

SPIRITUALITY IN THE TREATMENT OF ALCOHOLISM:
A WORLD VIEW APPROACH

Robert J. Chapman, Ph.D.

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Abstract

To consider alcoholism an addiction with a ‘spiritual’ dimension has historically posed a problem for the logical positivism and egalitarian orientations of most Western-trained therapists and academics. Many of these professionals argue that to define alcoholism as including a spiritual component invites non-scientific if not mystical approaches to treatment. For this reason, it has been difficult to legitimize a definition of alcoholism that considers spiritual components to etiology or treatment. In this article, the author suggests that issues of spirituality are an important focus in the treatment of alcohol dependence. To consider spirituality as representative of how one views the world and his/her role in creation may well relieve some of a professional counselor’s apprehension about inserting a “theology” into treatment.

Spirituality and the Disease Model

To view alcoholism as physical illness is not a new idea. This assertion can be traced back 200 years in American history to Benjamin Rush, a signatory of the Declaration of Independence and Surgeon General of the Continental Army. He suggested in his publication entitled, *An Inquiry into the Effects of Ardent Spirits on the Human Body and Mind, With an Account of the Means of Preventing and the Means of Remedies of Curing Them*, that dependence on alcohol more closely resembled illness than an issue of personal willpower or moral turpitude (Kinney & Leaton, 1995). In 1804, Trotter (as cited in Kinney & Leaton, 1995) authored an essay entitled, *An Essay, Medical, Philosophical, and Chemical, on Drunkenness and Its Effects on the Human Body* in which he specifically categorizes “drunkenness” to be a disease, “...produced by a remote cause, and giving birth to actions and movements in the living body that disorder the functions of health” (p.13).

While promptly overlooked, the resurrection of this consideration of alcoholism by the early members of Alcoholics Anonymous in the late 1930’s and its subsequent recognition as disease by the American Medical Association (A.M.A.) and World Health Organization (W.H.O.) in the mid 1950’s, are frequently perceived as precursors of this contemporary view of alcoholism and set the stage for a medical interpretation of alcoholism frequently referred to as the American Disease Model (Rogers & McMillin, 1989). This model asserts that alcoholism is a primary disease and does not result from other bio-psycho-social factors or conditions. The essence of the model is that alcoholism is a distinct disorder with a specific etiology unto itself and not the result of stress, psychopathology, other drug use or even heavy drinking (Thombs,

1994). While each of these areas may represent problems frequently associated with alcoholism, they are contemporaries of a primary disease.

The purpose of this article is not to debate the merits of the disease model so much as to address the issue of recognizing a spiritual component in the etiology of alcoholism.

Consequently, to argue the appropriateness of incorporating spiritual issues into the treatment of alcoholism necessitates a basic understanding of the disease model as it, or more accurately, Alcoholics Anonymous' representation of it, impacts the alcoholic individual. It is in the context of this model that we as counselors most frequently encounter the exhortation to address spiritual issues in treating clients with alcoholism (Alcoholics Anonymous, 1980). Furthermore, because of the perception that the language of AA's twelve suggested steps to recovery represents a theistic program of treatment, many professional counselors view this approach as tantamount to a call to religious conversion (Warfield & Goldstein, 1996).

A Brief History of Alcoholism Treatment

Authors have argued for the disease model, albeit with subtle differences in their definitions of alcoholism. Johnson (1980) described alcoholism as disease with affective symptoms and outlines an emotionally based etiology. Milam and Ketcham (1983) focused on the physiological characteristics of those who have alcoholism and examine the role enzymes, hormones, genes, and brain chemistry play in the origins of this disease. Vaillant (1990) argued that alcohol dependence exists on a continuum and offers a bio-psycho-social explanation of this medical diagnosis.

While the scientific study of alcohol abuse and alcoholism can be traced back to the 1930's and the work of Richard Peabody (Kinney & Leaton, 1995), the publication of E. M.

Jellinek's now classic, *The Disease Concept of Alcoholism* (1960) formally introduced the hypothesis that there are actually multiple "alcoholisms." Characterized by a variance in patterns of consumption and behaviors exhibited by the drinker, Jellinek identified five distinct "alcoholisms": Alpha (psychological dependence), Beta (physical problems but not psychologically or physically dependent), Gamma (tolerance, withdrawal and loss of control), Delta (psychological and physical dependence but no loss of control), and Epsilon (periodic or binge drinking)(cf., Kinney & Leaton, 1995). This text gave rise to one possible explanation for the difficulty that historically existed in diagnosing the disease of alcoholism, namely, that all alcoholic patients do not manifest the same constellation of symptoms or patterns of consumption.

In the 1950's, Yandell Henderson, Howard Haggard, Leon Greenburg, and E. M. Jellinek founded the *Quarterly Journal of Studies on Alcohol*. This scholarly publication ushered in a conscientious effort to apply the scientific method to the study of alcoholism (Kinney & Leaton, 1995). Vaillant (1983) brought many in the alcoholism treatment community to the point of accepting alcoholism as a distinct medical entity replete with a recognized cadre of symptoms, a documented course of progression, and an accepted method of intervention and treatment with the publication of *The Natural History of Alcoholism*.

During the past 65 years, alcoholism has moved from a little understood and often despised category of human behavior to a recognized and accepted diagnosable disorder. Prior to considerations like those cited above, alcoholism and its symptoms were viewed as indicative of either underlying psychopathology, i.e., the Psychoanalytic model which suggests that alcoholism, in part, results from a failure to accomplish the requisite tasks necessary to

successfully complete the oral stage of development (Thombs, 1994) or, from a moralistic vantage point, characteristic of a lack of personal willpower and demonstrable moral degradation (Rogers & McMillin, 1989). However, contemporary counselors and therapists are more likely to view alcoholism as a legitimate disorder with physical and mental symptoms.

Alcoholism's physical impact on the body is readily apparent. We need look no further than the medical examination of any patient diagnosed as having alcoholism to become immediately aware of the myriad of physiological complications that can accompany this diagnosis of alcohol dependence. Liver disorders such as cirrhosis, gastrointestinal problems exemplified by pancreatitis and enzyme imbalances, cardiovascular maladies such as cardiomyopathy, cardiac arrhythmia, hypertension and cerebrovascular disorders, neurologic disorders often seen as dementia, blackouts, seizures, hallucinations, or peripheral neuropathy simply speak to a sampling of the physical problems associated with alcoholism (7th Report to US Congress, 1990; Rogers & McMillin, 1989; Sioussat, 1988). Neurological based intellectual decline exemplified by organic brain syndrome rounds out a sampling of the physiological ramifications of chronic alcohol abuse and alcoholism.

Likewise, such mental aspects of alcoholism as depression, paranoia, mood shifts, personality changes, phobias, compulsions, and hysteria (Kinney & Leaton, 1987; Peyser, 1980) can be recognized and readily documented. Historically, these symptoms were diagnosed as primary presenting problems with the client's alcohol consumption only considered in passing as patient attempts at self-medication (Rogers & McMillin, 1989).

Other models besides the American Disease Model have been proposed to explain alcoholism. Each offers a different etiological explanation for the onset of symptoms.

Conditioning theory argues that alcoholism is the result of positively or negative reinforced drinking behaviors. Social Learning Theory points to one's self-efficacy or belief in her/his ability to affect change in drinking behavior as a predetermining factor of alcoholism. The Family Systems model contends that the etiology of alcoholism cannot be explained by looking at the addicted client alone, but must consider the interpersonal dynamics of the entire family in order to fully understand alcoholism (cf., Tombs, 1994). What is common to all these models is their recognition of physical and mental symptoms of the disorder. However, an appreciation of spiritual issues is conspicuous in its absence as each model views the disorder and its treatment.

While treatment according to any of these theoretical models can be argued as effective by its proponents, it is the disease model that has historically been argued as having first elevated alcoholism from the realm of moral turpitude and religious failing. Consequently, this model may well be responsible for the increase in diagnosed cases of alcoholism by the medical community, and subsequent acceptance of the diagnosis by the individual patient. Furthermore, it is the disease model's consistent exhortation that abstinence from alcohol is a prerequisite to recovery and that it is this fact alone that has had the most profound impact upon treatment strategies. As controversial as the abstinence conviction may be, it appears to have significantly increased the prognosis for recovery (Lawson, Ellis, & Rivers, 1996; Lewis, Dana, & Blevins, 1988). Vaillant (1995) went so far as to argue that whether alcoholism is treated effectively as representative of compulsive behavior or the result of a primary disease process, it is imperative that the individual with alcoholism receive medical attention for the acute symptoms of withdrawal in the detoxification process and the secondary medical problems which so often accompany alcohol dependence.

However, many proponents of the disease model might well argue that treatment of the physical and mental consequences of alcoholism stops short of providing the client with what is needed for lasting recovery. They argue that individuals with alcoholism not only need to address the physical and mental aspects of detoxifying from ethanol and recovering from the acute effects of dependence, but also must learn to approach what have come to be referred to as the spiritual (Alcoholics Anonymous, 1976), epistemological (Bateson, 1971), or, as is suggested in this paper, cognitive or 'world-view' issues. For those subscribing to this model, addressing the physical and mental symptoms of alcoholism represent the logical, pragmatic, i.e., "temporal" approach to treatment. While necessary, this approach is not sufficient to ensure a lasting recovery. It is by considering spiritual issues, issues related to "connectedness," a sense of purpose in being, and relationship with others, that, like the third leg on a stool that provides stability, a platform is created which enables the person with alcoholism to reach recovery.

In essence, this is the basic tenet of the twelve suggested steps of Alcoholics Anonymous. For recovery from alcoholism to take place, the addicted individual must realize the confluence of physical healing, mental stability, and an awareness that one is meant to be a participant in, rather than an observer of, creation. It is a sense of personal isolation and uniqueness that most proponents of the disease model believe leads alcoholic individuals back to drinking even when they are successfully detoxified from ethanol and have begun to return to a normal pattern of living (Alcoholics Anonymous, 1976). Hence AA hold the view that recovery involves not only the body and the mind, but the spirit as well.

Spirituality as a World View

The consideration of alcohol dependence as a disorder with a `spiritual' dimension has posed a distinct problem for empirically oriented academics who believe such an attitude resembles a non-scientific, almost mystical perspective (George, 1990; Warfield & Goldstein, 1996). This difficulty may well be the result of a cultural bias reinforced by Western views of healing presented in the training of most practicing therapists and counselors (Pedersen, 1988; 1987). For this reason, it has been difficult to address this aspect of alcoholism, especially for professionals outside the alcoholism treatment community.

For some professionals--psychologists, psychiatrists, and counselors alike--a sense of discomfort with the inclusion of spiritual issues in counseling may result from a formal education that is often steeped in traditional Western values. Independence, self reliance, and a pragmatic or `cause and effect' explanation for personal problems are examples of what Pedersen (1987) has suggested are cultural biases held by counselors and taught in graduate programs in psychology, counselor education, and medicine. In short, such assumptions may render the counseling experience of little significance to the culturally different client. When treatment is steeped in solely a physically (i.e., addiction) or mentally (underlying psychopathology) based explanation of alcoholism, clients may well reject and find such approaches of little use (Chapman, 1988). For the sake of discussion in this article, the term "temporal" has been used to describe those techniques of counseling that address the practical components of a client's physical and cognitive needs.

Brown, Peterson, & Cunningham (1988) explain spirituality as it is used in AA to be a three tiered concept comprised of affinity with others, self, and a higher power. Specifically, "(b)asic to these three dimensions is a sense of connection with self and other-than-self, and

behaviors that reinforce this felt connection” (p.414). Dyer (1995) described spirituality as, “...an inward journey of enlightenment...expanding the godlike qualities of love, forgiveness, kindness and bliss with ourselves.” He explains this journey as being “...free of dogma and rules” p. 5). It is the awareness of a higher-power and the perception of spirituality as a journey intended to access or “commune” with that other-than-self that presents the traditionally trained counselor educator or psychologist with the greatest difficulty in considering spiritual issues in counseling. Unfortunately, this perceived problem with incorporating spiritual issues into a formal treatment experience represents the myopic view of spirituality as being exclusively theistic and therefore the appropriate domain of religion.

To accept a spiritual dimension to alcoholism treatment and recognize its importance in recovery is to view human functioning, and consequently treatment, as engendering a world view that emphasizes the profound difference between a phenomenological and empirical understanding of the human animal. To this end, the role of spirituality in a recovery from alcoholism may actually be better understood and accepted by client and counselor alike if the professional community were to approach this aspect of treatment by exploring the client’s world view. How does a client view the problems she/he has faced to this point? Does the client observe an emic (internal) or etic (external) source of these problems? How is the client positioned to address the problems of recovery, and is this completed from an individual or group perspective?

To embrace a broader consideration of spirituality than the tenets of an organized religion, may well enable the counselor to quell a client’s objections to the perceived theistic orientation of Alcoholics Anonymous (AA). Counselors who accept this position see alcoholism

as more than physical addiction and acknowledge its etiology as involving a three-fold process involving not only body and mind, but spirit as well. In this context, spirit refers to the contribution to recovery made by a client's harmonious relationship with the environment in which s/he lives (George, 1990; Johnson, 1980). This is the embodiment of the basic AA view of recovery that is steeped in a relationship with a 'Higher Power.' Bristow-Braitman (1995) describes this relationship as, "... a sense of connection with self and other-than-self, and behaviors that reinforce this felt connection" (p. 414). Simply put, it is a sense of connectedness.

Ironically, this view of spirituality which is offered for consideration by the professional counseling community, is consistent with most cultural/religious systems. It closely parallels, for example, the traditional Native American belief that harmony is the organizing principle of all creation. Such a world view suggests that for any creature to disrespect or de-personalize any creation is to heap contempt on its creator (Richardson, 1981; Neihardt, 1959). The aboriginal peoples of Australia speak of this creator as, "the divine oneness," and view all creation as equal in significance and an extension of this spiritual principle (Morgan, 1994). Similarly, the Taoist concept of the Tao as the all encompassing principle that transcends both being and non-being compliments this view. As such, it embraces an individual's personal relationship with a Creator and a respect for the creation process itself (Mitchell, 1989). This focus on the significance of a spiritual world view becomes useful and meaningful to the vast majority of clients who ascribe to some religious belief system even if the system is nothing more than a function of their cultural heritage.

To characterize spirituality in this fashion opens the therapeutic relationship and invites the client's personal involvement in the recovery process. It places the client inside the process

of recovery as a participant rather than outside as an observer. By so doing, the client is encouraged to view recovery as a process that is ongoing rather than a destination that is finite. Such a consideration of spirituality acknowledges its significance and legitimizes its appropriateness as a focus in treatment.

Counselors professionally educated to recognize the values of independence and self-reliance, may be too narrowly focused on addressing physical and mental needs alone. To address only these prerequisites of recovery does not adequately ground the client in her/his living environment, nor allow the opportunity to overcome the isolation so frequently reported by individuals beginning treatment. It is important for the client to be able to see recovery as both a genuine possibility and abstinence as a personally attainable treatment goal.

Spirituality then is an aspect of alcoholism recovery that involves more than a consideration of religious principles. It encompasses the belief that individual human beings are but a part of a much larger reality, and as such are charged with a participatory rather than dominating role in that existence. While religion may be an important part of one's spiritual life, it is at best one dimension of a seemingly far more complex aspect of the human condition.

Consequently, to argue that the spiritual symptoms of alcoholism include a sense of disharmony, a perception of being alone and cut off from significant relationships with family, friends, and/or Higher Power, is to speak of a definition for spirituality that exceeds the traditional theistic view. It embraces a respect for each client's contribution to the very process of creation itself. Spirituality becomes an equally important aspect of recovery that needs to be treated along with the physical and mental attributes of alcoholism. This three pronged approach enables the counselor to more accurately help direct the client's focus in treatment. To consider

the client's spiritual needs or world view in concert with the more traditional foci of physical and mental aspects of alcoholism, permits the counselor to more completely prepare the client for the difficulties of early recovery, e.g., coping without alcohol and, perhaps most importantly re-involvement in establishing meaningful and trusting relationships.

Tripartite Model of Recovery

This model can be more graphically portrayed by considering a side-by-side comparison of Temporal (mental/physical) and Spiritual values important in a recovery from alcoholism. In considering these variances (see figure 1, Appendix A) the reader may begin to actually see the role a client and counselor *world view* may play when negotiating these continuums in the pursuit of recovery.

If such a world view of spirituality is included in the professional counselor's understanding of alcoholism, then the 12-step community's view of alcoholism as having three distinct foci may well be less threatening to the therapist. By addressing each focus, the therapist increases the likelihood of recovery. This will necessitate the confluence of the traditional approach to the treatment of alcoholism (i.e., medicine and psychotherapy) with the spiritual values of harmony with nature, importance of natural support systems, and a re-orientation of personal attitudes and beliefs. This is the key to recovery and must be clearly understood by both counselor and client. It is important for the professional counselor and client to address each of the three aspects of alcoholism with parity. To do so will help ensure that these separate but essential foci are addressed in the counselor's treatment plan.

Indications of progress when treating alcoholism according to such a model are illustrated in Figure 2, “Three Foci of Recovery” (see Appendix B). Aspects of alcoholism (i.e., physical, mental/emotional, and spiritual), are represented vertically while stages of recovery are noted horizontally. Each cell itemizes behavioral indicators that are indicative of recovery for the corresponding aspect of alcoholism and area of personal recovery. Recovery is most frequently noted in a ‘Southwest to Northeast’ diagonal movement through the process of recovery. (Time frames suggested at the bottom of the chart are consistent with the author’s clinical experience).

By educating clients about each of the three aspects of alcoholism, self-diagnosis is fostered. A personal understanding of the process of alcoholism (including its symptoms, stages, and progression) provides the opportunity for clients to relate this new information to their own life circumstances. No longer is the client placed in a position of being expected to master alcohol as a demonstration of willpower and personal dominance over one’s environment. Rather, the client is encouraged to view alcohol as a drug and recognizing addiction to it as a self-diagnosis that enables the beginning of a personal life style change necessary for recovery (Rogers & McMillin, 1989). In short, denial of dependence becomes less of an obstacle as the alcoholic person is offered a ‘new pair of glasses’ through which to view alcoholism and the process of recovery (Chuck C., 1985). Through education, that process ultimately becomes one of not only recovery, but self-discovery.

To this point, it has been argued that the counselor who includes issues related to spirituality as a world view in the professional treatment of alcoholism does not necessarily foster a religious or mystical approach to providing service. Rather, the inclusion of a spiritual

component in treatment plans to demonstrate the counselor's awareness of the historical significance of physical, mental, and emotional issues associated with this disorder while at the same time acknowledging individual client needs that often transcend an egocentric view of recovery. To address the spiritual aspect of alcoholism, or as Bristow-Braitman (1995) defined it, "...the ability to think, feel, or behave differently and in a way that was not possible previously when the individual was attempting recovery without assistance" (p. 414), is not only an appropriate, but necessary focus in alcoholism treatment.

This seems to be altogether congruent with the pioneering work of Johnson (1980) who suggested in the now classic, *I'll Quit Tomorrow*, that in order to do so, a client's spiritual issues (no matter how they are construed in definition) must be a factor of the recovery formula.

A Concluding Invitation

1. To consider that alcoholism treatment may involve not only attending to the physical, mental, and emotional consequences of chemical dependency, but also addressing its propensity to isolate clients from a sense of personal worth, is to acknowledge a spiritual dimension to recovery. Counselors working with the chemically dependent may be well advised to address this aspect of alcoholism in order to provide their clients with an important access to recovery--or egress from alcoholism--and the avoidance of relapse.
2. There can be little doubt that counselors, however well trained and in whatever school of counseling theory, will frame their technique for the delivery of service with the attitudes, values, and beliefs accumulated in their personal lives. This may well include a personal interpretation of terms like AA's 'Higher Power.' An understanding of such concepts--often

born of the counselor's personal spiritual beliefs, influenced by a particular religious and/or cultural orientation, and shaped by experience--may well be reflected in the way the counselor broaches the subject of that same spirituality in counseling.

3. To deny this possibility is to likely deny part of the special chemistry that helps shape the event of a healthy counseling intervention. It is with this knowledge in hand that we sensitively, respectfully, and firmly encourage others in the search for their own spiritual boundaries.
4. Addressing the issue of spirituality in the treatment of alcoholism as outlined in this article may be an appropriate focus for clinical supervisors in their work with interns and practicum students. To do so will both acknowledge the importance of this aspect of alcoholism treatment while at the same time legitimizing its presence in a comprehensive treatment plan for client.
5. Perhaps it is not so much our place as professional counselor's to identify the way to sobriety for our clients with alcoholism as it is to assist them in their recognition of sobriety as the way and spirituality one of its important road signs.

FIGURE ONE
TEMPORAL and SPIRITUAL COMPONENTS of COUNSELING

VALUE	TEMPORAL	SPIRITUAL
CONCEPT OF SELF	`I' ORIENTED	`WE' ORIENTED
LIFE GOALS	ACHIEVEMENT, ACCOMPLISHMENT, ACQUISITION	HARMONY WITH NATURE, HUMILITY, ACCEPTANCE
TYPICAL BEHAVIORS	CONTROL, DOMINANCE	CO-EXISTENCE, SHARING
APPROACHES TO TREATMENT SYSTEMS	MEDICINE, PSYCHOTHERAPY	SELF-HELP AND NATURAL SUPPORT
INTERVENTION	ADDRESS THE PATHOLOGY	ADDRESS THE DISHARMONY
UNDERSTANDING OF RECOVERY	PHYSICAL WELLNESS, MENTAL STABILITY	ACCEPTANCE, SERENITY
INDICATION OF RECOVERY	PHYSICAL AND MENTAL FITNESS	HARMONY AND SENSE OF BELONGING

TABLE 2
Two
Tripartite Construction of Recovery

EARLY SOBRIETY 3 to 6 months	MIDDLE SOBRIETY 6 months to 2 years	MATURE SOBRIETY 2 Years
<p>S 'pink cloud syndrome;' P notes physical change; I attends AA regularly; R actively participates I in treatment and T follows suggestions; U sense of well being; A able to accept L compliments</p>	<p>sense of humor returns; positive sense of self returns; let go of problems; personal sense of "connectedness"; absence of sense of isolation</p>	<p>meditation/"prayer" come more easily - individual able to "accept" and "surrender" to diagnosis; re-established sense of internal control; peace of mind and sense of "harmony" with nature return</p>
<p>preoccupation with M physical disorders E lessen: insomnia, N sexual dysfunction, T hypertension, A physical aches, L fatigue, lethargy lessen</p>	<p>rational thinking begins, 'stinking thinking' begins to dissipate; focus on self RE change replaces focus on others</p>	<p>able to meditate; sense of hope replaces feelings of desperation; depression dissipates and hopelessness gives way to belief that change is possible; return of ability to trust</p>
<p>P medical treatment for H physical problems, Y physical withdrawal; S abstinence from I alcohol & other C drugs, detoxification A begins L</p>	<p>eats regularly; sleeping/resting; exercising, talk of feelings; begins to change 'people, places, and things.'</p>	<p>knows alcoholism is problem, takes 'one-day-at-a-time' approach to living; views life as opportunity; relaxation exercises, deep breathing, guided imagery.</p>

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