Jewish community was not spoken of, but this has shifted over the past 20 years with the advancement of social media. The Jewish Community Watch is an organization dedicated to combating sexual abuse in the Jewish community through building community awareness and exposing abusers. There has been a recent advancement in using local authorities to get abusers out of the communities. Progress has been attributed to rabbinical authorities educating community members on the Jewish law pertaining to turning Jews over to non-Jewish authority figures (called *mesirah*). Rabbinical authorities have explained that this law does not apply when there is a risk to a life. Child abusers have been given the status of a *rodef*, someone on course to take a life (i.e., murder), and therefore every Jew is obligated to contact the law, to stop such a person. Hotlines (e.g., Shalom task Force and JSafe) for domestic abuse have been created for Jewish communities around the world. Feinson and Meir (2014) found that there was no significant difference in prevalence of abuse (physical, verbal, sexual) between Ultra-Orthodox and secular respondents.

What was once the local Rabbi's exclusive jurisdiction, Orthodox Jewish communities are now obtaining professional help for mental health issues. Communities have access to psychologists, social workers, and counselors who are Jewish and/or work closely with community rabbis. In the realm of addiction, several treatment options exist exclusively for the Jewish population (residential, outpatient, and sober living homes). Currently in the United States, there are five residential treatment centers: three are in Florida (Jewish Recovery Center, Recovery Road, and Torah and the 12 Steps), and two in Los Angeles (Beit T'Shuvah and the Chabad Residential Treatment Center).

Started in 1972, Chabad Residential Treatment Center has provided recovery services for both Jewish and non-Jewish men, using 12-step facilitation and evidence-based practices in therapy. The program adheres to Orthodox Jewish law in terms of providing strictly kosher food, prayer services, and rabbinical guidance. In 1999, Beit T'Shuvah opened the first residential treatment facility for both Jewish men and women. Chabad Residential Treatment Center and Beit T'Shuvah have provided treatment for thousands of Jews struggling with addiction and comorbid psychopathologies. SAFE is an outpatient center for Jews located in New York.

Amudim opened its doors in 2014 as a crisis intervention program for the Jewish population. Amudim currently releases videos and runs seminars for educating communities on current crises (e.g., abuse and addiction), and avenues for seeking help. Due to the recent increase in opiate overdoses, Amudim has been running Narcan trainings across the East Coast.

Self-help groups (e.g., AA and Narcotics Anonymous) have been the primary recovery programs for the Jewish population (Vex & Blume, 2001). With advances in technology, online groups for addicts can be found via social media. Addicts with Orthodox Jewish backgrounds have created groups on Facebook and WhatsApp. These groups offer support, advice, and information on meetings and recovery programs.

Summary and Transition

Chapter 2 provided a review of research on addiction, the 12-step recovery program, spirituality, and the Orthodox Jewish community. The literature provided a background for each construct by itself as well as combined with another construct. The

database search strategy was listed, theoretical frameworks were explained, and definitions for addiction, recovery, and spirituality were provided. Several concepts were explored including: the history of addiction and recovery, the development of the 12-step recovery model, its effectiveness, and proposed mechanisms of change, spirituality, and addiction in the Orthodox Jewish community.

Spirituality has been identified as an effective tool in combatting addiction, but the mechanism of how this works has not been fully explored. Research is also lacking on the relationship between negative experiences with spirituality, addiction, and the recovery process. This study provides a wealth of information for these unknowns through exploring the spiritual narratives of individuals who were raised in the Orthodox Jewish community, developed an addiction, and used the 12-step recovery program to maintain sobriety.

Chapter 3 reviews the research design and methodology for this study. Rationale for the proposed research design, role of the researcher, methodology (data collection and analyzing procedures), issues of trustworthiness, and ethical procedures will be reviewed.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the spiritual narratives of formerly observant Jewish addicts who engaged in the 12-step recovery program. The following sections describe the research design and rationale, the role of the researcher including concerns regarding bias and relationships, and the methodology (defining the population, instrumentation, data collection and analysis plan, validity issues, and ethical procedures).

Research Design and Rationale

A narrative analysis was used as the qualitative design to inquire into the research question "What do the spiritual narratives of formerly observant Jewish addicts reveal about their experience in a 12-step recovery model?" The primary phenomenon of interest was spirituality in recovery. The following subquestions were also explored:

- How does the narrative begin?
- What are the turning points in the spiritual journey?
- What is the meaning of spirituality?
- How is spirituality experienced in the 12-step program?
- What is the present moment of the narrative?

I chose a qualitative approach to better understand the spiritual narratives of formerly observant Jewish addicts as they engaged in 12-step facilitation. There is a substantial amount of quantitative research on substance abuse treatment effectiveness and the factors that contribute to addiction and recovery. Additionally, spirituality in

addiction and recovery has been studied but primarily as a protective factor against addiction or as a treatment intervention (e.g., 12 steps). The choice of a qualitative approach allowed for the investigation of the subjective recovery experience (Patton, 2015) and the meaning of religion and spirituality—as it exists for that person as part of the program as well as personally.

A narrative approach was chosen as the research design to interpret the complex and diverse experiences in the spiritual narratives of addicts in recovery. Storytelling gives life to content, as it is weaved together using the experience or experiences from the storyteller's perspective and the interviewer's observations as the story is being told (Riessman, 2008). The contexts in which the participants' experiences with spirituality occurred and the meanings drawn from those experiences can best be captured in narrative form.

An additional benefit of the narrative approach is that addicts in recovery have experience telling their story of addiction and recovery multiple times (e.g., speaking at meetings and with a sponsor). As mentioned in Chapter 2, this started in the Washingtonian Movement with the intention to increase membership by making the meetings more interesting (Maxwell, 1950). It was eventually found to be one of the most important parts of the recovery process by Bill W. and Dr. Bob. Recovery stories often include what life was like before addiction, the negative consequences of addiction, and the benefits of recovery and living a sober life. Thus, a narrative approach also aligns with this recovery model.

Other qualitative methods were unsuitable for investigating the research question. For instance, the research question was focused on the spiritual narratives of addicts in recovery and not on a bounded system (case study) or a single phenomenon (phenomenological). Additionally, although the population included Jews who were formerly religious, the research question did not focus on the culture of this religious group or the program, so ethnography was not appropriate. Grounded theory was also not appropriate because the intent of this study was not about theory building. The study explored the spiritual narratives of Jewish addicts in recovery from being raised in an Orthodox Jewish home (i.e., a religious environment), which included a break from the values and spiritual belief system they were taught, events that led them to addiction, and their treatment with 12-step facilitation, which is grounded in spiritual growth. Two theoretical frameworks were applied to develop interview guide questions and help identify emerging relevant themes: faith development theory (Fowler, 1995), and cognitive dissonance theory (Festinger, 1957).

The Role of the Researcher

The general role of the researcher in qualitative studies is to gather and interpret data, which is guided through personal knowledge, perspective, and subjectivity (Barrett, 2007). During the data collecting stage, the researcher's role falls somewhere on the spectrum between observer and participant, depending on the purpose of the study. For the current study, my role was to be an observer and interviewer, which involved interviewing the participants through different mediums: phone call, video-chat, and face-to-face.

My personal experiences, perceptions, and knowledge were considered as major contributors in how data were gathered and interpreted. If left unchecked, personal bias may have had a strong influence resulting in lower trustworthiness. The biases stemmed from my personal experiences with Judaism, educational/vocational experiences, and professional/personal relationships. Similar to transference in therapy, the researcher must keep in mind thoughts and feelings as the participant tells the narrative. Without employing certain procedures, personal experiences may have affected how I conducted the interviews and how I interpreted the data.

I also have experience in the addictions field through completing my practicum and internship at Chabad Treatment Center, which offers both residential and outpatient treatment for addicts in recovery. Throughout 4 years I developed close relationships with many of the staff and clients. My contact with the clients included conducting clinical intakes and as a therapist (facilitating groups and individual therapy). My contact with the staff included consultations with other therapists, discussing clients with counselors, and speaking with my supervisors as well as the director of the program. Over the years I worked closely with my supervisor on becoming aware of biases based on my religious beliefs, which involved making assumptions based on my experience with Judaism in the community and the clients' upbringing. I grew up secular and became Orthodox as an adult, which allowed me to appreciate the different lifestyle (i.e., secular versus religious). The clients, however, were born into Orthodox Jewish families, so they only knew of Orthodox Judaism until they moved toward a secular lifestyle somewhere between adolescence and adulthood. Their transition often came with

rejection and disdain from their Orthodox Jewish families. Thus, I had to be aware that I could not assume how these clients perceived and/or connected with Judaism and spirituality.

To keep bias in check for this study, member checking and an audit trail were employed. Member checking increases credibility and is the process of sharing the transcripts and researcher findings (e.g., emerging theories and inferences) with the participant, allowing the participant to judge the accuracy of the findings, provide feedback, and request any changes (Shenton, 2004). Member checking was discussed with the participants during the consent process. An audit trail helps to determine if bias is present as the researcher keeps a detailed journal throughout the stages of data collection, coding, and analysis.

As an Orthodox Jew, I recognized that participants may have felt uncomfortable openly discussing issues with Judaism or may have catered answers toward seeking my approval. Participants were encouraged to be open and honest about their feelings throughout the interview process. After the interview, participants were given the opportunity to contact me up to 30 days to clarify or add to their narrative. One participant contacted me to add a significant experience to her spiritual narrative. No other participants contacted me to change or add to their narratives, so no follow-up interviews were scheduled.

Other Ethical Concerns

Upon initial contact, potential participants were provided an overview of the research: reasons for conducting this research, the process, and potential applications

based on the findings. Once individuals agreed to participate, a date was set for the interview. An informed consent process took place prior to starting the interviews. This process included a review of the research process, confidentiality, and ethical concerns regarding possible reactions during the interview process. I explained to the participants that through relating their narratives, they would most likely discuss traumatic events that could bring up negative emotions, or cravings could be triggered through discussing their history of alcohol/drug abuse. Before the interviews started, participants were told they could stop the interview at any time. Additionally, they did not have to discuss any topics that made them feel uncomfortable. A list of crisis hotlines: national and several state locations—available 24-hours, 7 days a week—were provided to all participants during the informed consent process. The centers were a source in the event that participants felt the need for additional support.

Methodology

Participant Selection

Context. Recruitment for the study was focused on locations with large Orthodox Jewish communities within the United States. These locations included New York (Brooklyn, Queens, Manhattan, and Monsey), New Jersey (Lakewood), Florida (Miami), and California (Los Angeles). The study was open to including potential participants from other areas in the United States given that they fulfilled the inclusion criteria. Recruitment was accomplished through distributing invitation flyers through media applications (WhatsApp, Facebook, etc.), in 12-step groups, and referrals from potential participants (i.e., snowball sampling).

Sampling strategy. Criteria for inclusion were men and women between the ages 18 to 65, raised in Orthodox Jewish homes, have engaged in 12-step work, and fulfilled the DSM 5 criteria for alcohol and/or substance use disorder in sustained remission. The criteria are defined as sustained abstinence from the substance for more than 12 months and may still have cravings but no other symptoms.

Criteria for exclusion were individuals who were in the Chabad Treatment Program at any time from January 2013 to the present or self-reported that they were under the age of 18 or over the age of 65 (see Appendix for screening procedure). Individuals who were considered part of a vulnerable population (e.g., economically disadvantaged, have a mental/physical disability, pregnant women, etc.) were not excluded, as it would have been unethical to exclude them because of their circumstances.

Saturation. Selecting a sample size in qualitative research is determined by saturation. This is understood as the point where new information makes an insignificant addition to the study and that the study could be replicated. Any effort to gather information once saturation is reached is unnecessary, but it is equally important to not have too small of a sample size where critical information is missing. Narrative inquiries range in a sample size between 1 and 62, with a mean value of 23 (Mason, 2010). Several elements influence how much of a sample size is needed to reach saturation: participant heterogeneity, interviewer experience, interviewer personal lens, data collection methods, and available resources. These factors were applied in the current study through inclusion/exclusion criteria, increased participant heterogeneity, my personal experience

completing clinical intakes and providing therapy for this population, data collection, and the guidance of my dissertation chair.

Following the advice of previous research to take a portion of potential participants as the initial sample size, adding more if saturation has not been met (Guest, Bunce, & Johnson, 2006), I initially tried to gather a pool of 10 to 16 participants. Nine people contacted me to join the study. Two reported that they were in their first year of sobriety, and one excused himself from the study during the screening procedure. Six participants completed the screening procedure and were interviewed. Upon coding and analyzing the data, my chair and I agreed that saturation was not met and more interviews were necessary. Three more people were interested in joining the study; however, one had recently given birth and could not commit to setting up an interview. Thus, two participants completed the screening procedure and were interviewed. The overall results of data coding and analyzing eight interviews revealed that saturation was met.

Invitation and Recruitment

Acquaintances of the researcher for the purpose of this study are identified as *gatekeepers*. These individuals are members of recovery groups with the population of interest for this study. They distributed the invitation flyer at meetings and through groups they are a part of on social media (e.g., Facebook groups). I reviewed issues with confidentiality (i.e., I could not discuss participant identities and responses) and clarified that they were to distribute the flyer but not to encourage participation. Due to ethical concerns, I originally set up the screening procedure to exclude all clients of the Chabad

Treatment Center during my employment there. No one in treatment during that time contacted me to join this study.

Instrumentation and Materials

The interview guide was semistructured with a series of open-ended questions. The framework and questions were based on identified gaps in the literature, theoretical frameworks, existing qualitative studies on addiction and/or spirituality, and my professional experience working with this population. Cognitive dissonance theory was used to guide questions about participant struggles between what they learned, observed, and their personal behavior. Faith development theory was used to interpret parts of participant narratives relating to their spiritual journey. I was unable to secure a panel of experts for face and content validity review. Subquestions were used as a guide for the interview questions. Probing questions lead participants towards providing more details and clarifying parts of their narratives.

Table 1

Research Subquestions and Corresponding Interview Guide Questions

Subquestions	Interview questions	Examples of probing questions
How does the narrative begin?	Let's focus on your upbringing in the Orthodox Jewish community – what was your experience with spirituality?	• How was Judaism presented at home? At school? At shul (prayer services)? • What was most challenging about your relationship with Judaism? Can you describe an example? • What was least challenging about your relationship with Judaism? Can you describe an example? • At that time, what did spirituality mean to you? Can you describe an example? • Tell me about a person who was an important part of your spiritual experience in your upbringing?
What are the turning points in the spiritual journey?	What is the next meaningful event or experience in your spiritual journey? (this is repeated up to starting 12-step work)	• What do you remember about this event? • What makes this event a "turning point" in your spiritual journey? • What meaning did this event have for you? • Tell me about a person who was an important part of your spiritual journey at this point?

What is the meaning of spirituality?	What did spirituality mean to you at this stage in your life? (this is asked corresponding to the event of the previous question)	• Were you engaged in any spiritual practices? If so, what were they?
		• What was your experience with G-d/Higher Power?
		  o What did that experience mean to you?
		• What was your experience with Judaism?
		  o What did that experience mean to you?
		• What was your experience with Rabbis, teachers, Orthodox Jews in your community, and non-Jews?
		  o What did that experience mean to you?
		• What was most challenging in terms of making sense of what you learned about spirituality/religion and what you experienced (cognitive dissonance)?
		  o Was there another challenging event or experience that comes to mind?

(table continues)

Subquestions	Interview questions	Examples of probing questions
How is spirituality experienced in the 12-step program?	What was your spiritual experience when working through the 12 steps?	• What did spirituality mean to you when working through the 12 steps? • Were you engaged in any spiritual practices? If so, what were they? • What was your experience with G-d/Higher Power? • What was most challenging in the spiritual aspect of your 12-step work? Can you describe an example? o Was there anything else you found challenging?
What is the present moment of the narrative?	Where are you now in your spiritual journey?	• What does spirituality mean to you now? • What are your sources of support? • What would you say to someone who grew up in an Orthodox Jewish community, now struggling with addiction? • Is there anything else you would like to tell me?

Procedures

Data collection. Upon first contact with participants, the purpose of the study was reviewed, followed by a review of the inclusion and exclusion criteria (see Appendix for the screening procedure). Of the 12 people who initially contacted me, 8 met the criteria and joined the study. The informed consent process was reviewed and emailed in PDF format. Participants electronically signed and returned the consent letter before their interviews. Participants were advised to set a time slot for 2 hours – 60 to 90 minutes for the interview, with extra time for debriefing at the end of the interview. All interviews were set within 1 week of the screening procedure and transcribed within 30 days of the interview. Interview times ranged from 30 minutes to 2.5 hours.

It is a popular practice among addicts to write an autobiography, focusing on how they came to alcohol/drug addiction and what it did to their lives. All participants were

asked to provide their autobiography as a secondary source for their narrative. They were told that this was not a requirement for the study. None of the participants had their autobiographies easily accessible (in electronic format), and therefore no autobiographies were provided for the study.

All interviews were audio recorded using the Zoom H1 digital recorder. The participants were offered several options for the interview medium: in-person, phone call, or video chat (Skype or FaceTime). Saura and Balsas (2014) found that all three techniques are effective for qualitative interviewing. Six interviews took place through a phone call, one interview was via Skype, and one interview was in-person (in a secluded office). No follow-up interviews were needed.

Exit and debriefing. The debriefing procedure at the end of the interviews included: thanking participants for their willingness to share their stories, and a final question, "is there anything else you would like to add to your story?" Participants were told that a summary of their interview was to be sent to them for review via email or if they preferred a hard copy. The summary included a script to contact the researcher if they felt the need to clarify, revise, or add to their narrative. All participants requested a summary via email, which was sent within 30 days of completing their interviews.

Data Analysis Plan

I asked fellow peers in my dissertation course about their experiences with transcribing and software they used for coding/analyzing the data. One peer reported having a negative experience in paying a transcription company because it was expensive, and she found several mistakes in the transcriptions. I decided to personally

transcribe the interviews for three reasons: it was cost effective, I could ensure there were no mistakes, and I thoroughly reviewed the interviews during the transcription process (i.e., increased familiarity). One of my peers used NVivo, and another used Atlas.ti – both were pleased with the software. I initially planned to use NVivo 11 (student starter license) for organizing, managing, and analyzing data. Before purchasing the NVivo software, my chair suggested that I hand-code the first three interviews using two coding methods in Saldaña's coding manual. I chose to use thematic analysis for the first cycle, and in vivo coding for the second cycle. After coding the three interviews and reviewing the results with my chair, we decided that I should continue to hand-code the rest of the interviews. At that time, I had only completed six interviews, and my chair and I determined that saturation had still not been met. Two more participants joined the study, and after coding their interviews, we determined that saturation was met, and no more interviews were needed.

Issues of Trustworthiness

Establishing Credibility

In order to establish congruency between study findings and reality (i.e., credibility), qualitative studies adopt research methods that are well established (Shenton, 2004). Narrative inquiry is an established method in qualitative research (Riessman, 2008; Creswell, 2007). The story-telling process provides special insights into the complexities of human experience (Riley & Hawe, 2005). Due to its ability to shape social phenomena through the story-telling process, the narrative approach has been used

in several different fields including anthropology, literature, philosophy, and psychology (Jovchelovitch & Bauer, (2000).

The background, qualifications, and experience of the investigator are important in establishing credibility (Shenton, 2004). My experience working with this population and conducting clinical interviews adds to the concept of "prolonged experience" in the field. I have observed the recovery process, facilitated group and individual therapy where clients discussed their struggles with spirituality, and engaged in training modules that covered: addiction, clinical interviewing, attending skills, and documentation.

Creswell (2007) described substantive validation as interpreting the subject matter through comparing the researcher's personal understanding with understandings derived from other sources and documenting the process. An audit trail was sufficient for documenting this process, along with providing transparency for researcher bias. Shenton (2004) described the audit trail as the researcher's "reflective commentary" that documents initial impressions, along with patterns and theories as they appear to emerge. Frequent debriefing sessions (Shenton, 2004) with my chair provided me with a sound board to test my interpretations of the data and kept me focused in my role as a researcher – not a therapist.

Establishing Transferability

The thick description of a phenomenon under investigation gives readers/critics a better understanding, which enables a competent comparison between studies (i.e., transferability; Shenton, 2004). This requires extensive information across several areas including number of participants, participant restrictions, data collection methods, and the

time period of the data collection sessions (2004). Rigorous efforts were made to provide a substantial amount of details on the participants' spiritual journey, the data collection process, analyzing the material, and the formulation of the results. Rigor is the central factor in boosting confidence that research findings represent participant meanings (Creswell, 2007).

Establishing Dependability

While qualitative research shies away from demanding that a qualitative study should be able to be replicated, the research process must be consistent (Riessman, 2008). For the current study, an audit trail provided a detailed account of the research process, and there was triangulation of different sources (interviews, existing literature, and multiple theories). The ability for this study to be replicated (i.e., dependability) was established through reporting the process of the study in detail: describing what was planned, how it was executed, and reflecting on the effectiveness of data collection and analysis (Shenton, 2004).

Establishing Confirmability

Meanings that participants attribute to their experiences take priority over the perspective of the researcher. As such, to promote trustworthiness, the researcher must try to capture the unadulterated meanings from the perspective of the participants in a clear and concise way that could be confirmed by others (i.e., confirmability). The detailed methodological description and audit trail in this study demonstrated concern for objectivity and kept researcher bias/preferences in check (Shenton, 2004). Member checking and debriefing the participants at the completion of the interview, ensured that

the findings in this study emanated from their perspectives and meanings of ideas and experiences in their spiritual narratives (Riessman, 2008).

Ethical Procedures

Men and women between the ages 18 and 65 were invited to voluntarily participate in the study through flyers and referrals. There was an informed consent process before the interview. This form included: the purpose of the study, participant ability to withdraw from the study any time, confidentiality, criteria for inclusion to the study, interview procedures, and resources to contact if needed due to experiencing distress. An alpha-numeric combination created a pseudonym as a substitute for the real names of participants.

Data Management

The interviews were audio-recorded and stored on a password-protected computer, with a second copy stored on a flash drive. The flash drive, along with written notes and audit trails were labeled “confidential” and stored in a locked metal file cabinet. The computer and metal cabinet were located in the researcher’s home office. Upon completion of the research, the files were completely removed from the computer hard drive and saved on a second flash drive, labeled “confidential”, and placed in the locked metal file cabinet with the other materials. Five years after the completion of this study, the raw data will be destroyed through: electronic data will be completely erased from the flash drives (they will be formatted), and physical data will be burned in a fire.

Summary

Chapter 3 identified the qualitative method – narrative analysis and rationale for using this approach to better understand the spiritual aspect in the 12-step recovery experience of addicts who were raised in Orthodox Jewish communities. The role of the researcher and potential for bias were addressed. Methodology was divided into several sections covering: participant selection - defining the population as addicts raised in Orthodox Jewish communities, have engaged in the 12-step recovery model, inclusive criteria for participant selection, the data collection process - recruitment via invitation flyers and referrals, conducting semistructured interviews, and analyzing the data. Issues of trustworthiness and ethical procedures were reviewed.

Chapter 4 describes the results of the data collection and analysis processes including: the actual number of participants, when and where the interviews took place, coding, and the development of emerging themes. Evidence of trustworthiness will be presented.

Chapter 4: Results

Introduction

The purpose of this narrative analysis was to explore the meaning of spirituality of formerly observant Jewish addicts who maintained sobriety after working through a 12-step recovery program. My intent was to get a better understanding of the role of spirituality in addiction and recovery through exploring the spiritual narratives of individuals leading up to, during (active), and recovering from addiction. The following research question and subquestions were explored:

Research Question: What do the spiritual narratives of formerly observant Jewish addicts reveal about their experience in a 12-step recovery model?

Subquestion 1: How does the narrative begin?

Subquestion 2: What are the turning points in the spiritual experience?

Subquestion 3: What is the meaning of spirituality?

Subquestion 4: How is spirituality experienced in the 12-step program?

Subquestion 5: What is the present moment of the narrative?

In Chapter 4, I present the results of the data collection process, evidence of trustworthiness, and an analysis of the data including: codes, categories, and themes that emerged from the data. The results of the analysis will address the primary research question and subquestions. This chapter will conclude with a summary and transition to Chapter 5.

Setting

Participants were recruited through a combination of invitation flyers and snowball sampling. Potential participants contacted me through phone calls, e-mail, and WhatsApp. I called each potential participant back and followed the screening procedure (see Appendix). Of the 12 potential participants contacted me, only 8 joined the study. Two people were excluded because they were still within their first year of sobriety, one person excluded himself by stating that his upbringing switched between Orthodox and secular Jewish communities, and one person excluded herself because she gave birth after the screener and stated that she did not have the strength or time for an interview.

Demographics of Participants

The participants included a total of five men and three women. Their demographics are shown in Table 2. Of the seven participants who described their upbringing in an Orthodox community, one was in the Chassidic sect. One participant described a transition in her family from Conservative to Orthodox when she was a child. Ages of starting alcohol/drug abuse ranged from 10-17 years old. Current amount of time sober ranged from 1 year to 24 years. Seven participants completed residential treatment, and one participant completed outpatient treatment. Two participants relapsed several times after several treatments, one participant relapsed twice after treatment, and one participant relapsed once after treatment.

All participants described traumatic events in their upbringing including physical/sexual abuse, death of a close friend or relative, and bullying by peers/teachers. Four participants were raised on the East Coast (New York, New Jersey), three

participants moved to California during their teenage years (one from New York, one from Georgia, and one from Nevada), and one participant was fully raised in California. All participants were expelled from multiple high schools. Six participants post high school traveled to Israel to continue Judaic studies and reported an increase in alcohol abuse. Two participants had already started recovery when they traveled to Israel and continued to maintain sobriety.

Table 2

Participant Demographics

Participant	Time Sober	Age Started Drugs/Alcohol	Number of Relapses
A1	1 Year	15	0
J1	12 Years	15	0
R1	12 Years	10	0
S1	24 Years	11	0
S2	4 Years	18	4
S3	1 Year	14	2
T1	6 Years	12	1
Y1	5 Years	17	5

Interview Summaries

Participant A1. A1 described her upbringing as very religious. Her father held a rabbinical position where he taught Judaism to secular Jews. She had been molested in childhood and moved between friendships without getting close to anyone. Regarding spirituality in her childhood she stated, “I just did what you are supposed to do because that’s just how I was brought up.” There was a family tragedy when she was in high school, where she started asking questions about G-d and Judaism, but she was not getting answers. A1 stated, “They never answered my questions because I always asked, ‘How can you believe in G-d?’ I would ask these spiritual questions in 9th grade and I

never got one answer." She reduced religious practices, started alcohol and drug abuse, and was expelled from several high schools. By 12th grade she had completely stopped religious practices, though she stated, "I always believed in Hashem. I never lost my faith."

A1 traveled to Israel and tried reconnecting to Judaism, while increasing alcohol and drug abuse: "I went through periods of being spiritual and then just wanting to get messed up and get drunk." She eventually returned to California and described her life as "really really bad." She added,

> I mean there were times that I thought I would die. Like I would wake up and ask, "why am I alive?" but I didn't care. I didn't care if I died. I wasn't suicidal necessarily, but if I would not have woken up one day I wouldn't have cared.

A1 entered residential treatment and stated, "People are either an atheist or struggle on a Higher Power, but I always had a Hashem." Upon completion of 90 days in residential treatment A1 moved to a sober living. She started 12-step work but did not like her first sponsor. She switched to another sponsor who helped her to get serious in working the steps. She described her current spiritual practice as "I just connect with Him at my own level, it's definitely still Hashem, I just connect on a spiritual level, not a religious level. Praying is always the first thing I go to right now."

Participant J1. Participant J1 was raised in a strict Orthodox home where his father held a rabbinical position at a yeshiva. J1 was molested by several community members and stated, "It turned me off from spirituality at a young age." He had questions about G-d and Judaism but was told, "your thing is to make Hashem happy, and do

everything you need to do to make Him happy, and don't ask any questions." In 4th grade J1 was disconnected from Judaism but continued to outwardly follow Jewish law. He started alcohol and drug use in high school and was expelled several times. J1 traveled to learn in Israel but was expelled from different schools due to heavy drinking episodes. He eventually returned to the United States and entered a marriage that lasted 3 years. He described the entire marriage as, "drinking and using drugs to the point of blacking out." J1 entered residential treatment and started 12-step work. His current spiritual practice was described as "I really don't have a conventional Higher Power at all. My belief today is where like I'm a good person. I would say these days, my spirituality lies in doing, within doing the step work, more than anything else."

Participant R1. R1's parents divorced when he was 3 years old. His mother remarried when he was 6, and his stepfather was physically abusive. He had no father figure, and his family was very poor. R1 did not know how to practice Orthodox Judaism. During prayer services he said, "I had no idea what to say or do, so I would go in there and just feel stupid." Due to constant fighting he lived with different people and attended different schools.

R1 started heavy drinking at age 10. He had no interest in Judaism and had no friends. He described constantly having negative experiences with religious Jews, which added to his disinterest in Judaism. Heavy drug use started at age 15 until age 18 when R1 entered residential treatment. He stayed sober from drugs but described replacing women for drugs. R1 was living independently with high income but stated, "I had

everything I wanted, and I just wasn't happy. I thought I had everything that I wanted in life and really had nothing." He traveled to Israel to learn about Judaism and stated,

> I got very interested, very connected to it. And I started growing from there. And I started realizing that Judaism is not bad, and it's the right path for me, just the few people that I met had a negative, extremely negative impact on me.

R1 currently identifies as an Orthodox Jew, married with children.

Participant S1. S1 described her upbringing as very religious, where Judaism was presented as black-and-white and the system was not set up to answer individual questions outside of what was taught: "I wasn't getting any answers, or any feedback to the fact that maybe there's a big question mark over here." She was molested by a family member in childhood and started questioning Judaism at age 11 when her friend was killed by a terrorist attack in Israel. Due to unanswered questions, and feeling a lack of support, S1 described his behavior as "going through the motions but did not have the actual 'faith' that was being portrayed."

At age 11, S1 started sneaking alcohol from her parents' kitchen cabinets. She also gradually became less observant. Age 14 she was expelled from several schools due to outwardly breaking Jewish law. S1 eventually started living on the streets and was engaging in heavy drug/alcohol abuse. She had a negative introduction to AA when the person who brought her to her first meeting tried taking advantage of her after the meeting: "That kind of put a big X on getting help." She continued heavy drug/alcohol abuse, living on the streets until she was attacked by two men. S1 asked her parents for help, and they got her into residential treatment where she described her first sign of

spirituality. Upon completing 30 days of treatment, she traveled to Israel and entered another residential program. Throughout sobriety S1 considered herself on a spiritual quest. She visited sweat lodges, meditation groups, and traveled to India. She is currently married, keeps traditional Jewish values, and describes her relationship with G-d as,

> I could choose to follow what I want, if I want to, or need to, I don't need to explain. Like if I feel like He is there for me that I can turn to Him, and pray to Him, that He loves me - Something out there loves me, cherishes me, believes in me.

Participant S2. S2 described his family as Orthodox, but there was not much spirituality in the home. His father was a beloved rabbi in a community that was slowly becoming more Orthodox. When he was 13, his family moved from the East Coast to California. S2 went to a religious school where he was constantly bullied due to his lack of Judaic knowledge. He was expelled from several high schools due to not observing Jewish practices. Still he stated, "I always believed in G-d."

Upon graduating high school, S2 became very successful in business. His company kept growing, but it was highly stressful work. S2 turned to drugs and heavy weekend partying. Drug addiction eventually drove his company into the ground. He entered marriage while still in active addiction, and his wife convinced him to try residential treatment. After 30 days he returned home, and his wife filed for divorce. He relapsed and continued trying different residential programs. Finally, someone in the Jewish community reached out and helped S2 get into a 90-day residential program followed by 90 days in sober living. At that time, he started 12-step work but disagreed

with the “disease concept” of addiction. He described AA meetings as, “the most depressing place I've ever been in my life.” S2 currently keeps certain Jewish practices and speaks at AA/NA meetings.

Participant S3. S3 described her early home environment as Conservative, and her family gradually changed to become Orthodox when she was 11. At that time, she was molested by someone who presented himself as an Orthodox Jew and had befriended her family. S3 traveled to California to attend high school, which she described as negative: “I felt very different from the girls at school because they had an entire background of growing up this way and learning a certain way.” She was expelled from several high schools, stopped Jewish practices, and started abusing alcohol and marijuana. At age 18 she traveled to Israel but increased alcohol and drug abuse. S3 returned to California and continued active addiction until she entered residential treatment but left after 90 days because she felt the program promoted a lower level of Judaism: “they are more of a reform, conservative Jewish place. And I thought that it was pathetic what they were doing. I judged them for the kind of services they had, and I felt better than them.”

S3 re-entered a toxic relationship and relapsed. After several months she described, “I felt a spiritual bottom, an emotional bottom, and a physical bottom.” She tried residential treatment again and started 12-step work. S3 is currently engaged and stated, “It’s a constant work for me to bring spirituality and G-d into my life. I definitely don’t do it perfectly and I know that it’s something that every day I have to think about.”

Participant T1. T1 described his upbringing as religious but not extreme. He was not connected to any form of spirituality: "I basically, just didn't understand, um, religion, spirituality, etc. I kind of just went with the flow. I'm told to do this, so I do it." T1 started binge drinking at age 12 and was constantly getting into trouble in school. He went to several high schools, eventually traveling to California where he attended a Modern Orthodox school. He described it as, "Didn't really fit in as well, coming from a more extreme background than most of my classmates and the school as a whole." T1 reduced his religious observance and increased alcohol and marijuana abuse. He traveled to Israel for Judaic studies and alcohol/drug abuse became a nightly occurrence. After a short time in U.S. college, T1 returned to Israel and stated he was "chasing spirituality." He fully took on Orthodox Judaism, learned full-time in yeshiva, and continued binge drinking over the weekends. T1 entered a marriage that lasted less than 3 years, as he continued alcohol abuse.

T1 eventually entered treatment and was divorced close to a year in recovery. Two years later he described getting serious about 12-step work. He is currently sober for close to 6 years and shared, "This program is about doing the right thing. And that has to start with my spiritual connection, and I have to maintain that throughout my every day no matter what."

Participant Y1. Y1 described his upbringing as having very little spirituality where he learned that "G-d was a punishing Being Who was out to get you." He was bullied in school by his peers and teachers because he looked different (i.e., not Chassidic). Other traumatic experiences include losing his friends when his family moved

and getting humiliated and molested by a teacher in school. Y1 was expelled from several schools and summer camps due to smoking and delinquent behavior. He reconnected with Judaism his senior year of high school (in New York) and continued Judaic studies in Israel. Y1 described getting into a deep depression while in Israel and increased marijuana abuse. He returned to the United States and entered residential treatment but left and started heavy drug use. He said, "I was very depressed, completely despondent, and thought G-d was evil." Y1 became sober on his own at age 26 and decided to return to Judaic studies in Israel. He stayed sober for 3 years, then started drinking again and returned to New York. Y1 entered a marriage that ended within 6 months. He searched for spirituality in the Burning Man scene:

> I was exposed to a lot of people in the Burning Man scene that would talk about Greek gods and witches, I don't know what the hell they were talking about. I wanted to make a stance that I'm a Hashem man.

Y1 tried several residential treatments and eventually gained sobriety in 2013. He was introduced to completing 12-step work within a 3-day period, which he believes worked for him. His current view of G-d, "I don't understand Him at all, aside to say that G-d is very loving and that is why He does this, but I have a feeling that I'm going to be left with question marks for eternity."

Data Collection

Recruitment for participants started January 2018. Two gatekeepers were contacted, and invitation flyers were distributed to 12-step meetings frequented by individuals who were raised in Orthodox Jewish communities. Six participants joined the

study within 1 month of sending out the flyers. Two potential participants asked to join the study, but when asked for their sober time, both responded that they had not yet reached 1 year. Another excused himself from the study during the screening procedure. Two more participants joined the study May 2018. One potential participant passed the screener but had difficulty setting a time for the interview because she was due to give birth, which eventually caused her to not join the study.

I created the consent form in PDF format which allowed participants to sign and return the forms electronically. Six of the interviews were completed through a phone call, one through video chat (Skype), and one was in person. All interviews were conducted in a private office, not used for therapy, as indicated in Chapter 3. Unfortunately, I was unable to obtain written autobiographies, which would have helped in triangulation of the data.

Each of the interviews ranged from 30 minutes to 2 hours in length and all were completed in 1 session. The interviews were recorded on a digital audio recorder. Confidentiality was secured through using an alpha-numeric code for each participant. Upon completion of the interview, all participants were asked for an address to send the thank you gift. Three participants asked that their gift be given to someone currently in residential treatment. The four potential participants who did not join the study were also offered the thank you gift, but stated they were not interested in the gift.

Of the eight participants, one reported feeling emotional pain upon completion of the interview. He stated, “This is just a vulnerable process I just went through. I haven’t really tapped into my childhood, you know?” I directed him to the support hotlines on the

consent form and asked if he could easily access the information. He stated, “No, I’m fine, I’m saying, just a little – you know. A little like, I can feel it in my stomach. A little like, you know, a little knotted. But I’m fine.” The participant sent me a WhatsApp message the next day that he was feeling better.

Member checking took place through email where each participant received a summary of the interview and was asked to provide feedback and/or to clarify any points deemed necessary. Five participants responded that there was nothing to change, and two participants were contacted three times but did not respond. One participant clarified that during the interview she had forgotten to report that she was molested in early childhood, which she realized was an important part of her spiritual journey.

Data Analysis

Interviews were personally transcribed using a transcription foot pedal with Express Scribe software. The interviews were transcribed into MS Word (2016). Manual coding was employed through creating MS Excel spreadsheets for separating and comparing participant statements. There were two stages to the data analysis process. The first stage was thematic analysis, and the second stage was in vivo coding. Each of these are explained below, and then the results of each effort are presented.

Thematic Analysis of the Narrative Turning Points

Thematic analysis identifies common elements (i.e., patterns) of meaning across a dataset (participant narratives in this study) in order to answer a research question. Language is considered a direct path to meaning, and there is more of an emphasis on what is said (content) than how it is said (Riessman, 2008). Thematic analysis is

appropriate for interviews where there is a focus on exploring beliefs, identity development, and understanding personal experiences at a particular time in history (Saldaña, 2016). This study used a semistructured interview process which included identifying turning points in participant narratives. Participants clarified turning points when they answered the question, "What was the next meaningful experience in your spiritual journey?" Turning points were categorized as: the beginning, participant identified turning points (childhood trauma, starting unruly behavior, active addiction, starting recovery), and the present moment.

During my thematic analysis I had to distinguish between turning points within the spiritual narratives from other nonspiritual turning points. The interview questions provided a format for identifying turning points related to spirituality, and participants included "meaningful experiences" to their addiction and recovery, but not necessarily to spirituality. For example, when asked about the next turning point in his spiritual narrative, Participant T1 described his drinking behavior and defining himself as an alcoholic,

> My first time tasting alcohol, all of a sudden it made me feel more secure . . . what defines me as an alcoholic is the way I think . . . I don't like being present. I wasn't aware of this at age 12 or 13 as I'm taking shots and feeling different.

Participant A1 stated, "I went to the craziest festival called EDC Vegas. I went to this festival and had the best time of my life, and I was just completely messed up for three days."

In Vivo Coding

In vivo coding is the process of selecting actual words and phrases that participants use in their narratives. This type of coding enhances the understanding and meaning of experiences, cultures, and worldviews (Saldaña, 2016). Coding involved reading 160 pages of transcribed interviews multiple times in order to reinforce my familiarity with the material. Memos were also reviewed, and these included observing changes in participant tone of voice and emphasis on different experiences (e.g., drug use, trauma), participant clarity in telling their narratives (i.e., relating an accurate historical account of events), participant openness in providing details of certain life events, and feelings participants expressed upon interview completion.

Through reviewing participant statements and reflecting on memos, I found 343 codes that stood out when participants explained meaningful experiences in their narratives. Using the thematic analysis as a guide, I placed the codes in each of the respective turning points. Most of the codes overlapped among the interviews, and a total of 44 categories emerged. For example, the category "nescience" which is defined as lacking knowledge (Merriam-Webster.com, 2019), emerged from statements, "you are kind of in the dark" (A1), "I had no idea what to say or do" (R1), "wouldn't understand what I'm saying" (S2), "I wanted to understand more, but I wasn't being taught" (T1). The category "outsider" emerged from statements, "the whole class would be praying, and I would be pretending" (S1), "I thought everyone was right and I was wrong" (Y1), "feeling disconnected and needing help" (S3), "I never really felt like I belonged" (T1).

Through the comparison of these categories with the patterns identified in the thematic analysis, six themes emerged: religious not spiritual, pretending, rebelling, darkness, rebirth, and harmony. Each theme represents participant experiences and their meanings at each turning point in the spiritual narratives. I found that four of the six themes overlapped at several turning points. The two that did not – darkness and harmony, marked what participants described as the least spiritual (darkness) and most spiritual (harmony) points of their narratives. These are presented in detail in the subsequent section.

Results

Thematic Analysis of the Narratives

The beginning. Three patterns were identified across participant beginnings of their narratives: they were all taught to believe in G-d and Jewish law, lacked understanding of G-d and Judaism, and described their childhood as religious not spiritual. In the first pattern, all the participants were taught to believe in G-d. However, they had varied beliefs of G-d. Two participants were polar opposites in their beliefs. Whereas participant S3 believed in a, "loving and caring G-d", participant Y1 believed G-d was, "just a punishing Being." Six participants had no concept of G-d, with two specifically stating they had no interest in G-d.

A common experience related by all participants was being taught what to do (in Judaism) but not why to do it. Participants listed this as the primary reason for their lack of understanding in G-d and Judaism. Participant S1 stated, "It was more just about the black and white, what we are supposed to do . . . I'm supposed to trust this G-d. I'm

supposed to do what He said whether I understand it or not . . .” Participant A1 stated, “all of these *mitzvos* (commandments) you are supposed to do, I never got an explanation why.” Participant Y1 stated, “It was rote, you did stuff and you didn’t do other stuff, and there was no real explanation of that.” Participant S3 stated, “I don’t remember there ever being a dynamic between me and my parents where it was an open conversation about religion and why we do it.” When going to prayer services, participant R1 stated, “I had no idea what to say or do, so I would just go there and feel stupid, not knowing what I’m doing with the *siddur* (prayer book).” Four participants stated that their father was a rabbi in the community. Participant S2 stated, “My father is a rabbi, so in home I was exposed to Judaism . . . I didn’t know anything I said. The *brochos* (blessings) in the morning, I didn’t know what they meant.”

Participants clarified that they had a religious upbringing but lacked spirituality. Participant S1 stated, “In my home my parents were very religious, more based on religion than spirituality. I don’t remember coming across the word ‘spirituality’ until much later.” Later in the interview Participant S1 reiterated, “the word ‘spirituality’ in my childhood doesn’t fit well with the word ‘Judaism’ unfortunately.” Participant S2 stated, “there wasn’t a lot of spirituality in my life growing up . . . I really had no spiritual connection.” Participant Y1 stated, “So as a little kid, let’s say in the yeshiva system – really, really bad, like zero spirituality whatsoever.”

First turning point: Childhood trauma. All participants identified a traumatic experience as the catalyst for the first turning point. Traumatic experiences varied among participants and included: sexual abuse/molestation, physical abuse, verbal/emotional

abuse, neglect, and moving to another community. Participants, who experienced childhood trauma, described a break in trust of close relationships (e.g., family, community members), and change in their perception of G-d. S1 stated, “I was a happy kid before that (sexual abuse), and afterward I had major trust issues.” Participant R1 stated, “A few months later he would start using his belt, and the angrier he got, he would sometimes turn the belt around, um, and use the buckle on us . . . all I saw was from people that said they believe in G-d was anger and hate and violence.” Participant S2 described the move to another community,

> For several reasons I was bullied a lot, which was almost the opposite of what I was used to. I was very popular in (city). I was a very good athlete, and then, all of a sudden, we move here and everyday I’m being bullied . . . I didn’t care about Judaism at the time, I wasn’t into spirituality, it was all about getting out of high school and somehow making money.

Participant S3 stated,

> While we were staying there (rabbi’s house) we met a man who was 11 years older than me from a very *frum* community . . . he took a liking to me and this is really where my life took a very traumatic and downward turn . . . feeling disconnected, needing help, and not getting the help I needed, I was lost.

Participants described the effect of trauma on their relationship with G-d. Participant S1 stated, “I was at that point having a dialogue with G-d. I got angry with Him for the first time.” Y1 stated, “Because this guy tortured me, I did develop a

relationship with G-d. I started talking to G-d out of this." S3 stated, "And I really think that all my trauma – it was all G-d's fault."

Second turning point: Rebellion/downward spiral. Sometime after the trauma, participants started asking deep questions that challenged what they were taught in their childhood. They described receiving negative feedback from authority figures and were left with unanswered questions. S1 stated, "I started asking questions, being shut down with answers when I spoke with my parents, when I spoke with the school system, or when I was sent to different rabbinical figures." Participant J1 stated, "Another aspect of spirituality where I would ask a bunch of questions, and the main answer was 'don't ask'." In 9th grade A1 experienced a family tragedy and questioned the dissonance between what she was taught, and her personal experience, "I would ask why G-d does things to good people? If He loves us so much, why would He want to hurt us? . . . I never once got an answer."

Participants started to act out by reducing religious observances and engaging in alcohol/drug abuse. They were labeled as "problem children" which led to them being ostracized in the community. Participant T1 described the next turning point, starting unruly behavior, "definitely acted out a lot in terms of being the class clown . . . and I was always looking for some form of attention which I found easiest – negative attention." Participant R1 stated,

> I kept not getting along, I kept getting into fights with everyone . . . when I was 9 or 10 years old by a *Purim* (Jewish holiday) party, everyone is drinking and I was gladly helping off the cups that were half empty, or for my purpose half full.

Later in the narrative R1 stated, "I started hanging out with girls already, not any interest in Judaism whatsoever." Participant Y1 stated,

> Summer of 8th grade I went to camp, and in camp I was exposed to taking a lighter and spraying aerosol into the lighter . . . Somehow it got back to the head rabbi and then he kicked me out of camp for doing it . . . in 9th grade I started smoking, and then I smoked on *Shabbos* (Sabbath).

All participants were placed in multiple schools as a result of their unruly behavior. They were exposed to new ideas and behaviors from their peers. Participant Y1 stated, "I was exposed to a way of life that I had never been exposed to . . . I was around kids who had porn. It was like really weird; guys were cursing all the time." Participant J1 stated, "It was not a good school . . . and I found there one thing that I really found relaxed me, I guess in a sense, was alcohol, and I started smoking pot, and I was able to talk to girls." Participant A1 stated, "I switched schools . . . the girls were more modern, and I liked that . . . I had one best friend there who, I was in 10th grade, she was in 12th grade at the time, and we would ditch school a lot."

Still, participants described varying levels in observance of Jewish law. Participant J1 stated, "I was never very religious, it was more like going through the motions of what my family was doing, and what people around me were doing." Participant A1 stated, "In 12th grade I moved to (city) and I was the only semi-religious girl there, and I guess I felt I wasn't cool because I was like, *frum*." Participant S2 described the point when he stopped Jewish observance,

> After I graduated high school, I immediately got a job and a free apartment . . . and that's when I decided to go completely off the *derech* (way) completely. Like I grew my hair long, stopped keeping kosher, and stopped keeping *Shabbos* (Sabbath). I wasn't living with them (parents) anymore.

Participant S1 stated, "I stopped pretending and I started showing that I'm not going to go through the motions anymore, and that was kind of gradual. It took me a few years before I started putting religion aside."

Third turning point: Addiction. Alcohol/drug abuse and delinquent behavior ultimately led into addiction and high-risk behaviors. Participants did not identify when they moved into active addiction. Several described an increase in alcohol and marijuana use when they went to learn in Israel. A1 stated, "In Israel I was drunk every day." J1 stated, "The second I got to Israel I became a daily drinker." T1 described having no spiritual connection his first year in Israel where, "at that point in my life drinking became a nightly occurrence."

In active addiction Participant S3 stated, "I felt a spiritual bottom, an emotional bottom, and a physical bottom." Participant S2 described spirituality in addiction as, "I was like in a – almost like a darkness. I was like – there was like nothing. I had no spirituality in my life whatsoever. At this point I believed in G-d, but I felt that I proved everybody wrong." While living in a drug house, Participant S1 stated,

> I would cry a lot. I think I would cry to G-d, like, just asking Him to explain to me. But I tried getting as far away as I could from the community . . . I would do

> anything to not think about my childhood, not think about how my parents waited for me at home.

Fourth turning point: Early recovery. Participants differed in experiences that brought them to sustained recovery. Some reported multiple treatment programs and relapses, while others maintained sobriety from one program. Some stated they never overdosed, while others reported several overdoses. Participants differed on when they started 12-step work in their recovery and offered different descriptions of spirituality in early recovery. While in a residential program Participant S1 stated,

> We had meditation, which was my first sign of spirituality. Since I got clean, the first time I actually felt G-d was when they took us outdoors to meditate on the grass . . . and I started crying. I realized that, you know, maybe there is Something, you know, watching out for the world.

Participant A1 stated,

> My rehab was 3 months, and during the first 2 months I started praying, and I guess I started meditating a bit. But I wouldn't really pray. I would be like 'thank you' or 'hi'. I connected with the earth when we went camping and I was connected to the world on a spiritual level, but not really with G-d on a spiritual level.

Participant R1 stated,

> I went through steps in the first year and I started gaining spirituality, but no connection to Judaism at all. That was my most difficult problem in sobriety, was at that point I couldn't picture what a Higher Power is.

Participant T1 stated, “I struggled with the difference in definition of spirituality and tradition, and I had to learn how to pray and how to view that differentiation.”

While sustained recovery is defined as maintaining complete sobriety for more than 12 months, none of the participants described “moving” from early sobriety to sustained sobriety. This was similar to moving from alcohol/substance abuse to addiction (i.e., none of the participants identified the change from abuse to addiction). Members of AA describe this change as “a cucumber becoming a pickle”. This means that becoming an addict is a process, not an event (though some believe they were born an alcoholic/addict). Sustained recovery starts from 12 months and 1 day of sobriety, but individuals in recovery view this as a process as well.

The present moment: Sustained recovery. Three patterns emerged across participants present moment of their narratives: engaging in daily spiritual practice, staying connected/fellowship, and being of service. For daily spiritual practice Participant A1 stated,

> I need to keep spiritually fit, I need to keep praying, I need to keep going to my meetings, I need to meditate because I’m happy when I’m spiritually fit . . . my service work is reaching out to people, making sure they are doing ok.

Participant S1 stated, “I go to constant meetings and I hold several service positions. Participant R1 stated, “people asked to learn (Torah) with me . . . that’s what I do, and how I stay connected, and I try to give back to the community as much as possible in any way I can.” Participant J1 stated, “That’s what I call spirituality, being able to help

others. Like, I do a decent amount of service . . . I'm present for my family today. I practice meditation daily."

Summary of turning points. Participants were taught how to observe Orthodox Judaism in their childhoods. They reported early childhood trauma as the first turning point in their spiritual narratives. The trauma affected their trust and openness to others and Judaism. Participants reported dissonance between what they were taught and what they experienced/observed. The next turning point was identified as starting to outwardly question what they were taught, and a change in their behavior (i.e., rebelling against community standards and expectations). This led participants on a path toward school expulsions, delinquency, alcohol/substance abuse, and becoming ostracized from their communities. The next turning point was identified as addiction and high-risk behaviors. Participants described having zero spirituality during active addiction. Early recovery marked the next turning point where participants described experiences with spirituality. These were new experiences that carried a new understanding of spirituality that was different from childhood teachings. The present moment of participant spiritual narratives is identified as sustained recovery. Daily spiritual practice, fellowship, and service continue to help participants maintain sobriety through connecting to their Higher Power, family, and peers.

In Vivo Analysis and Resulting Themes

Through several passes in transcriptions, I highlighted statements on participant meanings of spirituality, experiences with spirituality, experiences at turning points in the narratives, and participants making sense of their lives. I used MS Excel to make a

spreadsheet, where each participant had a separate column, and the rows were aligned according to interview questions. Forty-four categories emerged from the in vivo coding. I compared these categories with the turning points identified in the thematic analysis and identified six themes (see Table 3). Here I present the six themes that encapsulate the spiritual narratives of the participants: *religious not spiritual, pretending, rebelling, darkness, rebirth,* and *harmony*.

Table 3

Themes and Associated Categories from In Vivo Coding

	Themes					
	Religious not Spiritual	Pretending	Rebelling	Darkness	Rebirth	Harmony
Categories	Taught to believe in Judaism	Following rules	Acting out	No self-worth	Surrender to Higher Power	Being of service
	Nescience	Envying less religious	Hatred toward G-d, community, and self	Trying to fill void	Dry drunk struggles	Ability to be vulnerable
	Cookie-cutter	Mistrust	Antireligious	Self-medicate to numb pain	No more running	Sick people don't represent religion
	Strict adherence to rules	Fear	Recalcitrance	Zero connection	First things first	Higher Power is loving and kind
	Spirituality is rejoicing	Unanswered questions	Stop caring about what others think	Miserable existence	Learning how to live	Autonomy
	Taught what, not why	Happy on outside, miserable on inside	Associating with wayward Jewish teens	Want to die	Seek help	Daily prayer
	Punishment for sin	Outsider	Keeping some Jewish practices	Shame and guilt	Cautious	Grateful today
		Uncomfortable in own skin		External pressure to get sober Lost everything	Someone/ Something cares	Connection

Theme 1: Religious not spiritual. Participants were raised in a Jewish home where they were educated on how live their lives as Orthodox Jews in the community. The meaning of spirituality in their recovery helped participants to clarify that their childhoods had limited spirituality and that religion was the focus of their upbringing. In describing experiences they had with spirituality in childhood, several participants described sporadic joyful occasions such as singing on Shabbat, or festive drinking on holidays. S1 stated, "When I felt any spiritual highs it was the people who were kind of celebrating in the religion. They were showing joy, dancing at a wedding or singing at the Shabbat table." J1 stated, "I guess spirituality was on *Purim* (Jewish Holiday), my father's students would come over and it was lively, and there were people getting drunk, and that's what I thought spirituality was about."

Whereas these joyous events were occasional, the day to day lives of participants revolved around being taught religion. Participants discussed growing up in a Jewish home where they were taught to follow Jewish laws and traditions. Punishment for not following the rules was either meted out by an authority figure, or it was stated that punishment would come from G-d. Praying to G-d and attending services was mandatory in all homes. Still, Participants clarified that they were not taught the reasons for what they were doing. Participants described their peers as similar, in the sense that no one questioned what they were being told to do. Even though some participants differed in being told of a loving versus punishing G-d, none of them could relate to G-d.

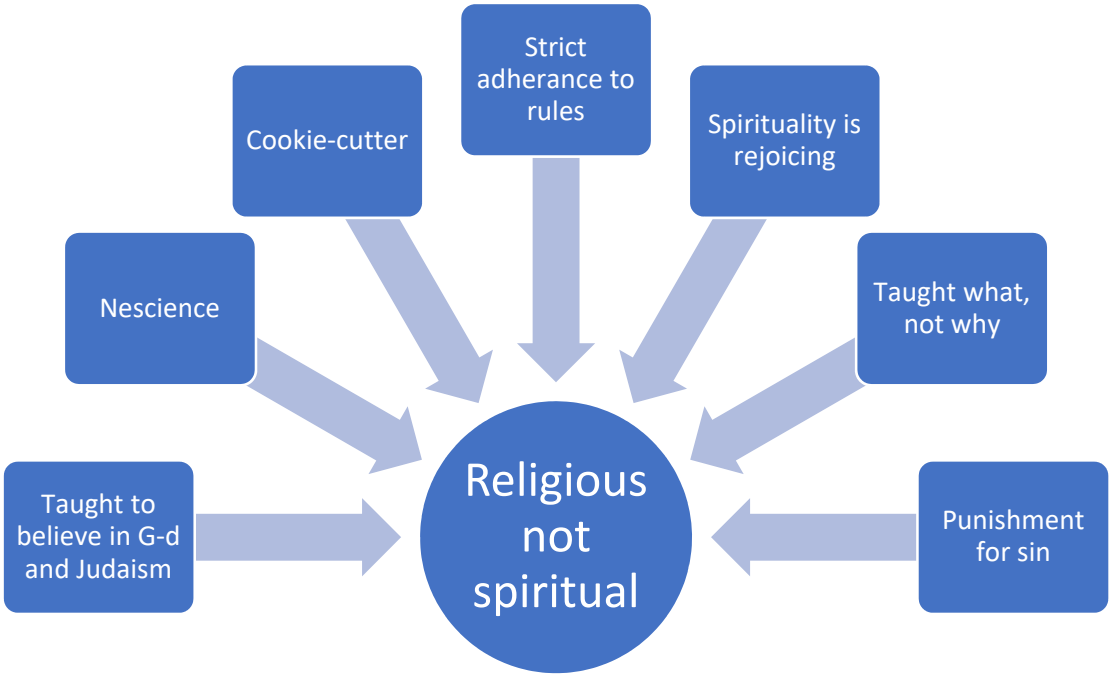

Figure 1. Theme 1 with categories from in vivo coding.

Theme 2: Pretending. After experiencing trauma in their childhoods, participants described a shift in their awareness, and they started asking deep questions. Not feeling satisfied with the responses, and describing a lack in support, they lost interest in Judaism, but continued to outwardly observe Orthodox Judaism (i.e., pretending). Regarding asking questions, S1 stated, "I asked why things happen to innocent people and those questions were shot down, because it showed a lack in my faith." The negative responses to their questions left participants in a negative state as well. S1 stated, "I felt like a bad person, questioning G-d." R1 stated, "I tried once or twice but the answers I got was I thought I looked like a troubled kid who, you know, I'm always doing the wrong thing." S3 stated, "The rabbi that was giving that class was upset with me, disappointed with me about my question, it was like a ridiculous question." Participants started losing interest in religion, as J1 stated, "4th or 5th grade I stopped buying into it

(Judaism).” Still, out of fear, they did not outwardly change their behavior, and continued to act similar to their peers. S1 stated, “The whole class would be praying, and I would be pretending. I was reading the book and my thoughts would be elsewhere.” J1 stated, “I was never very religious, just going through the motions of what my family was doing and what people around me were doing.” Participants envied peers who were less religious, as S1 stated, “wishing I could be like them (less-religious peers), just like free, kind of.” S2 stated, “I used to think to myself - if only I wasn’t religious, my family wasn’t religious or Jewish, maybe my life would be a little better.”

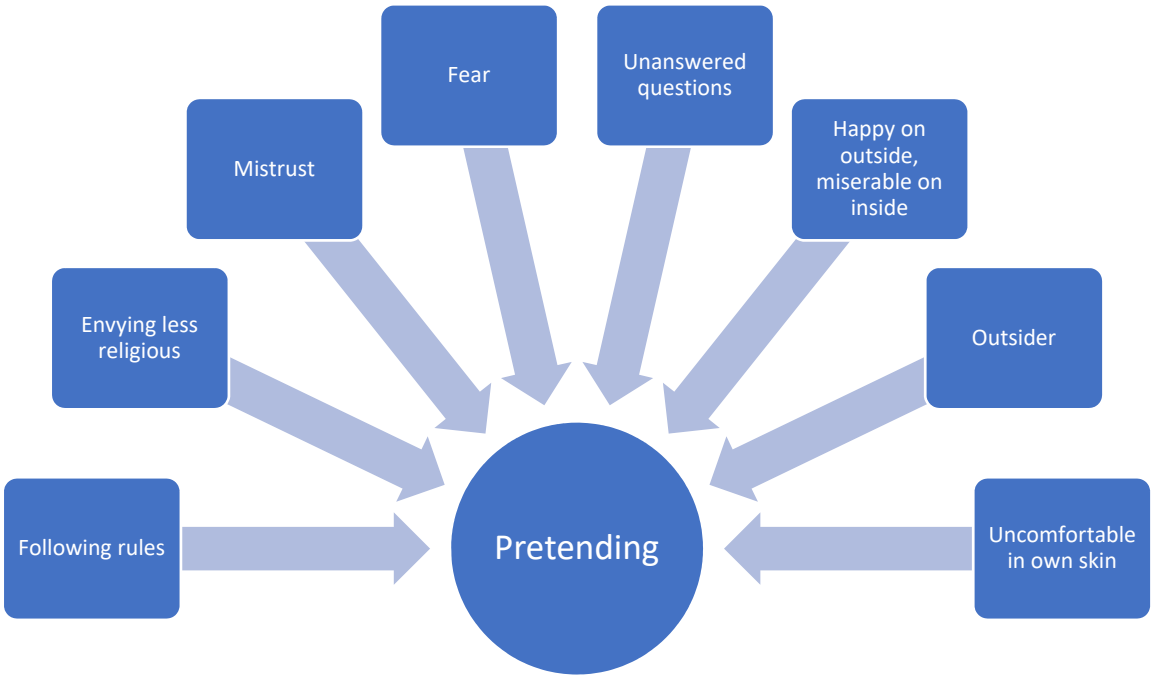

Figure 2. Theme 2 with categories from in vivo coding.

Theme 3: Rebelling. Participants started acting out through fighting, smoking and alcohol/drug abuse, communicating with the opposite sex, and going against the accepted dress code. A1 stated, “toward the end of 9th grade I started dressing a little different . . .

started talking to guys because, you know it's not really ok in the religious community." S1 stated,

> I saw it back then as a rebellion against religion. I felt like it was directed toward my religious upbringing, which was so wrong, which is very close-minded and doesn't let people express themselves . . . I stopped pretending and started showing that, you know, I'm not going through the motions anymore.

All participants were expelled from school and placed in schools that were either more modern (secular) or alternative schooling. Participants were exposed to more adverse behaviors in these schools. Y1 stated, "My class was Modern Orthodox, and I was exposed to a way of life that I had never been exposed to. I was around kids who had porn and guys who were cursing all the time." S2 stated, "I was introduced to a whole new lifestyle . . . way modern as opposed to my upbringing and I really ran with the freedom of being completely far away from home." Alcohol and drug abuse started at this point, as R1 stated, "I was drinking, I was smoking, doing whatever I wanted and had no interest in Judaism." J1 stated, "I was really just a wild teenager at this point, and I found that the only thing that relaxed me was alcohol. I started smoking pot, and I was able to talk to girls and just be ok in my own skin."

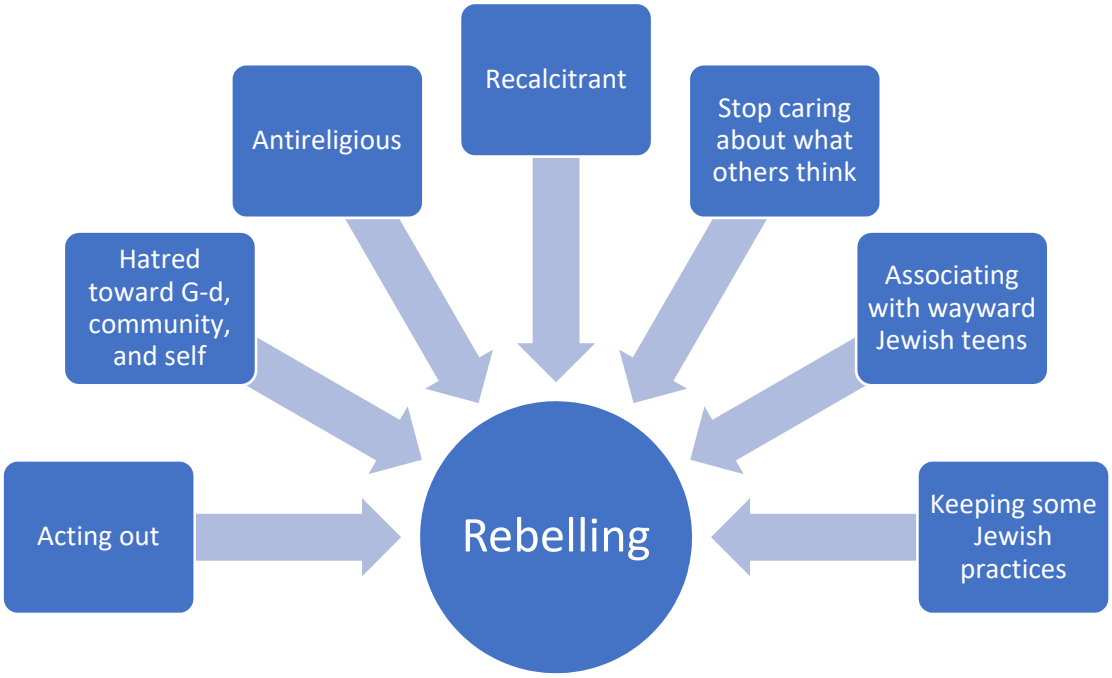

Figure 3. Theme 3 with categories from in vivo coding.

Theme 4: Darkness. Participants described an extreme negative state during their active addiction. They had negative feelings of hate and loneliness and used alcohol/drugs to numb the emotional pain. S1 stated, "I would do anything to not think about my childhood." S2 stated, "The pain, it was like the only thing I knew to keep myself balanced was drugs." S3 stated, "I really used that (drugs) to escape from the feelings that I had no idea I was feeling. I didn't allow myself to feel them, which was lack of connection and abandonment." After 6 months of sobriety S3 stated, "I relapsed, and I was full of shame and guilt." Thoughts of wanting to die were coupled with high risk behaviors. R1 stated, "I overdosed a few times . . . I was just miserable, I didn't want to feel anymore . . . it was dark and depressed inside." A1 stated that during active addiction, "I didn't care if I died." S2 stated, "I had no friends, I lost everything, I felt like I was in such a deep hole and I just wanted to die." Participants felt no connection to

family, and they did not consider the people they used drugs with as friends. S3 stated, "All my friends, I can't even call them friends, everybody that I surrounded myself with was just toxic and using." S1 made a similar statement, "I use the word friends, but I don't consider anyone from back then friends. We were all about just using each other." Participants described no spirituality during their addiction. J1 stated, "During that time, like zero spirituality - nothing at all." Still some participants continued their relationship with G-d, others with Judaism. S1 stated, "I would cry a lot, I think I would cry to G-d, just asking Him to explain to me." S2 described learning in Israel as an active alcoholic,

> In terms of spirituality I felt nothing. I wanted to want - to feel more spiritually connected, to be more religious. To be the people I looked up to at that time, and it was just a miserable existence. I was still heavily drinking...I wanted to understand more why I was doing what I was doing.

S3 stated, "A huge part of something I always held on to, I'm not sure why, was that I was a Jew. And the way to make sure that I'll only be with a Jew is that I would surround myself with Jews."

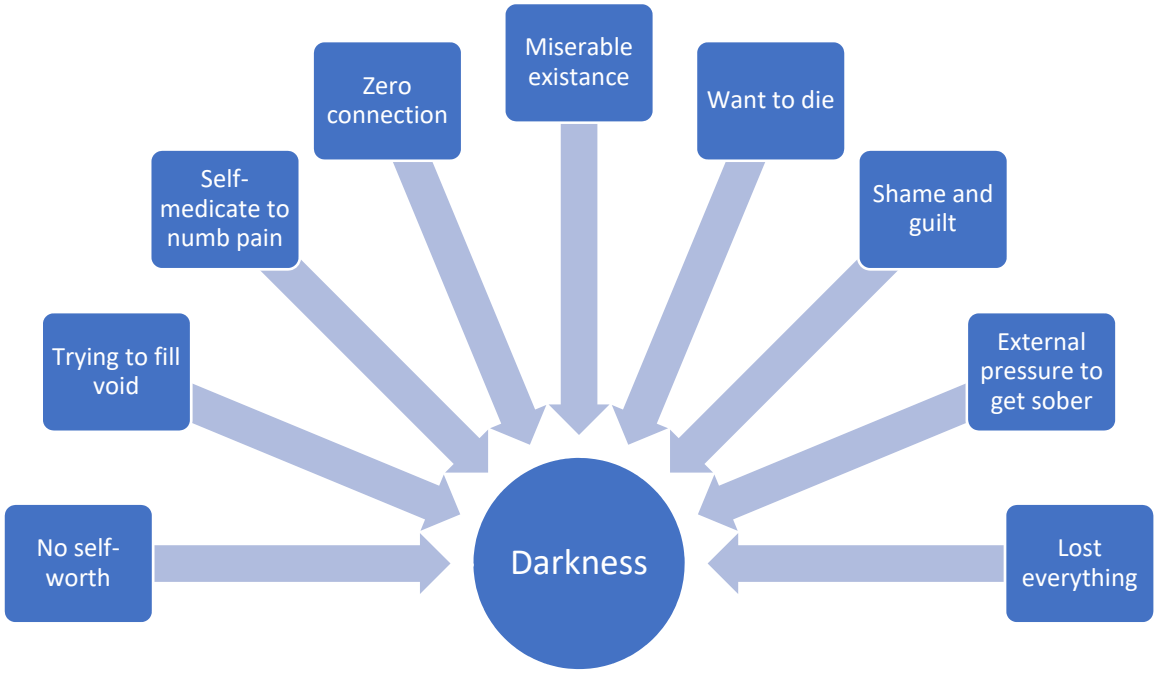

Figure 4. Theme 4 with categories from in vivo coding.

Theme 5: Rebirth. Rebirth is defined as spiritual regeneration, a new beginning (Merriam-Webster.com, 2019). After breaking away from their communities and sinking in the darkness of addiction, participants made a decision to seek help. Their thinking and behaviors were challenged as they faced the harsh reality that change was desperately needed, and they were willing to explore new meanings of life and spirituality. Participants shared similar struggles in early recovery. They reported issues with trust, falling back into old behaviors, resistance to working the program and jeopardizing their sobriety. A1 stated, "So many times I was so close to relapse. . . I was not praying at all; I was sober and that's it." T1 stated, "I was a dry drunk. I wasn't miserable or desperate enough. In the beginning I used to turn my will over and kind of sit back—I wanted instant gratification."

Participants described experiences with early 12-step work and how they related to G-d. S1 stated,

> I found it hard to wrap my head around the meaning. I would use the group strength and when it came to praying, I didn't have an image in my mind, I just didn't want it to be that old man with a long beard that I grew up on.

Y1 stated, "My first year of sobriety I couldn't hear of G-d, it sounded very weird to me. On my 1st anniversary a guy said to me, 'just pray to G-d' and I wanted to kill him." In describing the most difficult part of 12-step work, R1 stated, "I couldn't picture what a Higher Power is, and it took me 3 to 4 years of sobriety to really understand a full concept of what a Higher Power is." S2 had a different experience, "G-d was the only thing I had to hang on to, so I started getting spiritual on my own. I was begging G-d to please help me get through this." Similar to S2, S3 stated, "as far as G-d of my understanding, that came a lot easier for me because of the desperation I had and at that point I was very grateful to G-d for giving me the opportunity to get sober again." Participants described a new meaning of G-d and spirituality in their experiences. S1 stated, "The first time I actually felt G-d was when they took us outdoors to meditate on the grass." Later in the interview S1 stated, "Like a little peephole into spirituality. It's a possibility that Someone out there loves me and cares about me, and It's brought me to this place to get help." In treatment A1 stated, "I was connected with the world on a spiritual level but not really with G-d on a spiritual level."

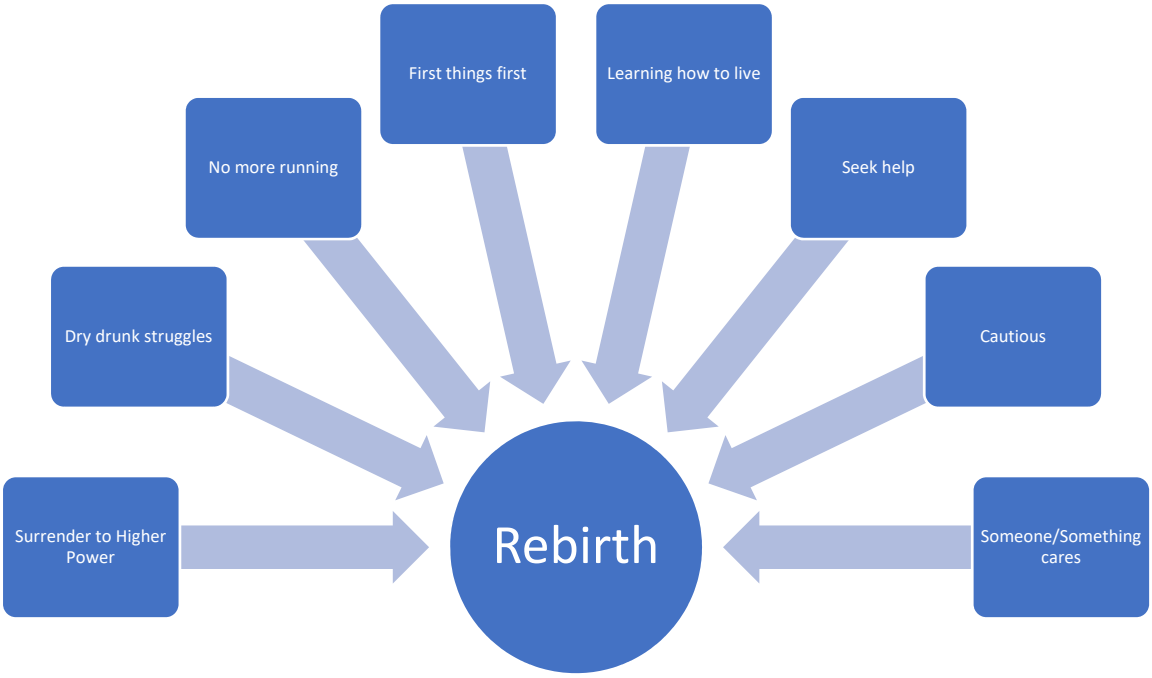

Figure 5. Theme 5 with categories from in vivo coding.

Theme 6: Harmony. Harmony is defined as the quality of forming a pleasing and consistent whole. As participants moved forward in their recovery they described "aha" moments, new meanings to their lives and spirituality. S1 described the difference between G-d in childhood, "The G-d of my childhood punishes" and current concept of G-d, "He loves me, cherishes me, believes in me. He is my #1 fan." S1 clarified, "The idea of G-d kind of formed when I realized that I could make up my own G-d. I would always clearly differentiate between the G-d I grew up on, and this new G-d of mine." R1 stated, "I built a relationship with G-d and in a sense of knowing what is right for me. And even though there's challenges and difficulties in life, that doesn't mean that G-d doesn't love me, it just means I'm challenged to grow." S2 made a similar statement, "I now believe that the G-d of my understanding is all-kind and does everything in my best interest. Even things that come off as punishing, upsetting, and hurtful."

All participants described being of service as an important ingredient in personal growth and life satisfaction. A1 stated, “my service work is reaching out to people, making sure they are ok. It definitely makes me happier - to me I really enjoy helping people.” S2 stated, “I take on service commitments which gives me that same responsibility and accountability.”

In discussing what they would say to someone who grew up in the Orthodox Jewish community now struggling with addiction, participants offered similar ideas of support and advice on seeking help. S1 stated,

> I would give them a hug, first of all, and I would tell them they are going to be ok, that they should take care of themselves first. Without any connection to the religious community, just take care of yourself first.

T1 stated, “I would say you’re no different than any other addict because you are religious, everyone relates to one another . . . the only thing that can and will help is the 12 simple steps that have been outlined for us.” R1 stated, “Try to remember that people who harmed you don’t represent what you think they represent. You can always give me a call to discuss what real people are.”

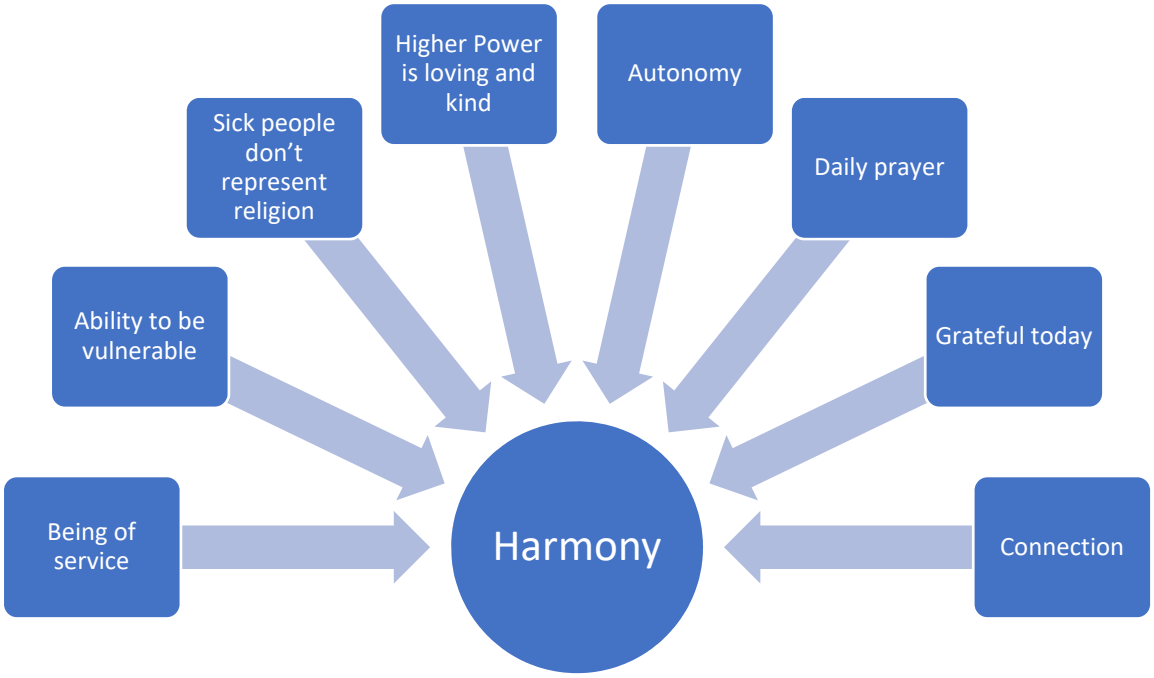

Figure 6. Theme 6 with categories from in vivo coding.

Discrepant Cases/Findings

This study included participants who were raised in Orthodox Jewish communities. Six participants described their communities as "Yeshivish" - mainstream Orthodox, and one participant was raised in the Chassidic community. One participant (S3) had a different upbringing, in that her family kept Conservative Judaism, and became Orthodox when she was 11 years old. Still, she stated,

> Religion has always been a part of my life. . . I don't ever remember having a negative feeling toward G-d or religion at that point, before the switch (to Orthodox Judaism). I actually remember loving doing what we were doing at that point and feeling connected the parts of Judaism that we were involved with at that point.

Once the family became Orthodox, S3 reported having similar experiences as the other participants (e.g., trauma, unanswered questions, and feeling different). Therefore, within the thematic analysis, S3 had a different "beginning" than the other participants, but her narrative was aligned with the other participants' childhood trauma to recovery.

Six participants stated that they believed in G-d throughout their lives. Two participants J1 and R1 stated that they stopped believing in G-d before adolescence. J1 stated, "In 4th or 5th grade I stopped buying in it." R1 stated, "After 4th grade I just lost interest." While both described strict upbringings, there were several differences in both their upbringings and recoveries. J1 was the son of a rabbi, he described himself as a good learner (Judaic studies) and had multiple traumatic experiences (molestation) in his childhood. R1 said he lacked the skills to learn and did not understand Hebrew. R1 described getting physically abused in his childhood. In recovery, R1 described the most difficult part of 12-step work, "I couldn't picture what a Higher Power is, and it took me 3 to 4 years of sobriety to really understand a full concept of what a Higher Power is." Today R1 practices Orthodox Judaism, and stated, "I started keeping the Torah, Shabbos, and mitzvos. . . and that's my life, I enjoy it." J1 described the most difficult part of 12-step work, "I couldn't wrap my head around the 2nd and 3rd steps." Today J1 does not practice Judaism, and he does not believe in G-d. He stated,

> I really don't have a conventional Higher Power at all. My belief today is that I'm a good person and my spirituality lies in doing the step work more than anything else. . . I define my Higher Power today as the rooms of AA and with being of service.

While J1 has a differing view of Higher Power than the other participants, the present moment of his narrative is aligned with the Harmony (Theme 6) experienced by the other participants. In describing the present moment J1 stated, “I’m loving to my family. I’m present for my family today. . . I feel a lot more accepted.” His advice for someone struggling with addiction, “Deal with your issues and make peace with yourself and find what makes you happy and content.”

All eight participants reported success in sustained sobriety through AA/NA and 12-step recovery. While seven participants expressed loyalty to the AA program, S2 stated,

> I became very anti-rehab and anti-12-step . . . If AA worked for someone, great. But I’ve been thrown out of a meeting for putting down AA. I got up there and basically said, “this is the most depressing place I’ve been in my life. All I do is hear about people sharing about being molested or raped . . . I have to start my day by hearing this?”
>
> It’s (addiction) an illness that can be cured in my opinion. Why should somebody stigmatize themselves for the rest of their life? I don’t want my kids to know that I was a drug addict.

Still, S2 reported sending people to rehab and he occasionally speaks at meetings. “I always go to the secretary at the meeting and say, ‘if you ever need a speaker please call me because I’ve got a good story.” Even though S2 views AA and 12-step work differently than the other participants, his spiritual narrative aligns with the other participants in both the thematic analysis and in vivo coding.

Evidence of Trustworthiness

To establish credibility for this study, I relied on my extensive experience completing clinical interviews which, similar to this study, followed a semistructured guide to chart the life experiences of addicts in recovery. I spoke with my chair upon completing the first two interviews regarding conversation flow, follow-up questions, and my thoughts of participant answers. During our conversation my chair reiterated the importance of staying grounded as a researcher while avoiding the role of a therapist. I used an audit trail to keep a thorough description of my thoughts and questions, along with each step in gathering and analyzing the data.

Participants were similar in that they were raised in an Orthodox Jewish community (S3 in late childhood), struggled with addiction, and ultimately maintained sobriety using the 12 steps, but they differed in several aspects including: community culture (e.g., Chassidim), types of traumatic experiences (e.g., sexual abuse), recovery efforts (e.g., multiple relapses), and support structures (e.g., mentors). The semistructured interview format promoted in-depth descriptions of both similarities and differences in the spiritual narratives. This allowed for a broader view on the turning points in the spiritual narratives of recovering addicts who: were raised in a home that promoted strict religious adherence, experienced childhood trauma, and engaged in 12-step work.

Although no autobiographies were provided, dependability was implemented through keeping an audit trail and triangulation of the sources: interviews, Cognitive Dissonance and Faith Development theories, and existing research on addiction, recovery, and spirituality. A summary of the interview was sent to each participant in

order to clarify, expand on, or change their documented experiences and the meanings from those experiences. Participants were also debriefed at the end of each interview which provided them the opportunity to add anything they felt necessary that was not covered during the interview. Providing participants with multiple opportunities to review and amend their interviews established confirmability.

Summary of Results

The results of this narrative analysis provided an elaborate picture on the 12-step recovery experiences of formerly observant Jewish addicts. This was accomplished through identifying participant meanings of spirituality and the surrounded events at the turning points in their spiritual narratives. Thematic analysis and in vivo coding identified six interconnected themes to answer the research question "What do the spiritual narratives of formerly observant Jewish addicts reveal about their experience in a 12-step recovery model?"

Participants reported minimal experiences with spirituality in early childhood. Religion took a central role in their education, but participants did not connect religious practices with spirituality. Childhood traumatic experiences were a catalyst to questioning the system, where the development of mistrust and letting go of Jewish practices were a result of questions unanswered coupled with lack of support. Spirituality, which had already started off as minimal, moved towards becoming non-existent. As T1 stated, "I really wasn't connected to any form of spirituality and I'm not making it to be that I questioned it - it wasn't even a question." J1 made a similar statement, "I didn't have any kind of spirituality in high school." Still, Participants continued to act

religiously even though they had no interest. Fear played a role in this behavior, as S1 stated, “Back then I didn’t see going off all the way as an option.” S2 continued observance until he graduated high school and moved out of his parents’ home, “They (parents) used to say, ‘our house, our rules’, now I’m not under their roof anymore so it’s my rules.” Eventually the pretending stopped, and participants outwardly acted out through stopping religious observance and engaging in delinquent behaviors. S1 stated, “I stopped pretending and started showing that, you know, I’m not going through the motions anymore.” When Y1 started acting out, his thought was, “Leave me alone, I don’t give a crap about what anyone says.” Alcohol and drug abuse led to addiction where all participants described zero spirituality. When asked about experiencing spirituality in the midst of addiction, R1 stated, “none at all, my only thought was what can I get? What can I try new?” T1 stated, “I basically had no connection, I didn’t pray, I didn’t dress the part, I didn’t study. I was just out being a rebel all the time.” Some participants clarified that they still believed in G-d but had no connection. S1 stated, “I was never an atheist at any point, but I was very angry at G-d and felt like I needed to rebel against Him.” A1 stated, “I always had Hashem” and later clarified, “I think I was fake connected.”

Narratives up to this point have been on a downward trajectory. Participants reported minimal to no positive experiences with spirituality in childhood. They were taught to believe in G-d and follow rules with no explanation as to why. They outwardly continued following rules/keeping Jewish practices and had no support to help cope with childhood trauma. They felt unheard and rejected when they asked questions. Participants

tried numbing emotional pain through alcohol/drug abuse and dropped Jewish practices while going through multiple schools. This downward trajectory bottomed out in addiction, where spirituality was completely absent and participants stated they were completely disconnected with hatred toward G-d, their community, and themselves. Early recovery was the start of a slowly moving, positive trajectory. Participants were cautious with connecting to their Higher Power and spiritual growth, while showing strong resistance toward Jewish observance. Negative experiences leading up to recovery also revealed a struggle in 12-step work. J1 stated, "I could admit that I was powerless and that my life was unmanageable, but I couldn't wrap my head around the 2nd and 3rd steps." A1 described early communication with her Higher Power, "I wouldn't really pray, I would be like 'thank you' or 'hi'." R1 stated, "I was too scared to do the 12 steps, based on my history at school I had a big fear of writing. I went through steps in the 1st year and I started gaining spirituality, but no connection to Judaism at all." Participants started developing a new meaning of what spirituality meant to them and conceptualizing their Higher Power. S3 stated, "My sponsor grew up in the ghetto of Compton and she shared with me her own understanding of a Higher Power which made it easier for me with my understanding of G-d." S1 stated, "In a meditation group, 10 minutes of silence is where I felt G-d. I would look at the candle on the table in front of me. I wasn't alone, I felt there was Something bigger there for me."

The positive trajectory has continued in their recovery where participants have gained clarity in what spirituality means for them today and how they apply this meaning in their 12-step work. S3 stated, "When I slack on praying and being grateful then I feel

disconnected from myself, and from my Higher Power, and from people around me." Some participants described daily spiritual practice to stay sober, without religious observance. S3 stated, "When I slack on praying and being grateful then I feel disconnected from myself, and from my Higher Power, and from people around me. . . I definitely don't live a religious life. I definitely have struggles today, but my struggles aren't toward any religion or feeling disconnected from the community." A1 stated, "I need spirituality in my life at all times, not religion, straight spirituality." Some of the participants reconnected with Judaism and are observant today. S2 stated, "I became a born-again Jew." R1 stated, "I know today that G-d does care, and I choose to believe that He controls every little thing." Y1 made a similar statement, "Spirituality and religion are one in the same for me today. Hashem is real, and He is revealed through the Torah. If you want to learn about G-d, you have to learn Torah."

Participants A1, R1, T1, S1, and S3 explicitly stated that they are grateful today for their experiences, and all participants discussed being of service today in their recovery. Gratitude is recognizing the good and kindness we experience in our lives. It is a core component of successful recovery, and it is expressed through helping others and taking on service commitments.

Summary and Transition

Chapter 4 described data collection and analysis of participant interviews. Thematic analysis and in vivo coding were used to identify themes in the spiritual narratives: religious not spiritual, pretending, rebelling, darkness, rebirth, harmony. The

themes identified a negative trajectory from the beginning of participant narratives through active addiction, then a positive trajectory from early recovery until now.

Participants were not educated on the concept of spirituality in their childhoods, but instead their education focused on religious observance. Some described what spirituality meant to them in childhood as joy and celebration. Childhood trauma, lacking support, and having unanswered questions initiated the negative trajectory toward dropping religious observance and ultimately hitting a spiritual bottom in active addiction. Spirituality in early recovery started moving in a positive direction from the bottom. Participants described it as a slow process where they were cautious and started to form a new meaning of spirituality in their 12-step work. As they progressed in recovery, they learned to separate the negative experiences in their childhood, religion, and spirituality. Today, participants have autonomy in how they behave whether religiously or spiritually, which includes how they define their Higher Power and how they work the steps.

In Chapter 5, I provide an interpretation of my findings, limitations of the study, recommendations for future research, implications for positive social change, and a conclusion.

Chapter 5: Discussion, Conclusions, Recommendations

Introduction

The purpose of this qualitative narrative analysis was to explore the spiritual narratives of formerly observant Jewish addicts who sustained sobriety through the 12-step program. Study participants included five men, and three women—all reported a DSM 5 diagnosis of Alcohol/Use Disorder in full remission. Seven participants were born into Orthodox Jewish homes, and one participant's family became Orthodox (from Conservative) when she was 11 years old. Participants provided their narratives through answering semistructured interview questions.

A thematic analysis was used to discover key moments in participant journeys, which identified six turning points: the beginning, childhood trauma, starting unruly behavior, active addiction, starting recovery, and the present moment. In vivo coding was used to single out statements (a total of 343, which produced 44 categories) that aided in identifying the meanings of participant experiences. Six themes emerged through comparing the thematic analysis with in vivo coding: religious not spiritual, pretending, rebelling, darkness, rebirth, and harmony.

Findings

The phenomenon of interest that guided this study was how recovering addicts experienced spirituality and what it meant to them at different times in their lives. Participant narratives started from their earliest memories in childhood, where they described experiences with spirituality and religion. They identified turning points where they recognized a shift in what spirituality meant to them and the role it played in their

lives at that time. Although each narrative contained unique elements, participants related many similar experiences and cognitions that showed a consistent, overarching spiritual narrative across their lives.

The coding and analysis of their narratives revealed six themes noted in the introduction of this chapter. The findings showed that the spiritual narratives of formerly observant Jewish addicts revealed a consistent lack of spirituality until the early stages of their recovery. Traumatic experiences and lacking support led their relationship with G-d, religion, and community to decline until hitting a bottom in active addiction. This downward trajectory included pretending to observe Jewish practice, which was replaced with openly rebellious behaviors. Active addiction contained zero spirituality and zero spiritual/religious practices, with expressed hatred and resentment toward G-d, Judaism, and the community. Participants identified their first experience with spirituality in early recovery. Through fellowship and engagement in 12-step work they learned to separate religion and spirituality. Recognizing the ability to forge their own understanding of a Higher Power initiated the rebirth of interest in finding meaning and experiencing life. They came to realize that those who hurt them do not represent religion or spirituality. Experiences with spirituality continued on a positive trajectory as spiritual practices increased (e.g., prayer/meditation and acts of service). The present moment of their narratives consists of a harmonious blend of daily spiritual practice, mended relationships, feeling grateful, and striving to accept and help others regardless of religious, gender, ethnic, or cultural differences.

There were also some discrepancies among the participants' stories. Participant S3 did not grow up in the Orthodox community. She stated, "my father was a rabbi of a more traditional shul . . . We kept Shabbos as traditional Jews; we drove to shul but that was something we had to do on Friday (night)." Still, she and her siblings went to an Orthodox Jewish day school (Chabad), where they learned about Orthodox Judaism. Her family became Orthodox when she was 11 years old, which she stated brought several traumatic experiences. First, her mother's previous conversion was questioned, which meant that all the children and their mother needed to go through a conversion according to Orthodox standards. Further, as the rabbi of the synagogue, her father changed it to Orthodox, which resulted in losing their congregation, money, and home, which S3 stated, "becoming religious was a very traumatic experience."

Another participant differed in his understanding of a Higher Power. Whereas all other participants call their Higher Power G-d or Hashem, participant J1 stated, "I really don't have a conventional Higher Power at all." As described in Chapter 4, his experience of a Higher Power was unique from the others (i.e., not identified with a traditional concept of G-d) and resided in working on the steps: "I really define it today with the rooms of AA and with being of service." The 12-step recovery model promotes daily prayer. Participant J1 also differed from all other participants in this as well. Whereas all other participants stated that they prayed daily, he stated, "I was told to pray for a lot of years within recovery. Right? Because it's part of the steps. And I just don't, like, it's not, I am not really capable of doing that. It just doesn't work."

Interpretation of the Findings

Comparison with Previous Literature

All participants reported experiencing childhood trauma (e.g., abuse, neglect, relocation). Trauma was identified as the catalyst that shifted their willingness in religious practice toward a break in trust and questioning the "system." Research has established that trauma can affect individuals' core belief system and religious affiliation (Exline, Yali, & Lobel, 1999; Gall, Basque, Damasceno-Scott, & Vardy, 2007). Participants sought support and wanted to understand the events in their life in relation to what they were taught. But they were left with unanswered questions and felt degraded, which resulted in having negative feelings toward G-d and their communities. Research has also identified a causal relationship between negative feelings toward G-d, increasing doubts about religious teaching, and high rates of emotional distress (Abu-Raiya, Pargament, Mahoney, & Stein, 2008; Johnson et al., 2006; Weber & Pargament, 2014). Negative experiences, coupled with lacking support, led to a decline in religious behaviors while increasing delinquent behaviors (e.g., smoking and fighting). This is consistent with the findings of Horan and Widom (2015) that child maltreatment is associated with engaging in antisocial behavior at a younger age. Participant narratives provided internal dialogues that connected negative childhood experiences with rebellious/antisocial behavior. It was the perceived lack of support after the trauma that participants identified as the catalyst for challenging the system.

The findings further support research indicating the success and popularity of the 12-step program from its focus on spiritual growth without adhering to religion (Rudy &

Greil, 1988). This study found that participants' childhood concept of G-d was replaced with a new perception of a Higher Power. In their early stages of recovery, participants separated religion and spirituality, which they attributed to the basic dynamic and openness of the 12-step program. Participants also reported developing healthy coping skills and progress in recovery as a result of working with sponsors, who related similar chaotic upbringings, which is consistent with stress and coping theory (Moos, 2008).

Further, all participants described the crucial need for daily spiritual practice (prayer/meditation, being of service, or continued 12-step work) to help maintain sobriety. They also reported an increase in spirituality with their increased length of sober time. This reciprocal relationship between recovery and spirituality is consistent with the findings of Laudet, Morgen, and White (2006). Sustained recovery (i.e., the absence of relapse) can be attributed to keeping spirituality as a central focus of their lives. Research has identified the powerful benefits of spiritual practice in implementing healthy responses to stressful cues (Tonigan, Rynes, & McCrady, 2013), and working as a protective barrier against relapse (Galanter, 2006; Pardini et al. 2000; Zemore, 2007). Additionally, continued engagement in 12-step work, attending fellowship, and helping others in recovery significantly increases success in recovery (Pregano, Friend, Tonigan, & Stout, 2004).

Despite similarities between participants' narratives and the research, participant recollections of instability and breaking away from their religious upbringings differs from some of the research. For example, Hayward, Maselko, and Meador (2012) described the internal drive of people to re-evaluate their religiousness through

harmonizing past with present identities. For example, someone who identifies as religious today, is more likely to view themselves as religious in childhood. However, participants in this study made clear distinctions between their religious upbringings and religious/spiritual practices in the present moment.

Theoretical Relevance

Festinger's theory of cognitive dissonance. Dissonance occurs when an individual is forming an opinion or making a decision (Festinger, 1957). The dissonance is a result of being confronted with a choice between two or more options, each carrying desirable (or undesirable) effects from that choice. This could be a child who wants to do something—for example, throwing an egg in the kitchen—where there is a possibility of a punishment. The child has dissonance between choosing the "reward" in observing the effects of the thrown egg (desirable effect) and the punishment for making a mess (undesirable effect).

Participants reported experiencing dissonance at each of the turning points in their narratives. Childhood trauma caused conflicting thoughts between what they were taught and what they experienced: G-d is loving, and I can trust others versus G-d is not loving, and I have mistrust in others. Choosing "G-d is loving, and I can trust others" carried the desirable characteristic of being congruent with what they were taught and the undesirable characteristic of not being congruent with personal experience. Choosing "G-d hurts us, and I have mistrust in others" carried the desirable characteristic of congruence with personal experience and the undesirable characteristic of it contending with what they were taught. As a dissonance reduction strategy (i.e., acquiring new

information), participants asked their parents and teachers questions that challenged what they had been taught (e.g., “If G-d loves us, why would He hurt us?”). When their questions were unanswered, and they were degraded for asking such questions, the dissonance continued to build until they changed their belief to “G-d is not loving, and I have mistrust of others” and “bought out of Judaism.” They then experienced a new dissonance between continuing to follow the rules or to rebel.

Participants also described the strict demand in following Jewish law in their childhoods. They were taught that Jews who do not keep Jewish law are bad and cannot be trusted. As participant S1 stated, “I was only shown Judaism one way, and that was the right way, with hopes that I come to believe that any other types of Jews were backstabbers, worse than gentiles because they didn’t believe.” The conflicting thoughts at this time were: I need to follow the rules and “pretend” versus “I need to rebel.” Following the rules carried the desirable characteristic of feeling secure in continuing with the same behaviors and the undesirable characteristic of feeling not true to self. Rebelling carried the desirable characteristic of congruence with no interest in practicing Judaism and the undesirable characteristics of getting punished and ostracized. Dissonance was alleviated through reducing the importance of not feeling true to self. Even though they were no longer interested, participants continued to outwardly observe Jewish law. The magnitude of dissonance caused by forced compliance increases as the magnitude of reward or punishment increases (Festinger, 1957). The choice to pretend and follow the rules was based on the fear of getting punished and ostracized. They described an increase in anger and loneliness during that time. As participant S1 stated,

"There's a theme, a bigger bigger difference between what I'm showing the world and what I really want to do myself."

Further, Festinger (1957) stated that the importance of a decision affects the magnitude of the dissonance (i.e., a more important decision produces stronger dissonance). The magnitude of dissonance in the post-decision is affected by both the desirable characteristics of the not chosen alternative and the undesirable characteristics of the chosen alternative. Reducing the importance of "not feeling true to self" reduces dissonance temporarily. Participants slowly started reducing religious practice as the dissonance strengthened. Socially, participants separated from their classmates because they believed that their classmates were interested in conforming to the system. In a situation where a person's opinion and knowledge are different from another's, dissonance is reduced through considering the other person incomparable (Festinger, 1957). This explains participants' self-labeling as "outsider." As Participant S2 stated, "I never really felt like I belonged. I always felt different, less than, not as intelligent, not as popular." In viewing himself as separate from others, Participant R1 stated, "Everyone hates me."

The existence of dissonance leads to seeking out others with similar cognitions/behaviors (Festinger, 1957). Participants started spending time with other adolescents considered "at risk." Participant A1 stated, "I started smoking weed, and all these kids that we would smoke and drink with were not *frum* at all." The dissonance was reduced through changing their behavior (i.e., observable rebellious behavior). Participant S1 stated, "I was never an atheist at any point, but I was very angry at G-d and

felt like I needed to rebel against Him. . . I stopped pretending and started showing that, you know, I'm not going through the motions anymore."

As participants stopped Jewish practice and engaged in delinquent behaviors, the relationship with their families and community deteriorated. Participants reported having conflicting thoughts: wanting to stay connected (which meant becoming compliant), versus wanting to cut off the relationships with those they felt let them down (which meant continuing on their destructive paths). The desirable characteristic of staying connected was having access to food and shelter, and the undesirable characteristic was staying connected to people (and G-d) who either hurt them or did not protect them. The desirable characteristic of cutting off their relationships was in consonance with their feeling abandoned, and the undesirable characteristics were loneliness and risk of losing food and shelter. Dissonance was reduced through focusing on the perceived neglect and resentments which minimized the importance of their relationships. As participant S1 stated, "I was accusing and blaming everyone for the way I was acting." Participants continued on their destructive paths which brought them to addiction.

Active addiction carried many repercussions: wanting to die, using and getting used by others, no connection to family, or physical harm. Participants reported conflicting thoughts: seeking help, versus continuing addiction. The desirable characteristic of seeking help was getting out of their grave situation, and the undesirable characteristic was in not knowing how they would manage their pain. The desirable characteristic of continuing addiction was self-medicating for the pain, and the

undesirable characteristic was continuing in the high-risk, damaging cycle of addiction. Dissonance was reduced through changing behavior (i.e., seeking treatment).

Participants were in a fragile state during early recovery. They reported conflicting thoughts: making an effort to stay sober versus stopping recovery efforts and relapsing. The desirable characteristic of staying sober was the possibility of having a better life, and the undesirable characteristic was inability to manage pain without alcohol/drugs. The desirable characteristic of relapsing was going back to self-medicating for pain, and the undesirable characteristic was sinking back into the vicious cycle of addiction. As they engaged in 12-step work and fellowship, dissonance was reduced through acquiring and integrating new information. They learned that spirituality is dynamic and could be personalized. They experienced connection to a Higher Power and started making sense of their lives. As their knowledge and recovery experiences increased, the dissonance between choosing to stay sober or to relapse weakened.

Participants described dissonance in their current state of sustained recovery: prioritizing daily recovery efforts versus reducing the importance daily recovery efforts in favor of other interests. They reported that a change in their behavior or attitude temporarily reduces this dissonance, but it never fully dissipates. The desirable characteristic of prioritizing daily recovery efforts is maintaining the benefits of sobriety, and the undesirable characteristic is losing interest in the repetitive practices of recovery while thinking about other exciting endeavors. The desirable characteristic of reducing the importance of daily recovery efforts in favor of other interests is the feeling of excitement in doing something different, and the undesirable characteristic is feeling

awry. As participant S3 stated, “When I slack on praying and being grateful then I feel disconnected from myself, and from my Higher Power, and from people around me.” Participants continue to prioritize their recovery every day, and reap the benefits: emotional stability, working on life goals, maintaining close relationships, and engaging in prosocial activities.

Members across 12-step groups describe the importance of keeping their recovery as the most important focus of their lives. Dissonance is created when the individual is faced with prioritizing something before or after recovery. The 12-step program identifies this as the battle between one’s will and one’s surrender. When recovery is replaced by work or a relationship as the primary focus, there is an increased risk of relapse. The protocol to prioritize recovery is often stated at meetings which is to use the steps, meetings, and phone to stay connected with the program.

Fowler’s faith development theory. Fowler defined faith as: the interrelated dimensions of human knowing, valuing, committing, and acting in order to find or give meaning to the conditions of our lives. Similar to cognitive, psychological, and moral development, the path of faith development can be predicted (Fowler & Dell, 2006). Fowler used Festinger’s theory of cognitive dissonance to explain stage progression (i.e., moving between the stages) is caused by a dissonance between an experience and a perceived reality (i.e., crisis; 1995). The emerging themes in this study support Fowler’s faith development theory and the mechanics of the progression in the spiritual narratives support Festinger’s theory of cognitive dissonance. However, the age frame for each stage suggested by Fowler is not aligned with participants in this study. To Fowler’s

defense, he explicitly stated that the ages for each stage represent most of the population, but there are a select few who, exhibit the characteristics of stages outside of their age bracket. Fowler's research did not explore possible reasons for the age-related inconsistencies. Next, I present participant narratives within the context of Fowler's stages of faith development:

Stage 1 Intuitive - Projective Faith (age 3-7, early childhood/toddler). This stage represents the birth of imagination, where the child can be powerfully influenced by the actions, moods, and teachings of primary caregivers. This places immense responsibility on the caregivers to provide quality stories and images as the child's imagination develops. Participants reported little to no spirituality in their childhoods. Sporadic experiences with spirituality included observing people "celebrating" religion. This was described in the drinking and lively atmosphere during the holiday *Purim* and singing at weekly Sabbath meals and holidays. Participant S1 related her description of G-d at that time, "The G-d of my childhood punishes . . . that old man with a long beard that I grew up on." In reconstructing their narratives, it was determined that caregivers failed to provide participants with valuable instruction, leaving their imaginations malnourished.

Stage 2 Mythical-Literal Faith (age 6-12, middle-childhood and beyond). Information is used to create self-generated stories that are understood concretely. Reality cannot yet be distinguished from fantasy, and the ability to think abstractly does not yet exist. This supports the theme "religious not spiritual" which emerged through participants explicitly stating that they wanted something beyond the raw information of being told what to do. As participant T1 stated, "I wanted to understand more, but I

wasn't being taught." Their experiences with spirituality in the sense of celebrating religion carried over from early childhood.

All participants reported traumatic experiences within Fowler's age range for this stage. Childhood trauma causes feelings of betrayal and mistrust, as participant R1 stated, "I always felt people would make fun of me." Participant J1 described his youth, "I found that there were a lot of people who I thought were meant to be spiritual people, and I felt constantly getting shafted by them." According to Fowler, the danger in this stage is having a sense of badness. Participants viewed themselves unfavorably and expressed a fear of getting punished, as participant Y1 stated, "I'm very bad and I'm going to get punished."

Stage 3 Synthetic-Conventional Faith (adolescence and beyond). Transition from Stage 2 is initiated through the recognition of conflicting stories (e.g., Genesis versus evolutionary theory). Individuals are able to think abstractly and start to form a personalized identity. Still, there is a strong focus on the judgments and expectations of others which is expressed through conformity. The characteristics of this stage support the theme "pretending". Participants reported an internal struggle where they were not interested in practicing Judaism but did not see dropping religious practice as an option. They envied the less religious and described feeling uncomfortable in their own skin. In questioning the system, they were shunned which led to increased mistrust and drive to rebel. According to Fowler, interpersonal betrayals in this stage create nihilistic despair which explains why participants "bought out" of Judaism at this point.

Four participants described having brief interactions with individuals who they felt understood them. However, they had an overall feeling of lacking support. As participant Y1 stated, “In terms of having someone to talk to, I didn’t have anyone I could confide in which is really sad when I think about it.”

Stage 4 Individuative-Reflective Faith (young adulthood and beyond). The autonomous self feels empowered and confident in choosing a value system. There is an overemphasis on logic and rational thinking in relationship choices and group affiliations. Familial/community beliefs and traditions are scrutinized and rejected if they do not align with the chosen value system. The characteristics of this stage support the theme “rebelling”. Participants disagreed with the “value system” of their communities and reduced their religious practices. As participant S1 stated, “I saw it back then as a rebellion against religion. I felt like it was directed toward my religious upbringing, which was so wrong, which is very close-minded and doesn’t let people express themselves.” They started associating with peers who were considered “less” religious than their families. With the reduction of religious practice there was an increase in adverse behaviors – increased alcohol/drug abuse, fighting, stealing, etc.

The theme “darkness” which describes the stage of active addiction does not seem to fit exclusively with any of the stages. Alcohol and drugs inhibit rational thinking, while numbing emotions. This can be described as a survival stage where individuals associate with others for selfish reasons. As S3 stated, “All my friends, I can’t even call them friends, everybody that I surrounded myself with was just toxic and using.” Participant S1 made a similar comment, “I use the word friends, but I don’t consider

anyone from back then friends. We were all about just using each other." All participants described having zero spirituality during this time, with minimal contact with their families.

Still, certain aspects of Stages 1-4 are seen in active addiction. Participants exhibited the self-centeredness characteristic of Stage 1. They were stuck in their personal narratives and unable to step out and see a larger picture – a characteristic of Stage 2. Addiction imperiled their autonomous judgment and intensified nihilistic despair – both are dangers found in Stage 3. Behaviors in active addiction included: manipulating others, high-risk behaviors, minimal self-care, with negative emotions fueled by anger, hopelessness, and resentments. This "value system" during active addiction was created through intensified narcissism and excessive overconfidence - dangers in Stage 4. As participant T1 stated, "My alcoholic behavior - the selfishness, the self-seeking, the 'all me', things have to go my way."

Stage 5 Conjunctive Faith (unusual before mid-life). Narcissistic tendencies fall away in the recognition that one does not and cannot hold all the answers. In accepting that there are other "truths", one can appreciate differing faiths, religions, and value systems. The theme "rebirth" fits with the characteristics of Stage 5. Participants came to the realization that spirituality and G-d do not have to be defined by childhood teachings. As participant S1 stated, "The idea of G-d kind of formed when I realized that I could make up my own G-d." They described working with sponsors from other religious backgrounds. The connection with these sponsors helped them to break free of close-

mindedness (i.e., black and white thinking), and they embraced the idea that other "truths" exist beyond what they were taught.

This embracement was a slow process in their early recovery which can be seen in how participants described their struggles, specifically with spirituality in 12-step work. Participant T1 stated, "I struggled with the difference in definition of spirituality and tradition. I had to learn how to pray and how to view that differentiation." Participant J1 stated, "I could admit that I was powerless, and that my life was unmanageable, but I couldn't wrap my head around the 2nd and 3rd steps."

Fowler stated that it is unusual to reach this stage before mid-life, but participants described reaching this stage in their 20's. It could be that addicts statistically have shorter life spans than the general population, which means that mid-life would technically be at an earlier age. Another explanation for the discrepancy is that there were certain life experiences that set these participants on a fast track to expanding and/or more mature thought processes. For example, after experiencing trauma, participants started asking questions that were not age-appropriate (i.e., asking deep questions about life in their childhoods). Additionally, in the depths of addiction, death seemed more of a tangible reality, something that tends to come in later stages of adulthood. These are just postulations and something for future research to investigate.

Stage 6 Universalizing Faith (very rare). Individuals in this stage promote universal peace and justice, often to the point of martyrdom. Their love and respect for humankind can be seen in their perpetual challenge of social norms that are perceived as the causes for discrimination and oppression. According to Fowler very few people reach

Stage 6, but I found that the theme "harmony" fits in this stage. Participant narratives follow the narratives of people that Fowler described in this stage: their sensitivity to injustice, challenging normalcies, imprisonment (addiction in this case), rebirth, and expanding love for life. Participants' daily striving to be of service and their remarkable acceptance of others makes them comparable Gandhi and Mother Teresa, albeit on a smaller scale. Still, one cannot deny the impressive selflessness and sensitivity that these participants have for others in need. Certainly, they described their sponsors as having these characteristics.

Limitations of the Study

Trustworthiness in qualitative research stretches across four areas: credibility, dependability, transferability, and confirmability. I used four tools to increase the trustworthiness of this study: audit trail, member checking, triangulation of the data, and my chair's oversight throughout the study. Through my experience in completing clinical intakes in a residential treatment center I was at risk of conducting the interviews from a "therapist" perspective. My chair worked closely with me to conduct the interviews and view the data as a "researcher" (i.e., with increased openness to participant answers and flexible subquestions with minimized assumptions).

I used an audit trail to document the data collection/analysis process, my questions and concerns (e.g., concerning saturation), and my understandings throughout the study. The audit trail provided transparency which increased the credibility of this study. Dependability was increased through using an audit trail along with triangulation of the data: interviews (audio-recordings and transcripts with summaries), existing

literature, and the theoretical frameworks. Individuals in recovery often write an autobiography when engaging in 12-step work. These autobiographies include detailed life events, relationships, clarifications, and how individuals make sense of their lives leading up to recovery. I asked participants to supply their autobiographies as another component of collected data, but I was unable to attain them. Still, member checking and debriefing allowed for participant review of their documented narratives which increased confirmability. Finally, the details of cognitive dissonance at turning points, and the interweaving of participant narratives into Fowler's stages of faith increased the transferability of the findings. However, Fowler stated that his research is limited to Western culture (Fowler, 1995).

For saturation, my initial goal was to obtain a sample size of 10 people. Only six individuals initially joined the study. I worked closely with my chair in coding the data from the interviews. Through discussing participant responses, participant heterogeneity, proposed turning points, and trustworthiness of the study, it was decided that saturation would not be met. I therefore continued advertising, and two more participants joined the study. The results from thematic coding and in vivo analysis substantiated that saturation was approached through the eight participant narratives. However, it is not known if more variation in narratives or turning points could have been discovered in interviewing more individuals.

Recommendations

Future research using a more diverse sample of recovering addicts would potentially provide greater insight to the role of spiritual narratives in the 12-step

recovery model. Individuals with different religious upbringings and different cultures may provide clarity to turning points, the role of cognitive dissonance in addiction and recovery, and expand on the characteristics of Fowler's stages in faith development. A follow-up quantitative study that surveys a large sample size of the recovering population may aid in identifying the causes for turning points of spiritual narratives.

All participants reported traumatic events during Stage 2 of faith development. An exploratory study on the role of trauma in this stage may provide insight into the effects of trauma of childhood development. Participants reported asking deep questions about G-d and suffering after they experienced trauma. While research has pointed to developmental delays and psychopathologies from childhood trauma (Aas et al. 2014), future research should focus on the cognitive processes, specifically the questions children may ask subsequent to the trauma. This research could expand to study the discrepancy between Fowler's suggested mid-life (or older) Stage 5 (Conjunctive Faith) and recovering addicts reaching Stage 5 at an earlier age.

Finally, this study did not investigate the role of spirituality in relapse. Four of the participants reported relapsing and combined that period with active addiction. In their present moment of recovery, participants attributed serenity and life satisfaction to daily spiritual practice. They feel disarray when they do not connect to their Higher Power. Future research that focuses on spirituality and spiritual practices between time sober and relapse may provide greater insight into relapse prevention techniques and prognoses. A quantitative study that identifies causes for resistance in the 12-step program due to

struggles with religion/spirituality may aid practitioners in choosing effective treatment strategies for addicts struggling to maintain sobriety.

Implications

The findings of this narrative analysis indicated how spirituality was experienced and the meaning it had for individuals leading up to addiction, during addiction, and in recovery using the 12-step model. The findings revealed actions for potential social change in educational policies and on an individual, family, and community level. The focus on religious practice – teaching what to do without reasons/meaning, revealed a lack of spirituality in the childhoods of individuals raised in the Orthodox Jewish communities. Informing communities (e.g., seminars) on the importance of providing reasons for religious practices may initiate a shift from the current focus on what to do, to include the reasons for doing it. Community leaders and respected scholars could run educational workshops for parents and teachers that provide reasons for religious practices (as it is possible that many do not know the reasons themselves), and how to convey them to the children. Additional workshops on stages of development in different areas, including Fowler's stages of faith for spirituality (1981) and Kohlberg's stages of moral development (1958), will aid in curriculum development and parental guidance. Through capturing their attention, promoting discussions, and satiating their imaginations, children may have improved experiences with spirituality in their childhoods.

This study also found that all participants asked deep questions after traumatic experiences, and not one participant reported getting satisfactory answers. Educating

parents and teachers on how to answer these types of questions (e.g., “If G-d loves us why would He hurt us?”) may offer support to these children through the children feeling heard and that someone cares – similar to participant descriptions of their brief encounters with mentors. A secondary implication from the responses of authority figures is that the Orthodox Jewish community lacks knowledge on taking notice of the symptoms and effects of childhood trauma. Educating the community in this area will increase community awareness and may initiate avenues of support for trauma victims, as evidenced by trauma-informed care systems (Hanson & Lang, 2016). This may be a difficult task, as these communities are insulated and highly resistant to change (Baruch, Benarroch, & Rockman, 2015; Loewenthal, 2014).

Another implication of this study involves the interventions used during the “rebelling” stage. Participants described the detrimental effects of being placed in schools for “youth at risk”. None of the participants reported remedial effects in the schools, but instead were exposed to information and behaviors that continued to pull them on the path toward addiction. While the focus on this study was not the effectiveness of these schools, the unified response from participants was that they lacked support and were heading on a downward trajectory similar to their peers in the schools. Therefore, further research on the effectiveness of these schools could potentially facilitate change in their educational policies and their use as an effective intervention for adverse youth behaviors. An examination of alternative interventions (e.g., homeschooling, therapeutic schooling) will provide parents with the information to make an informed choice on how to proceed with their children.

One final implication based on the findings of this study is that awareness of addiction within the Orthodox Jewish community is lacking. As participant S3 stated,

> I don't know what I would say to an addict struggling in the *frum* community. But what I would say to the community is that we need more places for kids who are struggling and adults who are struggling - where they would feel they could be open and honest and not judged or shamed.

As evidenced in Chapter 2, there are several possible reasons for inadequate community awareness including: stigma, denial, lacking education to identify such issues, competing priorities, fear, and praying to G-d instead of seeking professional help (Baruch et al. 2015; Tkatch et al. 2015; Lowenthal, 2014; Yashinsky, 2007). Educating the community on the reality of addiction amongst community members and its effects if untreated, may initiate a communal drive to implement currently known effective interventions including preventative and curative measures.

Conclusion

Addiction rates have been increasing on a global scale, markedly spreading beyond alcohol and substances to areas that incorporate daily living activities (e.g., eating, shopping, sex/intimacy, etc.). With its relentless assault on individuals, families, and communities, addiction has proven to be a universal, formidable foe. No community is immune to its destructiveness, which breeds in nescience and denial - both on a communal and individual level. There are no recent statistics on addiction in Orthodox Jewish communities, but the recent opening of several addiction-treatment programs, along with addiction becoming a more popular topic in Jewish magazines and community

awareness seminars, indicates that it is becoming increasingly recognized as a social issue.

I have personally witnessed the destructive nature of addiction within my own family. Becoming an Orthodox Jew in my early twenties led me on a path to help others. This started with mentoring youth at risk and earning rabbinical status to help individuals who struggled with spiritual/religious matters. Upon completion of this dissertation I will complete my PhD in clinical psychology in order to continue researching and providing therapy in both group and individual settings. The required internship for this doctoral program brought me to a residential treatment facility for addiction. The majority of clients were raised in Orthodox Jewish communities. I completed almost all of the clinical intakes over a 5-year period, and I noticed many similarities in the stories of those clients which included: childhood trauma, lack of support, expulsions from multiple schools, and the negative repercussions of active addiction. The frugal internship stipend, and trying to raise a family, compelled me to take on a second job at the local *Chevra Kadisha* (a mortuary for the Jewish community that prepares the deceased for burial). On several painful occasions, I found myself preparing the lifeless bodies of clients from the treatment center. I had completed their intakes and worked with them in hopes that they would beat addiction and live better lives. I became impassioned to do more to help these individuals and decided to research this population for my dissertation. In the early beginnings of my literature review it became very clear that research for this population was lacking (Baruch et al. 2015; Tkatch et al. 2015; Lowenthal, 2014; Yashinsky, 2007). My hope is to use the findings of this study as a stepping-stone for focused research on

each of the themes (religious not spiritual, pretending, rebelling, darkness, rebirth, and harmony) using both qualitative and quantitative methods.

The participants in this study described feeling grateful for all of their experiences (i.e., the good and the bad). Similar to others who reached Fowler's Stage 6 – Universalizing Faith, these individuals survived through tragic/traumatic experiences and suffering, which led to questioning and ultimately challenging the norm. Like the phoenix, they experienced a rebirth, which set them on a path toward greatness. These experiences may be the necessary ingredients for ascending to a higher level of being, where love and respect for life break through the social shackles that hinder progress toward unity and universal harmony.

I am inspired by the perpetual internal drive that these individuals have in helping others, with openness and sincere acceptance. I am grateful to hear their stories, and to connect with the meanings they give to their experiences. This gratefulness flows from their spiritual narratives which continue to inspire me to explore my personal meaning of spirituality and the role it plays in my life.

References

Aas, M., Dazzan, P., Mondelli, V., Ingrid, M., Robin, M., & Pariante, C. (2014). A systematic review of cognitive function in first-episode psychosis, including a discussion on childhood trauma, stress, and inflammation. *Frontiers in Psychiatry, 4,* 82. doi:10.3389/fpsyt.2013.00182

Abu-Raiya, H. (2013). On the links between religion, mental health, and inter-religious conflict: A brief summary of empirical research. *The Israel Journal of Psychiatry and Related Sciences, 50*(2), 130-139. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24225441

Abu-Raiya, H., Pargament, K. I., Mahoney, A., and Stein, C. (2008). A psychological measure of Islamic religiousness: Development and evidence for reliability and validity. *The International Journal for the Psychology of Religion, 18*(4), 291-315. doi:10.1080/10508610802229270

Agnew, R. (1992). Foundation for a general strain theory of crime and delinquency. *Criminology, 30*(1), 47-88. doi:10.1111/j.1745-9125.1992.tb01093.x

Alcoholics Anonymous World Services. (2001). *Alcoholics anonymous* (4th ed.). New York, NY: Author.

Alcoholics Anonymous World Services. (2009). *Alcoholics anonymous comes of age* (34th ed.). New York, NY: Author.

Alexander, B. K., & Schweighofer, A. R. F. (1988). Defining "addiction." *Canadian Psychology, 29*(2), 151-162. doi:10.1037/h0084530

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental*

disorders (5th ed.). Washington, DC: Author.

American Society of Addiction Medication. (2011). Definition of addiction. Retrieved from http://www.asam.org/quality-practice/definition-of-addiction

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C. H., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174-186. doi:10.1007/s00406-005-0624-4

Bahorik, A. L., Newhill, C. E., & Eack, S. M. (2013). Characterizing the longitudinal patterns of substance use among individuals diagnosed with serious mental illness after psychiatric hospitalization. *Addiction, 108*(7), 1259-1269. doi:10.1111/add.12153

Banducci, A. N., Hoffman, E. M., Lejuez, C. W., & Koenen, K. C. (2014). The impact of childhood abuse on inpatient substance users: Specific links with risky sex, aggression, and emotion dysregulation. *Child Abuse & Neglect, 38*(5), 928-938. doi:10.1016/j.chiabu.2013.12.007

Baruch, M., Benarroch, A., & Rockman, G. E. (2015). Alcohol and substance use in the Jewish community: A Pilot study. *Journal of Addiction*, *2015*, 1-4. doi:10.1155/2015/763930

Berger, R. (2014). Leaving an Insular community: The case of Ultra Orthodox Jews. *Jewish Journal of Sociology, 56*(1/2), 75-98. Retrieved from https://archive.jpr.org.uk/object-jjs121

Berke, J. D., & Hyman, S. E. (2000). Addiction, dopamine, and the molecular

mechanisms of memory. *Neuron, 25*, 515-532. doi:10.1016/s0896-6273(00)81056-9

Blakeney, C. D., Blakeney, R. F., & Reich, K. H. (2005). Leaps of faith: The role of religious development in recovering integrity among Jewish alcoholics and drug addicts. *Mental Health, Religion & Culture, 8*(1), 63-77. doi:10.1080/1367467042000208172

Bloomfield, K., Grittner, U., Kramer, S., & Gmel, G. (2006). Social inequalities in alcohol consumption and alcohol-related problems in the study countries of the EU concerted action 'gender, culture and alcohol problems: A multi-national study. *Alcohol & Alcoholism, 41*(Suppl. 1), i26-i36. doi:10.1093/alcalc/agl073

Bonelli, R. M., & Koenig, H. G. (2013). Mental disorders, religion and spirituality 1990 to 2010: a systematic evidence-based review. *Journal of Religion and Health, 52*(2), 657-673. doi:10.1007/s10943-013-9691-4

Borras, E., Coutelle, C., Rosell, A., Fernández-Muixi, F., Broch, M., Crosas, B., . . . Szczepanek, M. (2000). Genetic polymorphism of alcohol dehydrogenase in Europeans: TheADH2* 2 allele decreases the risk for alcoholism and is associated with ADH3. *Hepatology*, *31*(4), 984-989. doi:10.1053/he.2000.5978

Brooks, A. J., & Penn, P. E. (2003). Comparing treatments for duel diagnosis: Twelve-step and self-management and recovery training. *The American Journal of Drug and Alcohol Abuse, 29*(2), 359-383. doi:10.1081/ada-120020519

Brown, A. E., Tonigan, J. S., Pavlik, V. N., Kosten, T. R., & Volk, R. J. (2013). Spirituality and confidence to resist substance use among Celebrate Recovery

participants. *Journal of Religion and Health,* 52, 107-113. doi:10.1007/s10943-011-9456-x

Brownstein, M. J. (1993). A brief history of opiates, opioid peptides, and opioid receptors. *Proceedings of the National Academy of Sciences, 90*, 5391-5393. doi:10.1073/pnas.90.12.5391

Bury, M. (2001). Illness narratives: Fact or fiction? *Sociology of Health and Illness, 23*(3), 263-285. doi:10.1111/1467-9566.00252

Cantril, H. (1941). *The psychology of social movements.* Hoboken, NJ: Wiley & Sons.

Carrico, A. W., Gifford, E. V., & Moos, R. H. (2007). Spritiuality/religiosity promotes acceptance-based responding and 12-step involvement. *Drug and Alcohol Dependence, 89*, 66-73. doi:10.1016/j.drugalcdep.2006.12.004

Carroll, K. M., Connors, G. J., Cooney, N. L., DiClemente, C. C., Donovan, D. M., Kadden, R. R., . . . Zweben, A. (1998). Internal validity of Project MATCH treatments: discriminability and integrity. *Journal of Consulting and Clinical Psychology*, *66*(2), 290. doi:10.1037/0022-006x.66.2.290

Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/

Chambers, H. (2015). Spirituality and Quaker approaches to substance use and addiction. *Religions, 6*(2), 385-403. doi:10.3390/rel6020385

Chen, C. C., Lu, R. B., Chen, Y. C., Wang, M. F., Chang, Y. C., Li, T. K., & Yin, S. J.

(1999). Interaction between the functional polymorphisms of the alcohol-metabolism genes in protection against alcoholism. *The American Journal of Human Genetics*, *65*(3), 795-807. doi:10.1086/302540

Chiou, W. B., & Wan, C. S. (2007). Using cognitive dissonance to induce adolescents' escaping from the claw of online gaming: The roles of personal responsibility and justification of cost. *CyberPsychology & Behavior, 10*(5), 663-670. doi:10.1089/cpb.2007.9972

Clancy, I. (1988). *The History of AA.* New York, NY: Alcoholics Anonymous World Services.

Coats, H., Crist, J. D., Berger, A., Sternber, E., & Rosenfeld, A. G. (2015). African American elders' serious illness experiences: Narratives of "G-d did", "G-d will," and "life is better." *Qualitative Health Research, 1*, 1-15. doi:10.1177/1049732315620153 qhr.sagepub.com

Connors, G. J., & Dermen, K. H. (1996). Characteristics of participants in secular organizations for sobriety (SOS). *American Journal of Drug and Alcohol Abuse, 22*(2), 281-295. doi:10.3109/00952999609001659

Cutler, R. B., & Fishbain, D. A. (2005). Are alcoholism treatments effective? The Project MATCH data. *BMC Public Health, 5*(75), 1-11. doi:10.1186/1471-2458-5-75

Davidman, L., & Greil, A. L. (2007). Characters in search of a script: The exit narratives of formerly ultra-orthodox Jews. *Journal for the Scientific Study of Religion, 46*(2), 201-216. doi:10.1111/j.1468-5906.2007.00351.x

Dynner, G. (2014). "A Jewish drunk is hard to find": Jewish drinking practices and the

sobriety stereotype in Eastern Europe. *Jewish Quarterly Review, 104*(1), 9-23. doi:10.1353/jqr.2014.0003

Exline, J. J., Yali, A. M., & Lobel, M. (1999). When God disappoints: Difficulty forgiving God and its role in negative emotion. *Journal of Health Psychology, 4*(3), 365-379. doi:10.1177/135910539900400306

Faigin, C. A., Pargament, K. I., & Abu-Raiya, H. (2014). Spiritual struggles as a possible risk factor for addictive behaviors: An initial investigation. *The International Journal for the Psychology of Religion, 24*(3), 201-214. doi:10.1080/10508619.2013.837661

Fair, M. (2006). The relationship of the transformative learning experience on substance abuse treatment outcomes: The Hudson Lake recovery camp curriculum. doi:10.1.1.536.7287

Feinson, M. C., & Meir, A. (2015). Exploring mental health consequences of childhood abuse and the relevance of religiosity. *Journal of Interpersonal Violence, 30*(3), 499-521. doi:10.1177/0886260514535094

Ferri, M., Amato, L., & Davoli, M. (2009). Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database of Systematic Reviews,3*, 1-26. doi:10.1002/14651858.CD005032.pub2

Festinger, L. (1957). *A Theory of Cognitive Dissonance.* Evanston, IL: Stanford University Press.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: a conceptualization. *American Journal of Orthopsychiatry*, *55*(4), 530.

doi:10.1111/j.1939-0025.1985.tb02703.x

Fitchett, G., Rybarczyk, B. D., DeMarco, G. A., & Nicholas, J. J. (1999). The role of religion in medical rehabilitation outcomes: A longitudinal study. *Rehabilitation Psychology, 44*(4), 333. doi:10.1037/0090-5550.44.4.333

Fowler, J.W. (1981). *Stages of Faith: The Psychology of Human Development and the Quest for Meaning.* New York, NY: Harpercollins College Div.

Fowler, J. W., & Dell, M. L. (2006). Stages of faith from infancy through adolescence: Reflections on three decades of faith development theory. *The Handbook of Spiritual Development in Childhood and Adolescence* (pp. 34-45). Thousand Oaks, CA: Sage.

Gaghainn, S.N. (2003). Assessing sobriety and successful membership of Alcoholics Anonymous. *Journal of Substance Abuse, 8*, 55-60. doi:10.1080/1465989031000067254

Galanter, M. (2013). Alcoholics Anonymous and Twelve-step recovery: A model based on social and cognitive neuroscience. *The American Journal on Addictions,* XX, 1-8. doi:10.1111/j.1521-0391.2014.12106.x

Galanter, M., Egelko, S., & Edwards, H. (1993). Rational Recovery: Alternative to AA for addiction? *American Journal of Drug and Alcohol Abuse, 19*(4), 499-510. doi:10.3109/00952999309001638

Gall, T. L., Basque, V., Damasceno-Scott, M., & Vardy, G. (2007). Spirituality and the current adjustment of adult survivors of childhood sexual abuse. *Journal for the Scientific Study of Religion, 46*(1), 101-117. doi:10.1111/j.1468-

5906.2007.00343.x

Gawronski, B. (2012). Back to the future of dissonance theory: Cognitive consistency as a core motive. *Social Cognition, 30*(6), 652-668. doi:10.1521/soco.2012.30.6.652

Hall, K.T., & Appelbaum, P.S. (2002). The origins of commitment for substance abuse in the United States. *Journal of the American Academy of Psychiatry and the Law, 30*(1), 33-45. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/11931367

Hamarneh, S. (1972). Pharmacy in medieval Islam and the history of drug addiction. *Medical History, 16*(3), 226-237. doi:10.1017/s0025727300017725

Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child maltreatment, 21*(2), 95-100. doi:10.1177/1077559516635274

Harrawood, L.K., McClure, C.C., & Nelson, J. (2011). Using experimental activities to prepare counselors-in-training to understand the power of cravings when addressing clients with addiction. *Journal of Creativity in Mental Health, 6*, 105-117. doi:10.1080/15401383.2011.579872

Harris, K. S., Smock, S. A., & Tabor Wilkes, M. (2011). Relapse resilience: A process model of addiction and recovery. *Journal of Family Psychotherapy, 22*(3), 265-274. doi:10.1080/08975353.2011.602622

Hasin, D., Aharonovich, E., Liu, X., Mamman, Z., Matseoane, K., Carr, L.G., & Li, T. (2002). Alcohol dependence symptoms and alcohol dehydrogenase 2 polymorphism: Israeli Ashkenazis, Sephardics, and recent Russian immigrants. *Alcoholism: Clinical and Experimental Research, 26*(9), 1315-1321.

doi:10.1111/j.1530-0277.2002.tb02673.x

Hayward, R. D., Maselko, J., & Meador, K. G. (2012). Recollections of childhood religious identity and behavior as a function of adult religiousness. *International Journal for the Psychology of Religion, 22*(1), 79-88. doi:10.1080/10508619.2012.635064

Hilton, T.F., & Pilkonis, P.A. (2015). The key to individualized addiction treatment is comprehensive assessment and monitoring of symptoms and behavior change. *Behavioral Sciences, 5*(4), 477-495. doi:10.3390/bs5040477

Horan, J. M., & Widom, C. S. (2015). Does age of onset of risk behaviors mediate the relationship between child abuse and neglect and outcomes in middle adulthood? *Journal of Youth and Adolescence, 44*(3), 670-682. doi:10.1007/s10964-014-0161-4

Horvath, A.T., & Yeterian, J. (2012). SMART Recovery: Self-empowering, science-based addiction recovery support. *Journal of Groups in Addiction & Recovery, 7*, 102-117. doi:10.1080/1556035X.2012.705651

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Gallant, L., Haberle, B., . . . Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse treatment, 26*, 151-158. doi:10.1016/S0740-5472(03)00212-5

Inaba, D., & Cohen, W. E. (2014). *Uppers, Downers, All Arounders: Physical and Mental Effects of Psychoactive Drugs* (8th ed.). Ashland, OR: CNS Publications.

Jarvis, T. J., Copeland, J., Walton, L. (1998). Exploring the nature of the relationship

between child sexual abuse and substance use among women. *Addiction, 93*(6), 865-875. doi:10.1046/j.1360-0443.1998.9368658.x

Johnson, T. J., Sheets, V. L., & Kristeller, J. L. (2006). Identifying mediators of the relationship between religiousness/spirituality and alcohol use. *Journal of Studies on Alcohol and Drugs, 69*(1), 160-170. doi:10.15288/jsad.2008.69.160

Moreira-Almeida, A., Koenig, H. G., & Lucchetti, G. (2014). Clinical implications of spirituality to mental health: review of evidence and practical guidelines. *Revista Brasileira de Psiquiatria, 36*(2), 176-182. doi:10.1590/1516-4446-2013-1255

Mullins, J. W. (2010). Spirituality and the twelve steps. *International Journal of Applied Psychoanalytic Studies*, *7*(2), 152-160. doi: 10.1002/aps.242

Kaskutas, L. A. (1996b). Pathways to self-help among Women for Sobriety. *American Journal of Drug and Alcohol Abuse*, *22*(2), 259-280. doi:10.3109/00952999609001658

Kelly, J.F., & Greene, M.C. (2013). The twelve promises of Alcoholics Anonymous: Psychometric measure validation and meditational testing as a 12-step specific mechanism of behavior change. *Drug and Alcohol Dependence, 133*, 633-640. doi:10.1016/j.drugalcdep.2013.08.006

Kelly, J.F., Magill, M., & Stout R.L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research and Theory, 17*(3), 236-259. doi:10.1080/16066350902770458

Kerig, P. K., & Becker, S. P. (2015). 12 Early Abuse and Neglect as Risk Factors for the

Development of Criminal and Antisocial Behavior. In *The Development of Criminal and Antisocial Behavior* (pp. 181-199). Switzerland: Springer International.

Kok, B. E., Coffey, K. A., Cohn, M. A., Catalino, L. I., Vacharkulksemsuk, T., Algoe, S. B., ... Fredrickson, B. L. (2013). How positive emotions build physical health perceived positive social connections account for the upward spiral between positive emotions and vagal tone. *Psychological Science*, *24*(7), 1123-1132. doi:10.1177/0956797612470827

Krueger, R. F., Hicks, B. M., Patrick, C. J., Carlson, S. R., Iacono, W. G., & McGue, M. (2002). Etiologic connections among substance dependence, antisocial behavior and personality: Modeling the externalizing spectrum. *Journal of Abnormal Psychology, 111*(3), 411. doi:10.1037/11855-003

Kurtz, E (1991). *Not God: A History of Alcoholics Anonymous.* Minnesota: Hazelden.

Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. *Alcoholism Treatment Quarterly, 20*(3-4), 5-39. doi:10.1300/J020v20n03_02

Laudet, A.B., Morgen, K, & White, W.L. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug problems. *Alcohol Treatment Quarterly, 24*(1-2), 33-73. doi:10.1300/J020v24n01_04

Lembke, A., & Humphreys, K. (2012). Moderation Management: A mutual-help organization for problem drinkers who are not alcohol-dependent. *Journal of Groups in Addiction & Recovery, 7*, 130-141.

doi:10.1080/1556035X.2012.705657

Litten, R. Z., & Allen, J. P. (2012). *Measuring Alcohol Consumption: Psychosocial and Biochemical Methods*. New York: Springer Science & Business Media.

Levine, H.G. (1978). The discovery of addiction: Changing conceptions of habitual drunkenness in America. *Journal of Studies on Alcohol, 15*, 493-506. doi:10.15288/jsa.1978.39.143

Loewenthal, K.M. (2014). Addiction: Alcohol and substance abuse in Judaism. *Religions, 5*, 972-984. doi:10.3390/rel5040972

Longabaugh, R., & Magill, M. (2011). Recent advances in behavioral addiction treatments: Focusing on mechanisms of change. *Current Psychiatry Reports, 13*(5), 382-389. doi:10.1007/s11920-011-0220-4

Magura, S., Cleland, C.M., & Tonigan, J.S. (2013). Evaluating Alcoholics Anonymous's effect on drinking in Project MATCH using cross-lagged regression panel analysis. *Journal of Studies on Alcohol and Drugs, 74*(3), 378-385. doi:10.15288/jsad.2013.74.378

Malleck, D. (1999). "A state bordering on insanity"?: Identifying drug addiction in the nineteenth century Canadian asylums. *Canadian Bulletin of Medical History, 16*, 247-269. doi:10.3138/cbmh.16.2.247

Mankowski, E.S., Humphreys, K., & Moos, R.H. (2001). Individual and contextual predictors of involvement in 12-step self-help groups after substance abuse treatment. *American Journal of Community Psychology, 29*(4), 537-563. doi:10.1023/A:1010469900892

Maxwell, M.A. (1950). The Washingtonian movement. *Quarterly Journal of Studies on Alcohol, Vol. II,* 410-452. Retrieved from https://silkworth.net/pages/washingtonians/the_washingtonian_movement_introduction.php

McCrady, B., & Miller, W. (1993). *Research on Alcoholics Anonymous: Opportunities and Alternatives.* New Brunswick, NJ: Rutgers Center of Alcohol Studies.

McGue, M., Irons, D., & Iacono, W. G. (2014). The Adolescent Origins of Substance Use Disorders: A Behavioral Genetic Perspective. In *Genes and the Motivation to use Substances* (pp. 31-50). New York: Springer.

McKellar, J., Stewart, E., & Humphreys, K. (2003). Alcoholics Anonymous involvement and positive alcohol-related outcomes: Cause, consequence, or just correlate? A prospective 2-year study of 2,319 alcohol-dependent men. *Journal of Consulting and Clinical Psychology, 71*(2), 302-308. doi:10.1037/0022-006X.71.2.302

Miller, W.R. (2005). Are alcoholism treatments effective? The Project MATCH data: Response. *BMC Public Health, 5*(76), 1-4. doi:10.1186/1471-2458-5-76

Moos, R.H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction, 103*, 387-396. doi:10.1111/j.1360-0443.2007.02111.x

Mueller, S.E., Petitjean, S., Boening, J., & Wiesbeck, G.A. (2007). The impact of self-help group attendance on relapse rates after alcohol detoxification in a controlled study. *Alcoholism and Alcohol, 41*(4), 108-112. doi:10.1093/alcalc/agl122

Mueller, P. S., Plevak, D. J., & Rummans, T. A. (2001). Religious involvement, spirituality, and medicine: Implications for clinical practice. *Mayo Clinic*

Proceedings, 76(12), 1225-1235. doi:10.4065/76.12.1225

Musto, D.F. (1997). Opium, cocaine, and marijuana in American history. *The Scientific American, 265*(1), 40-47. Retrieved from www.jstor.org/stable/24936977

Narimani, M., & Sadeghieh, S. A. (2008). A study of the rate and causes of addiction relapse among volunteer addicts seeking help at the Center for the Prevention of Addiction affiliated to the Welfare Organization, Ardabil Province, Iran. *Research Journal of Biological Sciences, 3*(2), 258-264. Retrieved from http://docsdrive.com/pdfs/medwelljournals/rjbsci/2008/258-264.pdf

Nescience. (n.d.) In *Merriam-Webster.com.* Retrieved from https://www.merriam-webster.com/dictionary/nescience

Nicolaus, M. (2012). Empowering your sober self: The LifeRing approach to addiction recovery. *Journal of Groups in Addiction & Recovery, 7*, 118-129. doi:10.1080/1556035X.2012.705653

National Institute on Drug Abuse. (2012). How effective is drug addiction treatment? Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-addiction-treatment

National Institute on Drug Abuse. (2014). Drugs, Brains, and Behavior: The Science of Addiction. Retrieved from https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

National Institute on Drug Abuse. (2017). Trends & Statistics. Retrieved from https://www.drugabuse.gov?related-topics/trends-statitics

O'Leary Tevyaw, T., & Monti, P.M. (2004). Motivational enhancement and other brief interventions for adolescent substance abuse: Foundations, applications, and evaluations. *Addiction, 99* (Suppl. 2), 63-75. doi:10.1111/j.1360-0443.2004.00855.x

Ouimette, P.C., Finney, J.W., & Moos, R.H. (1997). Twelve-step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. *Journal of Consulting and Clinical Psychology, 65*(2), 230-240. doi:10.1037/0022-006X.65.2.230

Pardini, D. A., Plante, T. G., Sherman, A., & Stump, J. E. (2000). Religious faith and spirituality in substance abuse recovery: Determining the mental health benefits. *Journal of Substance Abuse Treatment, 19*(4), 347-354. doi:10.1016/S0740-5472(00)00125-2

Pegano, M.E., Friend, K.B., Tonigan, J.S., & Stout, R.L. (2004). Helping other alcoholics on Alcoholics Anonymous and drinking outcomes: Findings from Project MATCH. *Journal of Studies on Alcohol, 65*(6), 766-773. doi:10.15288/jsa.2004.65.766

Pegano, M.E., White, L.W., Kelly, J.F., Stout, R.L., & Tonigan, J.S. (2013). The 10-year course of Alcoholics Anonymous participation and long-term outcomes: A follow-up study of outpatient subjects in Project MATCH. *Substance Abuse, 34*, 51-59. doi:10.1080/08897077.2012.691450

Prest, L.A., & Robinson, W.D. (2006). Systemic assessment and treatment of depression and anxiety in families: The BPSS model in practice. *Journal of Systemic*

Therapies, 25(3), 4-24. doi:10.1521/jsyt.2006.25.3.4

Rebirth. (2019) In *Merriam-Webster.com.* Retrieved from https://www.merriam-webster.com/dictionary/rebirth

Reich, T. (1996). A genomic survey of alcohol dependence and related phenotypes: results from the Collaborative Study on the Genetics of Alcoholism (COGA). *Alcoholism: Clinical and Experimental Research*, *20*(s8), 133a-137a. doi:10.1111/j.1530-0277.1996.tb01763.x

Riessman, C. K. (2008). *Narrative Methods for the Human Sciences.* Thousand Oaks, CA: Sage.

Rippentrop, A. E., Altmaier, E. M., Chen, J. J., Found, E. M., & Keffala, V. J. (2005). The relationship between religion/spirituality and physical health, mental health, and pain in a chronic pain population. *Pain, 116*(3), 311-321. doi:10.1016/j.pain.2005.05.008

Rodriguez, L. M., Neighbors, C., & Foster, D. W. (2014). Priming effects of self-reported drinking and religiosity. *Psychology of Addictive Behaviors, 28*(1), 1. doi:10.1037/a0031828

Rosso, A.M. (2012). Beer and wine in antiquity: Beneficial remedy or punishment imposed by the gods? *Acta med-hist Adriat, 10*(2), 237-262. Retrieved from http://www.amha-journal.com/index.php/AMHA/article/view/402/353

Rudy, D. R., & Greil, A. L. (1989). Is alcoholics anonymous a religious organization?: Meditations on marginality. *Sociology of Religion, 50*(1), 41-51. doi:10.2307/3710917

Rush, B. (1791). *An enquiry into the effects of spirituous liquors upon the human body, and their influence upon the happiness of society*. Philadelphia, PA: M'Culloch.

Saldaña, J. (2016). *The Coding Manual for Qualitative Researchers.* Thousand Oaks, CA: Sage.

Sandoz, J. (2014). Finding God through the spirituality of the 12 steps of Alcoholics Anonymous. *Religions, 5*(4), 948-960. doi:10.3390/rel5040948

Saura, D. M., & Balsas, P. R. (2014). Interviewing and surveying over the phone: A reflexive account of a research on parenting. *Quality & Quantity, 48*(5), 2615-2630. doi:10.1007/s11135-013-9911-8

Schoenthaler, S. J., Blum, K., Braverman, E. R., Giordano, J., Thompson, B., Oscar-Berman, M., ... Demotrovics, Z. (2015). NIDA-Drug Addiction Treatment Outcome Study (DATOS) relapse as a function of spirituality/religiosity. *Journal of Reward Deficiency Syndrome, 1*(1), 36. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4455957/

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*(2), 63-75. doi:10.3233/EFI-2004-22201

Sperry, D. M., & Widom, C. S. (2013). Child abuse and neglect, social support, and psychopathology in adulthood: A prospective investigation. *Child Abuse & Neglect*, *37*(6), 415-425. doi:10.1016/j.chiabu.2013.02.006

Substance Abuse and Mental Health Services Administration: Recovery and Support (2015). Retrieved from https://www.samhsa.gov/recovery

The Language of the Heart (12 ed.). (2014) New York, NY: The AA.

Thomasson, H.R., Edenberg, H.J., Crabb, D.W., Mai, X., Jerome, R.E., Li, T., . . . Yin, S. (1991). Alcohol and aldehyde dehydrogenase genotypes and alcoholism in Chinese men. *American Journal of Human Genetics, 48*(4), 677-681. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1682953/

Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-Step self-help groups and 6-month substance use disorder outcomes. *Addiction, 101*, 678-688. doi:10.1111/j.1360-0443.2006.01391.x

Timko, C., Moos, R.H., Finney, J.W., & Lesar, D.L. (2000). Long-term outcomes of alcohol use disorders: Comparing untreated individuals with those in Alcoholics Anonymous and formal treatment. *Journal of Studies on Alcohol, 61*, 529-540. doi:10.15288/jsa.2000.61.529

Tonigan, J.S., Rynes, K., & McCrady, B.S. (2013). Spirituality as a change mechanism in 12-step programs: A replication, extension, and refinement. *Substance Use & Misuse, 48*, 1161-1173. doi:10.3109/10826084.2013.808540

Tonigan, J.S., Rynes, K., Toscova, R., & Hagler, K. (2013). Do changes in selfishness explain 12-step benefit? A prospective lagged analysis. *Substance Abuse, 34*, 13-19. doi:10.1080/08897077.2012.691453

Trezza, V., Baarendse, P. J., & Vanderschuren, L. J. (2014). On the interaction between drugs of abuse and adolescent social behavior. *Psychopharmacology, 231*(8), 1715-1729. doi:10.1007/s00213-014-3471-z

Unkovic, C.M., Adler, R.J., & Miller, S.E. (1976). The contemporary state of Jewish alcoholism. *Contemporary Jewry, 3*(1), 19-26. doi:10.1007/BF02965639

Vaillant, G.E. (2014). Positive emotions and the success of Alcoholics Anonymous. *Alcoholism Treatment Quarterly, 32*(2-3), 214-224. doi:10.1080/07347324.2014.907032

Vasilyev, P. (2012). Medical Science, the State, and the Construction of the Juvenile Drug Addict in Early Soviet Russia. *Social Justice*, *38*(4), 31-52. Retrieved from www.jstor.org/stable/41940957

Vex, S.L., & Blume, S.B. (2001). The JACS Study 1. *Journal of Addictive Diseases, 20*(4), 75-94. doi:10.1300/J069v20n04_07

Weber, S. R., & Pargament, K. I. (2014). The role of religion and spirituality in mental health. *Current Opinion in Psychiatry, 27*(5), 358-363. doi:10.1097/YCO.0000000000000080

White, W.L. (2014). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.* Bloomington, IL: Chestnut Health Systems.

White, W. (1999). The role of recovering physicians in 19th century addiction medicine: An organizational case study. *Journal of Addictive Diseases, 19*(2), 1-10. doi:10.1300/J069v19n02_01

White, W., & Kurtz. E. (2008). Twelve defining moments in the history of Alcoholics Anonymous. In Galanter, M. & Kaskutas, L. (Eds.) *Recent Developments in Alcoholism,* 18:37-57, New York: Plenum.

Williams, M.J., & Adinoff, B. (2008). The role of acetylcholine in cocaine addiction. *Neuropsychopharmacology, 33*, 1779-1797. doi:10.1038/sj.npp.1301585

Wilson, B. (1953). A Fragment of History, by Bill W. Retrieved from

http://silkworth.net/aahistory/history_fragment.html

Zemore, S. E. (2007). A role for spiritual change in the benefits of 12-step involvement. *Alcoholism: Clinical and Experimental Research, 31*(s3), 76s-79s. doi:10.1111/j.1530-0277.2007.00499.x

Appendix: Participant Screening Guide

Thank you for your interest in my study. I have a few questions to ask you to determine if your upbringing and recovery experience meets the criteria for the study. You are free to decline to answer any of the questions if you are not comfortable doing so. Do you have about 10 minutes?

Contact Information:

What is your name?

What is your phone number?

What is your email?

In which city are you located?

Screening

1. *Are you between the ages 18 to 65?*
2. *Were you raised in an Orthodox Jewish community?*
3. *Do you have a history of alcohol and/or substance use disorder (also known as addiction)?*
4. *Have you engaged in 12-step work to help maintain sobriety?*
5. *Are you currently sober for at least 1 year?*
6. *Were you in the Chabad Treatment Program at any time since January 2013?*

Thank you for your interest in my study.

For individuals who meet the criteria: "Let's set up a time, date and location for the interview. I will email you a Consent Form to return with your signature before or at the interview."

For individuals who do not meet the criteria: "Thank you again for your interest. I'm not able to interview you at this time, as the study has certain participant requirements. Do you know of anyone who fits the requirements for this study? If so, are you willing to contact the individual(s) and have him/her/them contact me directly? Thank you for your time."

Procedures for delivering the thank-you gift certificate will be confirmed.

For individuals that I am uncertain about their appropriateness for the study: "Thank you again for your interest. I'm not able to interview you at this time, as the study has certain participant requirements. However, there may be an opportunity to interview at a later date. May I verify your contact information and call you at a later time? Do you know of anyone who fits the requirements for this study? If so, are you willing to contact the individual(s) and have him/her/them contact me directly? Thank you for your time."

Procedures for delivering the thank-you gift certificate will be confirmed.