Cultural Points of Resistance to the 12-Step Recovery Process

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Abstract: This article addresses some of the key issues in developing culturally relevant approaches to drug abuse treatment and recovery, using the HAFC/Glide African-American Extended Family Program as a positive example of effective cultural adaptability within recovery. Cultural points of resistance to the recovery process are also addressed, including the perception that 12-Step fellowships are exclusive and confused with religion, confusion over surrender versus powerlessness, and concerns about low self-esteem, dysfunctional family structure, communication difficulties, and institutionalized and internalized racism. The authors also focus on professional resistance in other countries, where different treatment approaches and philosophies block the acceptance of a recovery concept in general and the 12-Step process in particular. In explicating these issues, addiction is presented as a multicultural problem in need of multicultural solutions. The challenge is to adapt the process of recovery to all cultures and races, to counter stereotypes on all sides, and to eliminate the perception that recovery only works for addicts from the White mainstream.

Keywords: African-Americans, cultural relevance, resistance, spirituality, treatment, 12-Step recovery

One of the most important collaborations for the Haight Ashbury Free Clinics (HAFC) relative to inner-city drug abuse treatment programs is the association of HAFC and Glide Memorial Methodist Church, headed by the Reverend Cecil Williams. Reverend Williams (1992) has described the Glide program in his excellent book No Hiding Place. The growing urban drug problem, particularly the use of crack cocaine, has fueled a public policy that is dominated by law enforcement and surrounded by therapeutic pessimism. This collaborative church-clinic program combines all the elements of an effective drug abuse treatment program that addresses the spiritual as well as the medical and psychological aspects of the disease of addiction. The recovery groups at the HAFC/Glide African-American Extended Family Program have been adapted to respond to the cultural needs of the African-American community. Special emphasis has been placed on specific points of resistance, including the issue of powerlessness inherent in the First Step of addiction recovery, and through the group process clients are empowered to take control of their lives by accepting that they are powerless over the drug. Such counseling occurs within the framework of a church program that is culturally and politically meaningful to them.

The influence of the recovery group process has exerted a major influence on HAFC programming. Darryl Inaba, director of the HAFC drug abuse treatment program, estimates that as many as 50 different 12-Step meetings a week occur at the various clinic sites.

The quiet revolution of recovery, using culturally relevant models, whether they be church, clinic or residential programs, has saved many lives and has done much to counter the therapeutic pessimism and despair that dominate so many inner-city communities ravaged by the drug epidemic. This article is based on a presentation at the Glide Church 1992 conference,”To Heal the Wounded Soul: Prevention/Recovery Values and a Non-Traditional Spirituality,” and describes a collaborative church-clinic program of recovery as well as cultural points of resistance to the recovery process.

THE AFRICAN-AMERICAN EXTENDED FAMILY
Any discussion of the cultural points of resistance to the 12-Step recovery process must begin on a positive note by looking at the HAFC/Glide Memorial Methodist Church African-American Extended Family Program (AAEFP). As pointed out earlier, the HAFC/Glide program represents an important collaboration that has made possible an effective intervention into the inner-city crack cocaine use crisis. The key to this intervention has been the adaptation of 12-Step principals of supported recovery to the African-American inner-city culture. In the HAFC/Glide program, the basic tenets of recovery are utilized in a model that is relevant to the African-American experience.

The Big Book of Alcoholics Anonymous (1976) uses the terms “spiritual experience” and “spiritual awakening,” manifesting in many different forms, to describe what happens to bring about a personality change sufficient to induce recovery. While some of these experiences may involve an “immediate and overwhelming “God consciousness,” most are what William James (1969) called an “educational variety” of revelation, developing slowly over time. According to a Big Book appendix on spiritual experience, the core of this process is the tapping of an “unexpected inner resource” by members who presently identify this resource with “their own conception of a Power greater than themselves.”

Many members of the African-American community afflicted with crack cocaine addiction have been raised in the church. There is a tradition of revelation, with many being saved and now believing they are sinners because they have used and sold crack cocaine to their own community. God has been described in a strict denominational sense. Spiritual awakening in a recovery model in a church program may produce conflict with traditional religious definitions, particularly the Third Step: “Made a decision to turn our will and our lives over to the care of God as we understood him.” Religious leaders, such as Reverend Williams, have played a leadership role in presenting a model of recovery theology that helps mobilize the church as a sleeping giant to better respond to the nation’s drug epidemic. In his model, Reverend Williams employs self-definition within a spirituality of recovery.

The African-American Extended Family Program Model

AAEFP grew out of an initial collaboration between HAFC and the Institute on Black Chemical Abuse (IBCA) in Minnesota, headed by Dr. Peter Bell. In 1988, Dr. Bell was looking for a West Coast site to replicate IBCA programs, based on a cultural interpretation of the Minnesota model that had been adapted to African-American drug abusers. After observing a number of treatment sites in the western United States, IBCA asked HAFC and its Drug Detoxification, Rehabilitation and Aftercare Program to work together to develop a new West Coast venue.

In keeping with IBCA’s African-American cultural approach in Minnesota, it was generally agreed that the best site for the new program would be a church. In a Glide Church conference panel debate on religion and spirituality, one of the authors pointed out that under the best of conditions religion equals spirituality plus culture (Seymour 1992). This is particularly true in the African-American community, where the church provides a point of cohesion and a center for both spiritual and community values, as well as a common ground for positive community activity. For a number of reasons, the clear choice was Glide Memorial Methodist Church in San Francisco’s Tenderloin District, a neighborhood that, though it includes a number of ethnic minorities, is predominantly African-American, low-income, and hard hit by the onslaught of crack cocaine dealing and abuse.

Under the leadership of Reverend Williams, Glide had been providing services for indigenous and homeless residents, including addicts, of San Francisco for 25 years. Because of his
growing concern over the crack cocaine problem, Reverend Williams and his wife Jan Mirikitani, executive director of Glide, attended a 12-Step recovery conference conducted by David Smith and Millicent Buxton. Following this conference, they decided to develop a culturally specific recovery program at Glide because they became aware of the resistance of people of color to participating in the 12-Step process.

In 1988, as a preamble to AAEFP, Glide initiated a “Facts on Crack” cocaine education program as an innovative approach to address the drug problem in the African-American community. Reverend Williams embraced the concept and the Black Extended Family (BEF) program was launched in that same year with funding from a Pell Foundation grant supplemented by a telethon hosted by KMEL, a local San Francisco radio station. Rafiq Bilal, an African-American author and counselor at HAFC’s drug treatment program was selected as the project’s first director. He and other key individuals then received several weeks of training at IBCA in Minnesota.

Problems and Priorities: Programs and Solutions at BEF

Reverend Williams placed the stamp of his own personality and ideals on BEF, working with the staff to mold it into a model synthesis of community activity and involvement, education, intervention, referral, treatment, and community-based support for recovery and reintegration of recovering crack cocaine users and dealers into the community.

The first task facing Williams, Bilal, and the staff was that of ascertaining what specific problems the project needed to address. According to Bilal, the problems of the African-American target population included the following:

1. Low self-esteem. Many African-Americans exhibit a marked lack of self-esteem. Additionally, it is difficult to have a healthy sense of self-esteem without self-knowledge. The history of African-America is not known to most African-Americans, nor are the contributions of the African nations and societies to world civilization. Low self-esteem often leads to self pity, and addicts are well known as persons inclined to self pity.

2. Late introduction into recovery. African-Americans frequently come into recovery very late in their drug using careers and by way of the criminal justice system. Therefore, many African-Americans are forced to seek treatment or be incarcerated. Programs for recovery are often looked at as part of a system that demands their adherence, thereby complicating the long-term recovery potential. In light of the history of slavery, African-Americans often respond to these demands with resentment and insincerity. As a result, there is a long history of failure of African-Americans in recovery programs, which is well known in the African-American community.

3. Short-term abstinence. Historically, there has been a focus on short-term abstinence rather than long-term recovery in the African-American community.

4. A unique, often dysfunctional family structure. Many African cultures have been matrilineal, and look to the “grandmother” for spiritual direction and values. Many African-American families developed a matriarchal structure to survive during slavery. The effectiveness of this structure in some areas is proving unable to address problems of alcohol and other drug addictions. The dominant Euro-American culture is based on a patriarchal family structure, the opposite of the African-American model. It is therefore difficult for African-Americans to relate to systems and to address dysfunctional families when the African-American model is not the norm. The most extreme example may be seen in children being taken from their mothers by the system.
5. **Dialect.** African-American speech patterns are often misunderstood by those outside the African-American community. Words that mean one thing to the general population mean the exact opposite in the African-American community, such as “good” and “bad.”

6. **Institutionalized racism.** African-Americans still confront institutionalized racism on a daily basis. Also, there is widespread apprehension among African-Americans that there is a plan to commit genocide through alcohol and other drugs and the criminal justice system, as with Native Americans.

7. **Internalized racism.** Suspicion of conspiracy to commit genocide and keep African-Americans down cripples many from taking steps into recovery. The African-American population still suffers from lack of positive images in the community. Predisposition to find problems and barriers impedes African-Americans from being able to open up and genuinely seek help.

AAEFP was conceived to address these and other problems within the African-American community. The first and foremost priority was the task of developing an intervention and recovery approach that African-Americans could identify and live with. Culturally responsive activities needed to be identified and developed. Many of AAEFP’s day-to-day activities are structured as workshops. Each of the following components is important in attracting and sustaining the interest of African-American clients into and through recovery:

1. **Support groups.** Daily groups begin with the singing of a selected spiritual from Glide’s Song Book; for instance, “Ain’t Going to Let Nobody Turn Me Around” or “This Little Light of Mine.” The meeting that follows is structured around the message from the song, and a set of commitments are developed by African-Americans in recovery. Drug use and addiction are related to slavery. Singing together creates a more relaxed and familiar cultural context for the meeting. The theme of the African-American extended family is also emphasized, and those who bond become members of an extended family.

2. **Women’s meetings.** Weekly meetings extend the idea that drug addiction equals slavery. For those who have lost their children, the comparison is made between the present and the capture of children in Africa during the slave trade. Meetings begin with spirituals that are pertinent to subject matter. Issues around lack of trust of the criminal justice system are aired. Systems are developed for mothers to be able to visit children who are with Child Protective Services and not be triggered to use drugs because of the emotions. Particular emphasis is placed on the role of women in the matriarchal African-American family. For many, the most positive role model is a grandmother who passed on the traditions of the family and represents a “higher power.”

3. **Intervention meetings.** Daily intervention meetings based on the 12-Step system take place at Glide with an open microphone. Addicts and alcoholics are exhorted to stop using and drinking, join the program, and enter into recovery. Active members of the support group participate in this event.

4. **Fun Day.** With the addition of crack cocaine to the drug scene, the first and fifteenth day of each month have taken on new levels of temptation for all drug dependents. This is when public assistance checks and most paychecks are issued. AAEFP provides Fun Days the first and fifteenth of each month, and the program and building become a sanctuary for persons with sums of money in their pockets and intense urges to slip from their recovery. The program provides movies, talent shows, and other entertainment.

5. **African history classes.** Each week a special course is taught about African history and African thought, particularly as it relates to recovery. Through generalized information about ancient Egypt, Songhay, Mali, and the Moorish Empire, African-Americans and others are shown that all great African civilizations have been based on spirituality or God-consciousness. A lifetime
of recovery can be accomplished by way of the individual getting in touch with his or her spirituality. Recovery is depicted as consistent with the highest achievements of African peoples. The history of the exploitation of crack cocaine, alcohol, and other drugs is spotlighted through a study of the connection between the African slave trade, which brought African-Americans to America, and the production of sugar and rum in the West Indies.

6. Development of a generation in Glide’s African-American extended family. Each support group of men and women is invited to become a generation of addicts born into recovery at Glide. As such, the generation attends support groups, classes, fun days and other activities together, bonding and graduating together.

7. Graduation of generations of addicts in recovery. On a designated Sunday, each generation experiences a ritual that involves the entire congregation at Glide. On that day, Sunday services at the church are devoted to the members of the graduating generation and their accomplishments and realizations over the past 80 days. Members of the generation speak before the congregation. The whole generation is literally given birth by the congregation, passing through a “placenta,” composed of previous generations, that surrounds the graduating group. There is a reception after the ceremony. This ritual enhances self-esteem in that each member of the generation has accomplished a milestone in his or her recovery within the context of a supportive extended family (Haight Ashbury Free Clinics 1990).

DEVELOPING CULTURALLY RELEVANT APPROACHES OF REATMENT

In its first four years, AAEFP has succeeded in providing a center for community action within the African-American community. The project has been showcased in three successive annual national conferences, presented by Reverend Williams, demonstrating how to make use of community resources to combat crack cocaine and other addictions. Besides the inestimable value of developmental contributions made by Williams, Bilal, past director Eddy Franks, current director Juanita Williams, and other highly innovative and involved individuals, the project owes much of its success to a recognition by all concerned of the need for culturally relevant treatment.

The first two national conferences presented by Glide, titled “The Death of a Race and Rebirth of a Race,” focused primarily on drug problems within African-American communities. The third conference, “To Heal a Wounded Soul: Prevention/Recovery Values and a Non-Traditional Spirituality,” was designed to emphasize cultural diversity and spirituality, and focused on how recognizing and utilizing diversity and spirituality could help all cultural communities become an extended human family. Although initiated as a means of addressing addiction, the conference goal extended well beyond the specific problems of addiction to explore cultural differences as a positive value and derive insights of mutual utility from cultural experiences of combatting addiction, abuse, misuse, humiliation, degradation, shame, and guilt.

Such culturally based and cross-cultural activities as these conferences, and the meaningful interaction that takes place in their development, provide a means for focusing on the cultural needs of individuals in treatment for addiction and other drug-related problems. Implicit within these activities is the recognition that treatment is more than prescribing medication or providing basic and generic counseling based on a homogeneous model of what constitutes addictive disease. Addiction has been described, in a paradigm developed in the 1960s by Chuck Brissette (1988), as a “three-headed dragon” that parasitically mirrors its human host, and is composed of interacting physical, mental, and spiritual components. To be effective, treatment and recovery must involve this tripartition, and be reflected in one’s physical, psychological and spiritual being, which is
strongly influenced by one’s cultural roots and cultural milieu. It stands to reason, therefore, that effective addiction treatment and recovery must be culturally relevant.

**ADDICTION, A MULTICULTURAL PROBLEM IN NEED OF MULTICULTURAL SOLUTIONS**

Just as addiction is a global rather than a national or regional phenomenon, addiction problems in this country are multicultural in their effect. Although characterized as a melting pot, the United States is actually a multicultural society composed of people of many different races, ethnicities, religions, and cultural backgrounds. Even European-American culture, seen by many as the dominant culture, is composed of people of many nationalities and ethnic groups far too numerous to list; Catholics, Jews, White Anglo-Saxon Protestants, and Moslems just to name a few.

Internationally, one cannot simply take a treatment program that is successful in New York or Seattle, replicate it in Florence or Addis Ababa, and expect it to be entirely successful. While the technical aspects of drug dependence may be similar, addiction takes place in and must be treated within a culturally specific milieu. The whole fabric of successful treatment needs to be woven around cultural realities. The same can be true for individuals. Individuals were not produced on an assemblyline like so many interchangeable units, and treatment outcome improves when there is a spectrum of care available (Westermeyer 1990). The same is true for both treatment and recovery within a multicultural society.

**THE RELATIVE EFFICACY OF 12-STEP RECOVERY**

In contemporary society, 12-Step fellowships, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Cocaine Anonymous (CA), are increasingly seen as the primary means to ensuring long-term abstinence and sobriety through addiction recovery. At least one government-supported symposium has taken place with the goal of improving general understanding of 12-Step fellowships within the medical, law enforcement and judicial communities, as well as for school counselors, clergy, and other individuals who come into contact with drug abusers and are in a position to refer these individuals into potentially life-saving supported recovery.

In the course of the symposium, “Referral to 12-Step Programs: The Vital Link in the Recovery Process,” hosted in 1990 by Robert L. DuPont, M.D. Ñ former director of both the National Institute on Drug Abuse and the President’s Special Action Office for Drug Abuse Prevention, and currently president of the Institute for Behavior and Health Ñ it became clear that although there is no hard data (due in part to the fellowships’ tradition of anonymity), many thousands of addicts have come to enjoy increasing years of sobriety and well-being as a result of fellowship support. That symposium has led to the publication of a book, A Bridge to Recovery: An Introduction to 12-Step Programs (DuPont, McGovern & Breck 1992), that provides many insights into the nature of 12-Step recovery fellowships.

It has been suggested that 12-Step fellowships and their success provide credibility to addiction treatment as the bridge between active addiction and active recovery. While this may be increasingly true for White, European-American mainstream culture in this country, it may be less true for other cultures within society.
In 1987, Buxton, Smith and Seymour enumerated a variety of points of resistance to the 12-Step recovery process. The focus of that article was on points of resistance within the mainstream of society, and concentrated on individual concerns. The focus here is primarily on cultural concerns; however, there is some distinct overlap. Some of the concerns that result from different cultural orientations echo those of individuals. In general, these concerns involve both real problems that need to be addressed if these cultures are to benefit from 12-Step recovery fellowships and a cluster of misconceptions, misinterpretations, and misperceptions about 12-Step recovery and its fellowships. In describing the problems facing the African-American community, Glide Church encountered a number of problems in developing AAEFP, and also found some solutions to these problems by adapting the program to meet specific cultural needs. Some of the problematic areas are discussed below and the ways and means of addressing these problems are provided.

**THE PERCEPTION THAT 12-STEP FELLOWSHIPS ARE EXCLUSIVE**

There is a pervasive perception by non-European-Americans that 12-Step fellowships are exclusively White, mainstream, middle-class fellowships. History indicates that the first 12-Step fellowship, Alcoholics Anonymous, was born in 1935 through an interaction between Bill W., a down-on-his-luck stockbroker from New York, and Doctor Bob, a surgeon living in Akron, Ohio (Alcoholics Anonymous 1957). Both of these men came from White middle-class backgrounds, as did most of the formative members of AA, who helped to develop the steps and traditions that gave the fellowship and succeeding 12-Step fellowships their basic form and character. Their ideals and concepts for the new fellowship were rooted in the Oxford movement, a Christian fellowship that later became known as Moral Rearmament. When AA first became interrelated with treatment for alcoholics, it was through the Minnesota Model, developed at Hazelden and with at least partial initial sponsorship from the Catholic Church (McElrath 1987). The writing style found in the Big Book (Alcoholics Anonymous 1976), originally published in 1939, also reflects the White, male, middle-class, Christian origins and values of its authors.

With such beginnings, one would expect there to be an ongoing adherence to Christianity and White middle-class values to the exclusion of other cultures within AA and subsequent 12-Step fellowships. And yet, from its inception, elements within the “group conscience” of AA began working to broaden the scope and flexibility of the fellowship. Early on, the fellowship began to distance itself from the Oxford movement, remaining friendly but moving toward a more eclectic spirituality that did not specify Christian dogma. In Alcoholics Anonymous Comes of Age (Alcoholics Anonymous 1957), Bill W. speaks of how the Twelve Steps were rephrased in their development to initiate such terms and concepts as “a higher power” and “God as we understood him.”

AA may have had its specific beginnings in the Oxford movement and the personal interaction between Bill W. and Doctor Bob, but its basic tenets reflect a spectrum of cultural antecedents, a number of which are discussed in Drugfree: A Unique, Positive Approach to Staying Off Alcohol and Other Drugs (Seymour & Smith 1987). Throughout history and within various cultures, attempts have been made to address addiction and associated human problems. The most generally successful of these have involved the development of individual spiritual maturity within a supportive environment. These authors see the Twelve Steps developed by AA and adapted by other 12-Step fellowships as a blueprint for developing spiritual maturity, similar in intent to such
entities as the Four Noble Truths and Eightfold Path of Buddhism, the Hindu Vedas, and the Zen Oxherding Panels.

While the history of AA in the United States has primarily involved European-American culture, the nature of the Twelve Steps and the precepts that underlie the fellowships can be seen as much more universal. They are both basic and flexible, and lend themselves to a wide range of interpretation and applications. In his book Physician, Heal Thyself!, Dr. Earle M. (1989) discussed his personal experiences with AA chapters in other cultures throughout the world. In his travels, Dr. Earle encountered Buddhist, Moslem, and other AA chapters that had adapted the 12-Steps to their own cultural needs and points of reference.

Individuals with certain religious backgrounds may have particular problems relating to certain tenets of the Twelve Steps. Many Buddhists, for example, venerate the Buddha as a fully enlightened being to be followed and emulated, but do not see him as a “higher power.” While not utilizing a concept of God or a higher power in their cultural background, Buddhists see their faith as a philosophy and a way of life rather than a religion. Points of reference need to be established in order for 12-Step recovery to become meaningful for these individuals.

AAEFP is a good example of how the precepts of 12-Step recovery can be adapted to African-American cultural mores and traditions and be made primary to recovery. The support system involves knowledge of and pride in African-American heritage and makes use of the spirituality inherent in that heritage to redefine goals and activities.

**AAEFP’s TERMS OF FAITH AND RESISTANCE**

In working to develop AAEFP, Reverend Williams took a hard look at what he saw as shortcomings in the traditional AA recovery model when applied to the African-American community. It was clear to him that few African-American addicts turned to AA and other existing 12-Step programs for recovery. He concluded that some of the traditional values of AA contradicted African-American cultural values. Instead of attacking traditional 12-Step approaches, as Rational Recovery and other variant recovery programs have done, Reverend Williams looked to the roots of recovery and adapted an approach that was in keeping with African-American cultural values.

First of all, he saw recovery as both a “miracle of healing” and a “movement for social change for our people.” African-Americans are a “communal” people, identifying strongly with an extended family and membership in the African-American community, unlikely to respond to the perceived AA focus on individual recovery, independently getting clean and sober. Collectively and as individuals, African-Americans have experienced a history of being anonymous and powerless. Reverend Williams pointed out (1992:8) that “to a black person who has felt invisible and unheard all of his or her life, being anonymous is already a familiar way of life.” While the anonymity in 12-Step programs is meant to protect members’ everyday lives, “Many of those who come to Glide have no everyday lives. They don’t have homes, jobs, or reputations to protect.” Anonymity for these people is yet another way to remain a nonperson, faceless and hidden from society. What was needed by the addicts at Glide was not anonymity and surrender, but recognition, a voice, an acknowledged heritage, and to take responsibility within a spiritually extended family dedicated to recognition, self-definition, rebirth in recovery, and community.

Acting on these insights, Reverend Williams (1992) initiated a list of ten “Terms of Resistance” that are repeated at Glide recovery meetings just as the Twelve Steps are at traditional meetings:
1. I will gain control over my life.
2. I will stop lying.
3. I will be honest with myself.
4. I will accept who I am.
5. I will feel my real feelings.
6. I will feel my pain.
7. I will forgive myself and forgive others.
8. I will rebirth a new life.
9. I will live my spirituality.
10. I will support and love my brothers and sisters.

Although the words may be different, echoes of the Twelve Steps can be heard throughout the Terms of Resistance. The First Step, admission of powerlessness, has been converted to gaining control, but the intent of taking responsibility for one’s own recovery is the same. When an African-American person hears the First Step admission of powerlessness, it is interpreted as “one more command to lie down and take it.” Yet, the first three steps correspond to the shift from inner-directed fear to outer-directed recovery that the recovering African-American addict makes in gaining control through a recognition of heritage within the extended family of recovering brothers and sisters. In effect, the overall process of self-exploration, spiritual housecleaning, forgiving oneself and others, through awakening to and living one’s spirituality, can be seen as heart, as the traditional path of recovery given an African-American cultural interpretation and lived within that context. There is very little difference between “support and love my brothers and sisters,” and the Twelfth Step’s “carry the message” and “practice these principles in all our affairs.” Reverend Williams captured the essence of what was needed and what the Glide program provides: “What we need to do to recover is to speak up, to tell our stories, to claim the truth about our lives before anyone and everyone.”

The success of the Glide program has been self-evident in the culturally and regionally diverse attendance at the “To Heal a Wounded Soul” conference and its many how-to workshops. The program’s tenets are being replicated in African-American communities throughout the country. Further, the process of adapting recovery to the African-American community is being studied as a method of bringing culturally viable recovery to a spectrum of culturally and ethnically different communities.

SPIRITUALITY IN 12-STEP FELLOWSHIPS: PUBLIC POLICY AND CULTURAL ISSUES

AA and other traditional 12-Step fellowships are spiritual programs. Spirituality is at the core of their effectiveness as a means to ongoing sobriety and recovery. That fact cannot be denied. That does not mean, however, that AA and other 12-Step fellowships constitute a religion. While it is true that AA came into this world trailing clouds of Christian rhetoric, it is no more a religion than is secular humanism, though there are those who would call secular humanism a religion too.

In his article, “The Twelve Steps: A Political Timebomb,” Andrews (1991) raised the issue of 12-Step religiosity in terms of fellowship vulnerability to constitutional restriction under the separation of church and state. He pointed out that while in the past most meetings were held in churches or private clinics and hospitals, today they are increasingly to be found in such public institutions as schools, universities, community health centers, town meeting halls, prisons, and juvenile halls. While many would applaud this increasing secularization of scope, some who
identify 12-Step recovery as a religion see its appearance in public institutions as a violation of the constitutionally guaranteed separation between church and state. The situation becomes more volatile as public-sector entities become increasingly involved in the referral of alcoholics and other addicts and see 12-Step fellowships as the preferred mode of recovery. This was, indeed, the gist of the referral symposium led by Dr. DuPont in 1990.

Given the politics of the day, Andrews foresees the possibility of funding being denied to hospitals and other publicly funded institutions that refer or even advocate the referral of clients to AA, or allow meetings to take place within their precincts. He also foresees curious realignments of forces for and against, with the conservative “prayer in the classroom” minions lining up behind recovery to do battle with rigid ideologues within the American Civil Liberties Union. While the religiosity of 12-Step fellowships may become a point of constitutional law, it is a point based on basic misunderstandings of these fellowships.

One of the misunderstandings is the misconception that AA and other 12-Step recovery fellowships are cohesive entities that have clear-cut rules and regulations for their memberships. For purposes of discussion here, AA will be used as an example; however, generalities can be extended to other primary recovery fellowships. In actuality, although AA has a national council and an office with the primary task of publishing and distributing materials, it is primarily an idea that has been adopted and adapted by largely autonomous groups of recovering people throughout the world. Its program for recovery, consisting of the Twelve Steps and supplemented by the Big Book and other publications, is referred to within the fellowship as a “suggested” course of action and is open to wide interpretation. According to the AA Third Tradition, “The only requirement for AA membership is a desire to stop drinking” (Alcoholics Anonymous 1952).

The focus of 12-Step recovery is spiritual, just as the focus of most treatment approaches involves some combination of the physical and the psychological. Spirituality and a spiritual focus also infuses most of what is deemed religion, but religion is more than spirituality, and it is the “more than” that comes into constitutional concerns. Religions are by their nature exclusionary. No matter how broad their frame of reference, someone is left out. School prayer issues revolve not around whether people have a right to pray. Everyone has the right to pray as he or she sees fit — or not to pray, if that is one’s conviction. The unspoken issue in school prayer involves the ascendency of one religion, recognized by the government, to the exclusion of others, and that is a constitutional issue.

By contrast, the 12-Step recovery process is spiritually inclusionary. Within the basic desire to stop drinking (and using), a full spectrum of spiritual options is open to the recovering addict. The autonomy of individual groups is upheld by the Twelve Traditions. These form the by-laws of 12-Step recovery and differ as little as the Twelve Steps do between fellowships. The traditions also ensure that AA-based fellowships have no opinion on outside issues, and religion is an outside issue. The core of the Twelve Steps is spiritual and relative. The truth of this is born out by the variety of cultures, including those in Eastern Europe and Asia, embodying a wide variety of religions and religious beliefs as well as degrees of atheism and agnosticism, wherein the 12-Step movement has taken root and begun to flourish.

While there are many meetings that have a distinct Christian orientation that goes far beyond joining hands and reciting the Lord’s Prayer, there are many others that do not. Definitions of God and a higher power can and do include an open range of options. In his book, Dr. Earle M. (1989) described meeting groups for atheists, agnostics and free-thinkers, and discussed his own activities in developing programs, such as The Forum, for individuals who were uncomfortable with what they perceived as religious language in the steps. Essentially, religiosity and a belief in
God as represented in any particular religion is unnecessary for the workings of 12-Step recovery; however, belief in a power outside oneself capable of bringing one to sanity in terms of one’s addiction is necessary, even if this power is characterized as the meeting group itself.

In reaction to 12-Step recovery, some programs, such as Rational Recovery, have appeared that strongly oppose the tenets of AA, particularly the insistence on belief in a higher power. These other programs claim success in helping individuals to stop drinking and using, but unfortunately they miss the point as to why belief in a higher power is important to recovering people in 12-Step programs.

Addiction can be seen as a disease of self-centered fear that depends on isolation and deeply held positive convictions regarding the nature and effects of the addict’s drug(s) of choice. Isolation renders the addict incapable of understanding the disease and its personal effects; this is the basis of denial. So long as the addict attempts to fight the addiction on personal willpower alone, he or she is fighting a losing battle, locked in emotional gridlock in a state of “white-knuckle sobriety” where increasing anxiety from stress will inevitably result in relapse. The reason for this is that the positive convictions about use are buried within the individual’s spiritual belief system, where he or she can only be reached if the addict is willing to accept that there is something outside his or her own immediate being that can lead him or her to sanity; that is, a power higher than oneself.

SURRENDER AND POWERLESSNESS

The concept of surrender, given its many war-related connotations of occupation, rape, and loss of freedom, is hard enough for anyone to accept, but particularly hard for cultural groups that have over time suffered more than their share of occupation, rape, and loss of freedom. African-Americans, for example, may feel that they have been in a state of individual and cultural powerlessness for many generations, and have no desire for further surrender. Native Americans have similar difficulties with that aspect of 12-Step recovery because it runs counter to tribal mores of self-reliance and stoicism. Although their cultural cohesion to adolescence is transitory, adolescents are in the process of developing their own individuality and are often loath to the appearance of giving up something they have so recently gained. Moslems may have the least problem with the concept of surrender, because Islam literally means “Submission to God’s will” (Guralnik & Friend 1962).

In explicating and to some degree expiating the term “surrender” as it is used in recovery, members of the community speak in such terms as “joining a winning team,” and urge newcomers to “hang out with the winners.” In admitting powerlessness over the disease, addicts are in effect gaining power, through enlisting the support of their higher power and the fellowship itself, to be responsible for their own recovery. A misunderstanding of this process can lead to an interpretation that people in 12-Step recovery are somehow “copping out” from personal responsibility. The point is that while the addict may not be responsible for having a disease that involves physiological and possibly genetic, psychological, and overwhelming environmental components, in 12-Step fellowships the addict is most certainly responsible for his or her own recovery.

The following excerpt from the Big Book (Alcoholics Anonymous 1976:83) may clarify the nature of “surrender” and “powerlessness” as they are interpreted and practiced within 12-Step recovery:

If we are painstaking about this phase of our development, we will be amazed before we are half way through. We are going to know a new freedom and a new happiness. We will not regret the
past nor wish to shut the door on it. We will comprehend the word serenity and we will know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and of economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us. We will suddenly realize that God is doing for us what we could not do for ourselves.

POINTS OF RESISTANCE AMONG HEALTH PROFESSIONALS

Some cultures are heavily invested in treatment approaches to addiction that do not recognize 12-Step recovery and its promises as the goal of addiction treatment. These treatment approaches may be based on the concept that addiction is not a disease but a cluster of symptoms and behaviors that are secondary to preexisting psychopathology. In these terms, addiction is not a viable object for primary treatment but rather something that will clear in the course of psychotherapy; recovery, therefore, is not a viable goal. Even though the efficacy of 12-Step recovery is generally recognized by addiction medicine specialists, the treatment community in the United States is still somewhat divided on this issue. There are individual physicians and professors who will argue that the whole concept of addiction is an artifice, that alcohol and other drug abuse is a moral issue, to be dealt with primarily through the courts and the criminal justice system.

One way in which professional resistance is being countered in this country is through medical education. For example, providing medical students with firsthand knowledge of AA and NA has been a goal at the University of Nevada since 1974, when substance abuse education was added to the medical curriculum. Today, this exposure includes attendance at one AA or NA meeting in the second year and four in the third year, with appropriate class work to meet educational objectives. These objectives include learning what happens at AA or NA meetings and becoming familiar with the importance of a home group, the role of sponsors, the pitfalls and benefits of working with the Twelve Steps, and the value of service (i.e., the recovering addict carrying the message to other suffering alcoholics and addicts). Students also learn the differences between spirituality and religion, the importance of the Twelve Traditions, and the problems and paradoxes found in 12-Step fellowships. The goal of the program is to produce physicians with positive attitudes toward 12-Step fellowships and sufficient skills and knowledge to support clients in 12-Step programs (Chappel 1990).

In addition, it is not unusual to encounter strong professional resistance to both the disease concept and 12-Step recovery in certain foreign countries. In France, for example, where the toxicomanes or physicians dealing with chemical dependency are heavily invested in a psychotherapeutic approach to drug dependency, there is professional denial that 12-Step programs exist or if they do that they are not at all effective with French clients. Some toxicomanes maintain that even if they themselves championed 12-Step recovery and attempted to refer clients to recovery programs, the French, with their heritage of individual freedom and idiosyncratic behavior and belief, would never abridge their freedom by joining such fellowships as AA (Smith & Seymour 1992). Health professionals in such wine-producing and consuming countries as Italy, Spain, and France have also expressed concern over the issue of addicts needing to maintain abstinence from all psychoactive substances. Wine, they maintain, is a food, and should not be included in such a blanket prohibition.
Acceptance of 12-Step recovery overseas has differed from culture to culture, from country to country, and in some cases from community to community. In Scandinavia, for example, some countries (such as Finland, Iceland, and Sweden) have experienced phenomenal multiplication of existing AA groups over the past 20 years, while others (such as Denmark and Norway) have experienced a decline in groups over the same period (Stenius 1991). With the advent of glasnost, narcologists in what is now the former Soviet Union discovered AA. Since that time, treatment has been increasingly linked with 12-Step recovery in Russia and other republics (Zimmerman 1988).

OTHER POINTS OF RESISTANCE AND CONCERN

Even though 12-Step recovery is open and inclusive by its nature as a spiritual program, its origins and predominance in White, male, Christian, middle-class society can make it appear exclusionary to members of other cultures. In lecturing about this to mostly White audiences of health professionals, one of the authors (Bilal) asks, “hat if it were the other way around? What if you, an addict seeking support for your recovery, walked into a room full of African-Americans and yours was the only White face? How would you feel?”

The distance between cultures may seem like a chasm at times, but it is being bridged by such projects as AAEFP that provide both recovery and a means to developing cultural parity. Society is changing rapidly, and recovery has the flexibility to change along with it. The autonomy guaranteed by the Twelve Traditions makes it possible to be innovative and adaptable. Many special groups within AA have learned that if there is no meeting that fits their special need, then they can start their own meetings.

New fellowships have been born when people within existing fellowships decided that adaptation even beyond the loose confines was called for. Such was the case in the mid-1950s when young recovering drug addicts who felt that their specific needs were not being met in AA, which focused on alcoholism, founded NA. Since that time, a plethora of other fellowships have been born, including Cocaine Anonymous (CA) and Marijuana Anonymous (MA).

The challenge is to adapt the process of recovery to all cultures and races, and to counter stereotypes that recovery only works with certain groups. Relative to public policy, when addiction occurs in the White middle-class population it is called a disease and the response is appropriate treatment, whereas when addiction occurs in lower socioeconomic non-White populations it is called a crime and the response is prison. The HAFC/Glide model demonstrates that when the recovery model is adapted culturally, it can work for other populations.

CONCLUSION AND FUTURE DIRECTIONS

Although some of the major cultural points of confusion and resistance regarding 12-Step recovery have been discussed, the topic is far from exhausted. Spirituality, by its very nature, is amorphous and mysterious, and spiritual programs are open to interpretation, misinterpretation, and constant reinterpretation. If Reverend Williams’ conference has accomplished anything, it has shown that in all the cultures represented, through all the cultural diversity, there is a deep flow of spirituality. Beneath all of the addiction, abuse, misuse, humiliation, degradation, shame, and guilt, there is a healing, unifying mutual wellspring of spirituality.

While there are some points of resistance manifested in cross-cultural understandings of recovery, there are also means of bringing cultures together and of making 12-Step recovery
available to those who may be in need of it. Furthering the transcultural spread of 12-Step recovery is by no means a totally altruistic endeavor. Individuals and fellowships both die by rigidity and self-absorption, they live and grow by flexibility and renewal from that which is external to them. Societies grow by the increasing parity and cross-fertilization of the cultures of which they are composed, and so it is with the fellowships of recovery.

The recovering individual enhances his or her recovery by helping other addicts; therefore the newcomer or the potential newcomer is what in the end gives the program meaning. Just as the individual in recovery brings his or her story to other addicts, clarifying and helping them toward wholeness, the fellowships bear their own witness in bringing their story in a process of attraction, placing principles before personalities, to those in cultures who feel themselves, for whatever reason, to be outside the support of 12-Step recovery.

APPENDIX
Dr. David E. Smith’s Plenary Presentation
at the Glide Memorial Church National Conference,
“To Heal A Wounded Soul” : September 25, 1992

I speak as a representative of the European-American community as I understand it. I am also a physician who specializes in addiction medicine, the grandson of farm workers who had to carry the stigma of being Oakies, a participant in a 12-Step recovery group, a member of a 12-Step fellowship, and a member of the Glide community.

My minister, the Reverend Cecil Williams, has brought many blessings to my life, the life of my family, and the life of our Clinic. One of the greatest blessings was introducing me to Judy Hunt (Executive Secretary of the Health and Welfare Ministries, Board of Global Ministries, New York), who makes the best fudge in the United States.

In this conference, we have dealt with many social, cultural, and political issues. Here, I intend to focus on the basic nature of the addictive process. I submit that unless we deal directly with addiction, then all the goals and aspirations that have been talked about in this conference cannot be achieved.

I applaud Reverend Williams and the Glide community for trying to awaken the church as a sleeping giant to deal directly with the addiction problem in the United States. Addiction represents our country’s number one public health problem. When we look at the disease of addiction, we must accept and understand that it is an equal opportunity disease. It is not just a disease of people of color. It strikes all ages, sexes, and skin colors.

For example, in my profession, physicians have a very high rate of addiction. Even people who have achieved success, acquired material goods, and are well educated can die from this disease. I was painfully reminded of this last week, when a physician who I have worked with for many years, relapsed and died with a needle in his arm, of a fentanyl overdose. That physician died in the same fashion that any addict on the street dies of an overdose.

As we deliberate, we must address the basic nature of the addictive process. I submit that although this disease has physical and psychological components, it is fundamentally a spiritual disease, or more precisely a disease that prospers in the absence of spirituality. The manifestation of addictive disease is a very powerful force in the spiritual crisis that we are experiencing in the United States at the present time.

Our Clinic was born in 1967, and is based on the philosophy that health care is a right, not a privilege, and that the addict deserves the right to treatment. For those of you who don’t know, the
“Free” in the Haight Ashbury Free Clinics, received its inspiration from the civil rights movement from Martin Luther King, Jr.’s, “Free at last, free at last, thank God almighty, I’m free at last.” We perceived that the addict was being discriminated against in this system, and deserved the right to care. In that sense, our mission is a spiritual mission, receiving inspiration from Glide and from conferences like this one.

Spirituality is a fundamental aspect of the 12-Step recovery process, a process in which I am a participant, one that our Clinic endorses, and one that Reverend Williams has adapted here at Glide and has described so brilliantly in his book No Hiding Place: Empowerment and Recovery for Our Troubled Communities. There was a classic interaction between Bill Wilson, cofounder of AA, and Carl Jung, in which Jung said, “The compulsion to use alcohol is so great that it is likely that only a spiritual experience could overwhelm that compulsion” (Alcoholics Anonymous 1985).

Addiction is characterized by an overwhelming compulsion to use a drug, loss of control over that drug, and continued use in spite of adverse consequences. The consequences can be so adverse that they destroy the body, mind, and spirit. Adverse consequences can be destructive to the degree that the addict cannot participate in the church community, cannot participate in the family, cannot participate in any of the positive things that we have talked about at this conference.

The steps of recovery begin with the First Step, admitting that we are powerless over the drug. In our book Drugfree (Seymour & Smith 1987), we talked about the principles that Reverend Williams has described, of how difficult it has been for different cultures to deal with that step. Powerlessness has been a major issue in dealing with racism, poverty, and discrimination. In this cultural context, we all need to be aware that the first step is not talking about powerlessness over your community or your life. It is talking about powerlessness over the drug. You cannot gain power over crack cocaine. No matter what happens in your life, you cannot control that monster, and addiction is a monster.

The Second Step talks about coming to believe in a power greater than ourselves. That “came to believe” is essential, because addicts cannot deal with their disease alone. As we say in the treatment field, “an addict alone is in bad company.” It requires the fellowship of recovery and of people who are participating in what Reverend Williams, in his book, calls “self-definition, the spirituality of recovery theology.” It requires redefining yourself from a using addict to a recovering addict. That starts with abstinence, but does not end with abstinence. It requires learning to live a comfortable and responsible life without the use of psychoactive drugs.

The Third Step, “Made a decision to turn our will and our lives over to the care of God as we understood him” (Alcoholics Anonymous 1976), is very critical. It is not God just as a particular church defines him, it is God as we understand it in whatever social and spiritual context we bring to bear. The decision to turn our will and our lives over to the care of God as we understand him is critical because you cannot survive this disease alone. You need the recovering community and you need the spiritual fellowship. What better place to have that fellowship than in a church and within the extended family that surrounds that church. We believe that we are a part of the extended family here at Glide.

The Twelfth Step involves a spiritual awakening as a result of the other eleven steps, and carrying our message to alcoholics and addicts who are still suffering. In keeping with the Eleventh Tradition, citing “attraction rather than promotion,” the Twelfth Step further reminds us to “practice these principles in all our affairs.” Some of the most spiritual people I know are recovering addicts. No matter what they may have done in active addiction, when they recover and they help others, they are some of the most spiritual people I know. Their transformation makes it clear that addiction is a disease, not a moral failing. These are not fundamentally sinful people,
these are people who have the disease of addiction. The spiritual principles of recovery not only help them, but these people in turn help others.

How then can we redefine the disease of addiction in such a way that we can mobilize and deal with it? One of the great tragedies that I’ve seen and that I’ve shared at past conferences, and with Reverend Williams, is that when addiction affects White, middle class people, it’s called a disease and you get treatment. When it affects people of color, it’s a crime and you go to jail. Seventy percent to 80% of the people in the criminal justice system are people of color who have the disease of addiction.

One of the most important tools for working with addiction is the Serenity Prayer. “God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.” That is the only way that we who work in the addiction field can survive, because addiction means death. I experienced the death this week of somebody I’ve worked with for a long time. The serenity prayer helped me get through that.

True serenity is important for recovery, but there is no room in recovery for serenity born of denial, and Reverend Williams challenges that kind of serenity. We cannot be serene when we look at the racism and the poverty and the discrimination that occurs in our community. The wisdom and the courage that I receive from Reverend Williams, from Glide, from the extended family of Glide Church and the Haight Ashbury Free Clinic, and from all of you, is the thing that keeps me going in this field.


