Selected Beliefs about Alcoholism and other Addictions Held by Recovering Psychologists

Fred Ponder, Diane Way, Christine A. Contreras and John Slate

Fred T. Ponder, Professor, Texas A&M University-Kingsville
Diane Way, Private Practice, Adkins, Texas
Christine Contreras, University of Texas Health Sciences Center
John Slate, Professor, Sam Houston State

Abstract

In this study, the beliefs and attitudes of 76 doctoral level psychologists and/or health care providers who were recovering alcoholics/addicts were obtained regarding alcoholism and other addictions held by these recovering psychologists. Through a survey of 20 personal beliefs and attitudes, our sample of recovering psychologists responded that they had positive feelings about their addiction; considered addiction to be a disease; had others in their immediate families with an addiction; believed that genetics contributed to their addiction; were raised in families that were dysfunctional; and that addictions were the greatest behavioral and social problem in the U.S.. Implications of our findings are discussed.

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Psychologists and other mental health clinicians often identify and treat addictions in the course of their professional careers. Addictions manifest themselves in overt behaviors as well as covert attitudes and beliefs. Healthcare professionals frequently disagree over the etiology, characteristics, and nature of addictions. Vaillant (1983) addressed these differences and concurred that practitioners often disagree on the cause(s) of alcoholism. Whereas some psychologists believe that alcoholism is a disease, other psychologists depict alcoholism as a bad habit or a culturally-induced behavior (Vaillant, 1983).

Although reliable numbers are difficult to obtain regarding the extent to which mental health practitioners have experienced addictions, it is undoubtedly clear that some mental health practitioners have experienced addictions in their own lives. As such, recovering mental health professionals may have personal insights into the nature, etiology, identification, and nature of alcoholism and drug addiction. These personal experiences with addictions and with recovery programs may influence how the medical and mental health communities therapeutically

approach the problem of addictions in their own practices. Thus, this study was specifically targeted at psychologists who were recovering or had recovered from one or more addictions to obtain a better understanding of the identification and nature of addictions.

An Evolving Definition of Alcoholism

Attempts at defining alcoholism have been as numerous as the number of scientists, health care professionals, and professional societies that have been concerned with the nature, identification, and treatment of alcoholism. Early on, the World Health Organization maintained that alcohol dependence could only be defined by first determining cultural norms with respect to what is acceptable; and that alcoholism exists when consumption by an individual exceeds limits to the extent that health is injured or impaired and/or social relationships are compromised (World Health Organization, 1952).

Limitations became apparent in defining alcoholism by cultural norms alone; thus, the great debate at establishing a precise definition of alcoholism occurred. A confounding factor still present today concerns the many variations in the patterns of obsessive drinking. To gain a clearer understanding of the ways in which people drank, Jellinek (1960) categorized the various types of drinkers among selected members of Alcoholics Anonymous. As such, Jellinek's work (1960) marked the first known attempt to study alcoholism using scientific inquiry. Five types of alcoholics identified by Jellinek (1960) were: (a) the alpha type where psychological symptoms were reported being present, but physical dependence was not present; (b) the beta type where medical problems were observed in the individual, but physical dependence was not identified; (c) the gamma type where both medical symptoms and physical dependence were present; (d) the delta type where physical dependence on alcohol was present, but few symptoms were observed; and (e) the epsilon type where intermittent drinking episodes occurred. In disagreeing with Jellinek, Valliant (1983) noted that although the sample represented a good cross-section, Jellinek's study was time specific and did not represent longitudinal data. Valliant stated that the idea that alcoholism is a progressive disease, with clear symptoms at each stage, as Jellinek proposed, is not supported by studies which are more longitudinal in nature.

A dozen years later, the National Council on Alcoholism (1972) published three categories of criteria for diagnosing alcoholism: (a) physical dependency, (b) medical symptoms, and (c) behavioral, psychological or social abnormalities. Decades later, Alan Leshner (2000)

categorized users of alcohol and drugs as either novelty/sensation seekers or self-medicators. He stated that adolescents are often in the first group using substances to obtain pleasant sensations or to feel accepted whereas persons who self-medicated tended to use alcohol and drugs to relieve depression or to assist in coping with life's problems.

Attitudes and Beliefs Impact Identification and Treatment

American attitudes toward drinking are at best ambivalent. These attitudes are not just modern day occurrences, but also have been demonstrated historically. Leshner (2000) emphasized that societal stigmas often encompass addictions causing many people to be afraid of addicts and afraid of the people who treat or study them. Inconsistencies in acceptability influence how mental health professionals, criminal justice workers, and parents identify and treat problematic drinking. Though many social situations exist where the use of alcohol is acceptable, many groups of people are discouraged from drinking alcohol and are even punished for drinking alcohol. These groups include women who are pregnant, teenagers, and persons driving vehicles (Scott & Rosenberg, 1998). The acceptability of drinking alcohol is also determined by one's moral and/or social status. Alcohol problems may be seen as abnormal when persons of high moral or social status are involved. The type of occupation often determines a person's social status and may affect the degree to which the alcohol-dependent person in stigmatized (Fichter, 1982). Another group where the identification and treatment of alcoholism may be compromised is among professionals. Bissell and Haberman (1984) reported evidence that alcohol problems among professionals often exist without being challenged or addressed.

Clinicians involved in the treatment of possible addictions may ensure positive outcomes by accurately diagnosing patients. Although definitions and criterion for diagnosing have been historically controversial and inadequate, the *Diagnostic and Statistical Manual of Mental Disorders, 4th TR Edition* published by the American Psychiatric Association (2000) is the latest professional standard for diagnosing addictions. The *DSM* IV TR defines alcohol dependence by the presentation of physiological dependence and tolerance. With physiological dependence: evidence of tolerance or withdrawal. Withdrawal includes the manifestation of two or more of the following symptoms: (a) autonomic hyperactivity, (b) increased hand tremor, (c) insomnia, (d) transient hallucinations or illusions, (e) psychomotor agitation, (f) anxiety, (g) grand mal seizures, and. Symptoms must occur within 12 hours of the cessation of alcohol use where the

intake has been heavy or prolonged. Tolerance is defined as the need for increased amounts of alcohol to achieve the desired effect or the presence of a greatly reduced effect with continued use of the same amount. Without physiological dependence: No evidence of tolerance or withdrawal. Alcohol abuse is defined as a pattern of use leading to clinically significant impairment or distress as manifested by one or more of the following within the last year: (a) impairment in functioning at work, school or home, (b) drinking without regard for self and others, (c) reoccurring legal problems related to alcohol use, and (d) and continued use even though chronic social and interpersonal problems occur and are exacerbated by the effects of alcohol.

Leshner (2000) stated that many doctors do not view substance abuse as a medical issue; rather they treat alcoholism and drug addiction as social issues. He also noted that physicians need to recognize that once their patients have begun to use drugs or alcohol voluntarily, their use eventually gives way to compulsive cravings that require assistance to overcome. Leshner (1998) commented that evidence suggests that addiction is a chronic, relapsing disease. He stated that addiction should be treated like an illness rather than a condition representing a failure of the will. In another article, Leshner noted that neuroscience research has begun to reveal that the addicted brain differs in biochemical ways from the non-addicted brain. He reported that the brain has experienced elevated levels of dopamine due to substance abuse thereby affecting the mesolimbic reward system. Hence, alcoholism qualifies as a brain disease or disorder.

An issue in understanding alcoholism and other addictions is the possible role of genetics. Khoury, Beaty, and Cohen (1993) wrote that most researchers agreed that, whereas people may be genetically predisposed to alcoholism, genetic make-up is not the determining factor for the development of an addiction. These authors believed that a combination of genotype and environmental pressures is the best predictor of the disease. Eaves, Last, Martin, and Jinks (1977) discussed this genotype-environment correlation and described the dynamic which exists between people with a high genetic risk for alcoholism and their exposure to risky environments.

According to the National Council on Alcohol and Drug Dependence, Inc., the first step in preventing addiction is gaining an understanding of the disease and an awareness of the onset of early symptoms. To avoid high-risk drinking, family history should be evaluated, resources for assistance should be available, and the recognition of health risks to the individual should be present. Silkworth (1960) discussed the problem of alcoholism in the United States and

expressed a series of questions which were developed by members of Alcoholics Anonymous and aimed at aiding those persons with potential drinking problems.

Though limited research studies are present about the development of alcoholism due to religious beliefs or the impact on prevention, substantial evidence exists that references to *God* may be barriers to treatment. According to Room (1998) and Galaif and Sussman (1995), spiritual emphasis of the 12 steps may be an obstacle to commitment to recovery in Alcoholics Anonymous. This finding may have implications for the successes of treatment programs that utilize the 12-step model.

Not directly addressed in the literature is whether acquiring information about recovery programs influence the alcoholic or addict to seek help. Aday and Andersen (1974), however, created treatment delivery models for a series of barriers and incentives that were identified as economic, geographic, or social influences, and/or personality characteristics in response to the idea that barriers exist and keep persons from seeking help. Regier, Narrow, Rae, Manderscheid, Locke, and Goodwin (1993) documented that the majority of problem drinkers do not participate in alcoholism treatment programs or Alcoholic Anonymous. The conclusion made by the Regier et al. was that understanding the influences on help-seeking behavior patterns was important for increasing service utilization systems, and whether or not this process includes disseminating information to potential addicts and alcoholics is unknown at this time.

The literature is on dysfunctional families is abundant. Communication patterns appear to influence the emotional health of the family. Sheridan and Green (1993) demonstrated that alcoholic families express more negative messages, engage in greater levels of anger, and exhibit lower levels of warmth, cohesion, and direct communication than nonalcoholic families (Garbarino & Strange, 1993; Rojas, 1993). According to the National Association for Children of Alcoholics (1998), the experience of growing up in an alcoholic family appears to lead to vulnerabilities in children; these vulnerabilities include lowered perceptions of self-esteem and worth; increases in depression, anxiety, stress-related illnesses, and difficulties in school. Children of alcoholics also experience greater incidences of neglect and physical abuse, role confusion, role reversals, and distortion of the family hierarchy (Chase, Deming, & Wells, 1998; Goglia, Jurkovic, Burt, & Burge-Callaway, 1992; Sheridan & Green, 1993).

Dysfunction of the family system, the factors influencing the social structure of the individual including acquisition of personal social skills and inherent personality traits have been

projected as common components among the various types of addictions including those of non-substance abusers. The degree of the presence of these characteristics is perhaps what separates addicted from non-addicted persons. Even children of the addicted person appear to be impacted by dysfunctional behaviors. Sheridan and Green (1993) demonstrated that adult children of alcoholics are less functional than non-adult children of alcoholics (Garbarino & Strange, 1993; Werner & Broida, 1991). Rationale for this phenomenon was projected by Chase (1999) who stated that the diminished functionality of the family support structure often requires children to parent themselves. The development of individuals living with an addicted person is disrupted and transformed and may result in insecurities, feelings of unworthiness, and perceptions of not being loved (Jacobvitz, Riggs, & Johnson, 1999; Robinson, 1999). As adults, these persons use a cornucopia of coping mechanisms to overcome feelings of inadequacy including overeating, using drugs or alcohol, overachieving, or becoming excessive caretakers (Claydon, 1987). Though these behaviors represent different types of addictions, they function in a similar way by compensating for negative feelings (Robinson & Kelley, 1998).

Personality has been described as an individual's distinct, consistent outlook and actions toward life, which emit an overall style of behavior. According to Miller (1976), genetic factors do not play a role in the development of the personality except that they could influence behavior. In studying the development of alcoholism, researchers have generally rejected broad personality theories because researchers have failed to reveal consistent personality traits among different groups of alcoholics. The foremost argument against the idea that personality predisposes a person to become alcoholic has been that personality traits observed in alcoholics are the result of and not the cause of their alcoholism.

According to the Twelfth Tradition of Alcoholics Anonymous (A.A.), anonymity is defined as the spiritual principle of sacrifice meaning that members are guided by spiritual precepts rather than the drive to achieve personal desires including the natural desire for personal distinction as A.A. members (Alcoholics Anonymous World Services, Inc., 1985). A phenomenon is present, however, that occurs in A.A. between the notion of sobriety and anonymity in the virtual community. Some members have begun posting their sobriety dates or by attaching their dates to their signature profiles. Whether these members do so to demonstrate that A.A. works to serve as encouragement to new members, as an element of ego, or to establish credibility is unknown (Denzin, 1995; Pollner & Stein, 2001).

Childhood physical abuse and exposure to parental violence are associated with the development of alcohol-related problems in adulthood, but are gender specific and follow lines of ethnicity. Researchers have documented a connection between parental violence, alcohol problems, and childhood physical abuse among Caucasian, Afro-American and Hispanic females and Hispanic males. Similarly, a link exists between parental violence and alcohol problems among African-American males (Caetano, Field, & Scott, 2000).

Non-substance intake addictions, which are fantasy, urge, and behavior-induced mood alterations are well documented and closely associated with compulsive gambling, problematic sexual and/or romantic relationships, binge eating and many others. These addictions often co-exist with substance use disorders. Noted in the *Manual of Therapeutics for Addictions* (1997) is that the evolution of the primary disorders, as compulsive and maladaptive behaviors, is learned in the family system.

The National Institute on Alcohol Abuse and Alcoholism has projected that alcohol consumption can alter the structure of certain genes. Miles examined how genes, involved in a variety of physiological functions such as, cellular communication, could play a vital role in the brain's adaptation to alcohol. These maladaptations have already been implicated in a study conducted by Demir, Ucar, Ulug, Ulusy, Sevinc, and Batur (2002) where decreased levels of monoamine oxydase (MAO) activity was evidenced in the brains of alcoholics.

Purpose of the Study

The purpose of this study was to obtain information from recovering psychologists regarding 20 personal beliefs and attitudes about whether these ideas about alcoholism and other addictions influenced the way potential alcoholics/addicts were identified and treated. The assumption here was that beliefs about addiction born out of personal experience would influence the identification of addiction and a more adequate understanding of addiction. The authors hoped to gain professional insights from the recovering professionals psychologists who participated in this study. Moreover, the findings may reveal clinically useful information regarding the nature and identification of addiction. The study may highlight and point out commonalities and discrepancies in concepts and language used to define and communicate concepts and ideas concerning addictions.

Method

Participants

This study was an inquiry of 20 personal beliefs and attitudes of a national sample of psychologists regarding alcoholism and other addictions held by these recovering psychologists. The sample included 76 doctoral-level psychologists who were members of Psychologists Helping Psychologists (PHP), a resource group organized to assist psychologists who are experiencing addiction in their personal lives. The PHP group is a national and international group of psychologists whose headquarters are located in Arlington, Virginia. Of the 76 psychologists who responded to the survey, 28 states of residence were represented. All respondents were psychologists who held one of three doctoral-level degrees; these degrees included the Doctor of Education, Doctor of Philosophy, or Doctor of Psychology degree. The majority of participants (90.7%) held the Ph.D. degree. The age at the onset of recovery varied from age 21 to age 60 with the highest frequency of onset occurring at age 38; this age represented (13.3%) of the sample population. Length of abstinence ranged from 9 months to 37 years with the mean number of participants reporting (18.2) years of sobriety and a standard deviation of 8.0 years of sobriety. The age range for the onset of recovery was 21 years to 60 years of age. The mean of onset of recovery was 39.3 years of age with a standard deviation of 8.6 years of age. Of our sample, 66.7% had not been treated in an inpatient alcohol/drug treatment facility. Only a third (33.3%) had been treated in an inpatient treatment facility.

Instrumentation and Procedures

Questions were developed to examine 20 beliefs of recovering alcoholic/addict psychologists which were addressed by reviewing the literature on addictions. Questions were focused on obtaining information and/or beliefs organized in 16 broad categories: (a) personal data and demographic information regarding type of degree, state of residence, length of abstinence, age at onset of recovery, presence of other addictions, preferred substance of use, and whether or not abstinence was a result of entry into a treatment facility; (b) belief about the disease concept of addictions; (c) belief about the similarities among the various types of addictions; (d) belief about addiction as a function of the personality, and belief in the concept of the addictive personality; (e) belief about addictions as social, behavioral, or medical problems; (f) belief about whether addiction is a diversion-seeking activity; (g) incidence of addiction among other

family members; (h) belief about genetic factors in addictions; (i) belief about the functionality of the family structure when addiction is present; (j) belief about religious factors and if religious ideas impact the development of addictions; (k) belief about aspects of prevention and having access to early information as to the nature of addictions and/or treatment options; (l) belief about the possibility of a cure for addictions and if a cure would impact the global prevalence of addictions; (m) belief about exploring all types of addiction when conducting research; (n) personal feelings about having an addiction; (o) belief about legalizing drugs; and (p) belief about whether anonymity is the guiding principle of recovery.

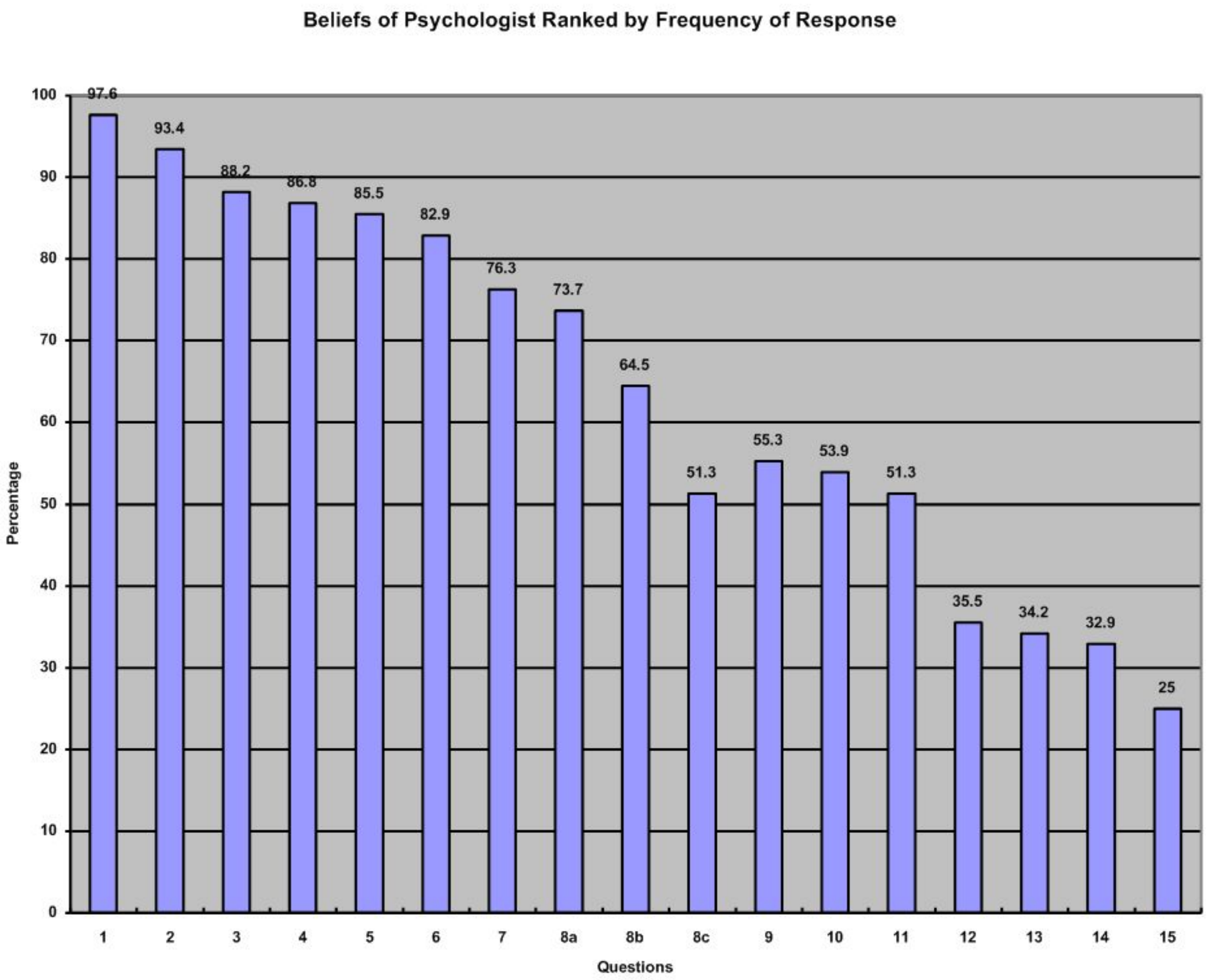
All participants were requested to complete a questionnaire, which was mailed in a monthly newsletter by the group's secretary. A self-addressed stamped envelope was enclosed for return of the questionnaire to the senior investigator. Questionnaires did not contain any identifying data; thereby assuring the confidentiality and anonymity of respondents.

Results

Beliefs of Psychologists Ranked by Frequency of Response

To draw conclusions about the results of this study, these researchers ranked the frequency of responses expressed in percentage of psychologists who held the given belief. Beliefs were ranked in descending order from the highest frequency of responses to the lowest. A bar graph is presented to allow the reader to view the results in a graphic form. Questions asked are presented in an abbreviated form and in some instances combined so that they may be examined in relation with the graph.

An exception was made for question 8a, 8b, and 8c because this question is the same, and presented as one question, except for different disciplines of psychology, sociology and medicine.



1. My personal feelings about my addiction might be characterized as: (97.6% Positive to Highly Positive).
2. Do you consider addiction as a disease? (93.4% Yes)
3. Do you feel significant similarities exist between addictions? (88.2% Yes)
4. Do others in your immediate biological family have an addiction? (86.8% Yes)
5. Do you feel your genetic inheritance contributed to your addiction? (85.5% Yes)
6. I feel my family of origin is (was) dysfunctional. (82.9% Yes)
7. Do you feel anonymity should remain the primary principle of recovery? (76.3% Yes)
8. Do you feel addictions are: a. greatest behavioral problem in America? (73.7% Yes)
   b. greatest social problem in America? (64.5% Yes)
   c. greatest medical problem in America? (51.3% Yes)

9. Do you believe addiction is a function of personality? (55.3% Yes)
10. Do you believe that more addiction earlier in life would have lead to earlier recovery? (53.9% Yes)
11. Do you believe that there is an addictive personality? (51.3% Yes)
12. Do you feel drugs should be legalized? (35.5% Yes) with 11.8% of those persons indicating marijuana only.
13. Do you feel the scientific study of alcohol/drug addiction can be complete without studying other addictions? (34.2% Yes)
14. Do you feel medical science will find a cure for addictions? (32.9% Yes) Of this one-third of respondents, 29.3% believed it would not be a sufficient cure for addictions.
15. Are you in recovery from a second addiction? (25.0% Yes)

The first bar in the bar graph represents the highest number and percentage of respondents indicating "Yes" responses and indicated a positive to a highly positive adjustment to their own alcoholism/addiction. One of the choices for this question was: "Thank God I am an alcoholic/addict—it has made all the difference in my life". Interesting, almost half, 48.7% of our participants responded "Yes" to this statement. Only 2.6% of respondents indicated a negative answer to this item.

The second most frequent response was that 93.4% of participants indicated that they felt alcoholism/addiction was a disease. In support of this result, we direct readers to question 5 from the graph where 85.5% of participants believed genetic factors played a role in their addiction development. Another factor supporting the disease concept might be question 4 where 86.8% reported members of their biological families had experienced some type of addiction.

The disease model does not seem to tell the whole story of beliefs about addiction development because, in question 6, 82.9% responded that their families of origin were dysfunctional. In addition to this finding, in question 9, 55.3% believed addiction was a function of personality, and in question 11 51.3% believed that addictive personalities exist. In question 15, only 32.9% of participants indicated that medical science would find a cure for alcoholism/addiction in the relatively near future.

Almost all, 88.2%, of participants indicated that they believed that a similarity between various types of addictions existed, question 3. From question 15, 34.2% agreed that the study of

addiction would not be complete without studying other addictions. Thus, almost two-thirds were supportive of examining the various types of addiction as a way of understanding any single addiction.

Additional factors include that, with question 7, 76.3% of our recovering psychologists believed that the Alcoholic Anonymous axiom that anonymity should remain the guiding principle of recovery. As per question 8a, 73.7% believed that addictions are the greatest behavioral problem in America. Concerning religion, as assessed in question 18, 19.8% of our respondents believed that it played no role in the development of their personal addiction. Question 16 indicated that 35.5% of respondents felt that some drugs should be legalized. A small percentage, 11.8%, believed that only marijuana should be legalized. In Question 10, 53.9% felt that acquiring information about addiction resources for obtaining help earlier in their lives would have led to earlier entry into recovery.

Discussion

One question concerning religion in the family of origin played a role in the participants' development of addiction, and another question concerning the use of alcohol/drugs as a diversion seem to have been misunderstood by the participants. Because these questions may have been worded poorly giving rise to misinterpretation, participant responses to these items were excluded from this article.

The findings of this study showing beliefs and attitudes of doctoral level psychologists who are also in recovery from one or more addictions may not give definitive sorely needed answers. One of the primary strengths of the study is the perspective of a highly trained psychologist who, for the most part are highly experienced in recovery from addiction. They may have a unique perspective on the subject of recovery from addiction. Phenomenological approaches might say that we all see things differently depending on our history and our life situation. Though this statement has merit, participants in this study had at least two major life situations (i.e., being a psychologist and being a recovering addict) in common. Hopefully, this study might suggest some answers, but more importantly that it can generate questions.

It might be surprising to some to find that the most agreed on area was the positive to highly positive notion that, with little exception, there was the idea that having been an active addict is not viewed with total disdain, but with a sense of acceptance, hope and optimism. One

might conclude that those in recovery from addiction have gained something in the process that they feel that they could get nowhere else. The conclusion might be that a significant change happened in the lives of these individuals which might not have happened, except the pain of addiction forced them into recovery.

The second highest consensus of the study was the strength of response in stating the belief that alcoholism is a disease. This is a simple statement of belief and not necessarily a statement of truth, only a statement of belief. These doctoral level psychologists seem to have concluded that something physiologically possibly changed within them at some point in their development of alcoholism/addiction. They probably do not know, nor do they need to know what, where, when, nor how the change took place. Most may know of the irreversibility of their addiction and accept that they can never safely drink or drug again. Additional evidence of medical or physiological involvement is the reported high incidence of addiction in their biological families. Other evidence has surfaced over the years of genetic involvement in the development of alcoholism including the Swedish identical twin studies where twins were raised apart during the 1930's can be found where twins reared apart from birth showed an extremely high correlation of the development of alcoholism if the other twin developed it.

Strong beliefs about psychological involvement in the development of alcoholism/addiction have been expressed. Many expressed that they grew up in a dysfunctional home and that there were members of their family who suffered from some form of addiction. Addiction in families may be attributed to genetics, to cultural factors, to learning, or to other psychological factors. A considerable number felt that personality factors were involved and that there is an "addictive" personality. More than half of the participants in this study believed that addiction was the greatest problem in America.

A considerable number of respondents felt that medical science would eventually find a "cure" for the physiological part of addiction, but did not believe that this would be all, and end all cure for addiction its self. Some 25% reported that they were in recovery from a second addiction. A majority felt that more information earlier in life would have led to earlier moving into recovery. More that three-fourths indicated that they believed the Alcoholics Anonymous axiom of anonymity should remain a principle of recovery. A relatively small number of respondents believed that some drugs should be legalized.

This study was conducted to determine the beliefs and attitudes of a particular group, doctoral level psychologists who should be quite familiar with psychological science and practice. Most importantly for purposes of this study, this group was comprised of individuals who are in mostly long term recovery from alcoholism/addiction. Few, if any, final or definitive answers may be gleaned from this study because it is a study about beliefs. The psychologists largely agreed on a number of areas, but expressed considerable disagreement in other areas. Given the extent of disagreement within the same academic discipline, we believe that these findings suggest the possibility of communication difficulties across disciplines regarding alcoholism and addiction. We believe our findings provide evidence that a strong need exists for a common vocabulary to describe variables within the scope and breadth of addiction. Addiction is ultimately behavioral thus psychology must have a strong role in addressing and dealing with addiction. Evidence is ample too that medicine and pharmacology have a role to play. Other disciplines too may have a role to play in discovery of principles of addiction.

Psychological theory concerning addiction is available from a number of theorists, however much of it is lacking and inadequate. Psychological theorists may need to advance more adequate theories of addiction. Medicine may need to do the same. A common vocabulary sorely needs to be developed concerning addiction in all its forms.

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