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An Overview of Spirituality in AA (and Recovery)

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1. Spirituality and AA

AA has attracted harsh criticism and strong praise in equal measure. Criticisms of AA have had much to do with AA's spiritual content, and they hold lineage in a long history of academic discomfort with religion. Albert Ellis and Sigmund Freud were early critics of religion, proposing that a religious orientation indicates a neurotic and childish response to the world. A more recent critique has come from the evolutionary biologist Richard Dawkins in his book *The God Delusion* (2006), which argues that religions foment war; promote bigotry; terrorize children; lead to sexual repression and perversions; promote falsehoods about the nature of reality; and encourage irrationality and anti-intellectuality. Dawkins' critique comes amidst a spate of similar attacks; for example, see *God Is Not Great* (2007) by Christopher Hitchens; *The End of Faith* (2004) and *Letter to a Christian Nation* (2006) by Sam Harris; *Breaking the Spell* by Daniel Dennett (2007); and *Atheist Universe* by David Mills (2006).

It is curious that this outpouring of anti-religious sentiment comes at a time when the public health field is accumulating a substantial body of evidence relating higher spirituality to better mental health (Pearce et al., this volume). Addictions researchers have also generated substantial evidence for the efficacy of AA (Tonigan et al., this volume), considered by some a religious and by others a spiritual program. Still, critics of religion tend to be unwilling to acknowledge the evidence for psychological and health benefits of religion/spirituality, just as advocates of AA and other spiritually oriented interventions can be

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reluctant to acknowledge any danger in blending secular and religious spheres. This is unfortunate, as it seems important to achieve a balanced view of the curative potential and risks that spiritual interventions offer.

The current section discusses AA's approach to spirituality and reviews evidence surrounding a role for spirituality in mental health, AA's efficacy, and recovery from the addictions. This section also considers the impact of the spiritually inspired, but secular, mindfulness meditation, along with evidence that helping others may promote recovery (helping being a secular behavior that may likewise be inspired or instigated by religions). Chapters on meditation and helping are especially appropriate since these practices are encouraged in AA. This section is highly relevant to addictions researchers. It is also relevant to the wider cultural debate on the societal impact of religion. I use this introduction to summarize the chapters and to explore some possible pitfalls of spiritual interventions that they do not address.

2. The Chapters, in Brief

The chapters in this part of the volume express an exceptional diversity of perspectives on what spirituality is and how it might function in recovery and AA. To begin, a chapter by Robinson and Johnson provides an overview of the complexities involved in defining and measuring spirituality. These complexities arise, as is described, from a certain lack of consensus on what the core dimensions of spirituality/religiosity are and how they relate to each other. The authors note that 20 or more conceptually distinct factors have been proposed. Part of this debate surrounds whether and how spirituality should be distinguished from religiosity, some investigators preferring to define spirituality (conceived of as a private, internal experience) against religion (conceived of as a public, institutionalized experience) and others framing involvement in a religious tradition as one expression of spirituality (meaning the search for the sacred or transcendent). Subsequently, the chapter discusses specific measures used in alcohol research. The chapter does not argue for any single definition of these constructs, but suggests that researchers think carefully about their definitions in relation to their study hypotheses and results, considering (and making explicit) assumptions inherent in the measures.

In the second chapter of this section, Pearce, Rivinoja, and Koenig provide a comprehensive treatment of the relationships between spirituality and mental health outcomes. Conclusions point to some positive effects for religious involvement on depression, anxiety, suicidal thoughts and attempts, and positive emotions. However, the picture is not entirely rosy, as the reviewed evidence shows negative effects for some forms of religiosity. This chapter also examines potential causal pathways for spirituality's influence on mental health and argues that the spiritual components of AA may operate to affect recovery outcomes in analogous ways.

Connors, Walitzer, and Tonigan then follow with a chapter presenting a more detailed discussion of spirituality as it is understood and practiced in AA. Additional sections of the chapter review the evidence for associations between spiritual change and recovery from alcoholism, which is meager in quantity but promising. A highlight is the chapter's description of AA's idiosyncratic conceptualization of alcoholism as a "spiritual disease," a framing that emphasizes AA's appreciation for biological, psychological, *and* spiritual forces in the onset and maintenance of drinking. There is admittedly a tension in the AA literature around these superficially oppositional frameworks and specifically around the disease model's troubling implications for notions of control and responsibility. AA assumes some biological causation in the onset of alcoholism (see "The Doctor's Opinion," Alcoholics Anonymous, 2001), but this raises a problem: If alcoholics have a disease that makes them powerless over alcohol, how can they learn to control their drinking? AA's ingenious solution is to *accept* that individuals cannot control their drinking and that abstinence is thus the only option. Moreover, AA accepts that alcoholics cannot maintain even abstinence on their own; rather, they must solicit the help of a power *greater than themselves*, such as God or AA, to avoid drinking again. This solution retains compelling aspects of the disease model while avoiding the negative implications of such a mechanistic approach; that is, it retains the model's destigmatizing implications while jettisoning the implication that biology makes alcoholics helpless. Hence, AA members may find themselves able to support both a positive, nonblaming self-view and hope. It will be interesting to see how issues around control and hope are handled outside of AA as the academic mainstream moves to embrace a largely biological, "disease model" view of the addictions.

Chapters headed by Hsu and Zemore then expand the scope of the section to explore relationships between AA, mindfulness meditation, peer helping, and recovery. These chapters recognize that spiritual development in AA is understood to be an ongoing practice rather than a fixed belief system or end state; spiritual development must be achieved and maintained by *doing things* for oneself and others. The chapters also recognize that spiritual engagement in AA can take many forms. Despite AA's emphasis on developing a relationship with God or another "higher power," many AA members aim at forms of spirituality that do not entail embracing theism. Thus, meditation practices and helping others may represent the heart of spiritual growth for some members, and not simply a pathway to or product of that growth.[1]

Hsu, Grow, and Marlatt introduce the practice of mindfulness meditation and describe evidence for its efficacy in treating addictions. Hsu et al. also compare AA to both pure Buddhist meditation and secular mindfulness meditation. Importantly, the chapter argues that attachment to self (or

[1] Readers interested in the vast heterogeneity in interpretations of AA's literature and practice might refer to AA's publication *The Grapevine* (http://www.aagrapevine.org, 2007), which demonstrates a limitless variety of approaches to spirituality and the Twelve Steps.

"self-centeredness") occupies a central position in both AA's approach and pure Buddhism. Both approaches recognize self-seeking as a source of suffering and addiction, although they address this problem differently—Buddhism encouraging a more or less intellectual approach and AA emphasizing reparations and actively helping others. Likewise, despite some differences, the chapter finds convergences between twelve-step approaches and secular mindfulness meditation, including the encouragement of an attitude of acceptance (exemplified in AA's serenity prayer), focus on the present, and awareness or monitoring of negative thoughts and behavior without extreme judgment. The chapter also notes that meditation is explicitly encouraged in AA (see Step 11; further, Connors' chapter confirms that almost half of AA members seem to practice meditation). Hsu's chapter emphasizes that AA and mindfulness meditation can be compatible and even synergistic, perhaps again partly because of the enormous latitude in possible interpretations of both.

Zemore and Pagano then discuss the role of peer helping in recovery. This chapter examines whether the evidence supports AA's claims that helping others benefits helpers. Recall that, in AA, helping other alcoholics is considered an antidote to unhealthy self-focus and a good reminder of the devastating effects that alcohol can have. The chapter tentatively concludes in favor of helper therapy principles, based on research exploring effects for altruism in the general population, recovery in diverse mutual help groups, and recovery from chemical dependency within and outside of AA. That is, helping can contribute to recovery from alcoholism and may be one of the ways that AA achieves its positive outcomes. However, the chapter concludes that helping not only does not always help helpers, but can sometimes be harmful—as is true of spiritual involvement. Research on this topic is also quite scant, so more studies are needed.

Last, Galanter closes with a chapter providing a broader conceptualization of spirituality. For example, the chapter discusses spirituality from a utilitarian perspective, arguing that spirituality may (a) help people to reduce uncertainty and (b) increase the survival value of the organism. Thus, the prominence of spirituality may be a result of its contributions to (i) psychological needs and (ii) evolutionary fitness.[2] Additional space is devoted to the historic and ongoing controversy in psychiatry and psychology over whether and how to study spirituality. The final paragraphs illustrate that AA is actually only one of

[2] A similar argument has been made by Karen Armstrong (2005), who suggests that mythology satisfies universal human needs for transcendence, meaning, and coping with problematic aspects of existence, such as the fear of death. Strong forms of this argument are difficult to reconcile with the substantial cultural and historical variation in religious and spiritual behavior: If religion is evolutionarily adaptive, why are only 5% of Swedes religious, as Galanter points out? However, a good case can be made for a nature–nurture interaction; that is, individuals are influenced by their genetics but also do what works in a given cultural context. Along these lines, Armstrong frames the historical decline of mythology in much of the Western world as a consequence of changing life conditions overriding natural proclivities toward mythologizing.

several useful treatments inspired by or embodying spiritual traditions: Other examples include meaning-focused therapy and mindfulness meditation. Favorable results for integrating twelve-step approaches into formal treatment (as in the Minnesota model approach) are presented, and seem to argue for integrating twelve-step groups into addictions treatment. An emphasis is the need for empirically supported treatments; Galanter suggests that spiritually based interventions should be subjected to the same kind of scientific scrutiny as are other interventions.

3. Common Themes

A crucial theme in these chapters surrounds the importance—and difficulty—of nailing down just what is meant by "spirituality." Robinson and Johnson offer a taste of the fundamental discord that exists even around basic definitional issues (such as the distinction between religiosity and spirituality) and the diversity of approaches to measuring the many facets of spirituality. Chapters by Connors, Pearce, and Galanter echo such difficulties, adopting working definitions characterized by a certain vague all-inclusiveness. Cook's (2004) definition, cited by Connors et al., provides a good example. Cook proposes that spirituality is a universal experience that can arise at a multitude of levels (individual, group, and culture) and in relation to a multitude of objects (self, others, and that which "transcends" self and other). This definition, which (as is common) includes religious experience as a form of spirituality, is so far so broad as to be almost meaningless. Cook then adds that spirituality "is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values" (p. 549). This seems like an improvement, but even so Cook's spirituality could include many experiences engendered by exposure to philosophy, science, and art. Yet, greater precision could mean excluding certain religious traditions or forms of spiritual experience. To his credit, Cook explicitly recognizes limitations in his definition, suggesting, "This proposed definition is offered in recognition of its provisionality, vagueness, and inherent limitations. . . . It is hoped that the relationships fostered by academic debate will one day be creative of a more complete and satisfactory definition" (p. 548).

Clearly, it would be a great challenge to develop a measure of spirituality encompassing all forms of spiritual experience without conflating that experience with obviously secular experiences or mental health itself. Indeed, rather than attempt this, many researchers have developed and used measures addressing one or a small set of constructs that are theoretically related to spirituality, including such traditionally religious constructs as religious self-identification, church attendance, and prayer, but also more subjective and tenuously related constructs such as beliefs and values, purpose in life, and forgiveness. Empirically, some of these measures are correlated with each other and some are not (or at least, not very well).

The question is, is thinking about all of these constructs as expressions of spirituality useful? Is the *category* of spirituality useful? This is, at least in part, an empirical question and relates to the question of whether diverse forms of what we think of as spirituality *function* equivalently. Importantly, the data suggest that they do not—or not always. Chapters in this section have emphasized that different, and even oppositional, effects are found as a function of the choice of spirituality measures. Pearce and colleagues make this point explicitly in relation to the work on depression: "It is important to note that not all studies have reported a protective role for religion in depression, however. The relationship is dependent upon what aspect of religion/spirituality one measures. . .. For example, some types of interpersonal religious experiences have been associated with greater depressive symptoms among adolescents" (p. X). They also describe associations between increased guilt and dogmatism and "certain types" of religious beliefs and between lower well-being and both negative religious coping and higher frequency of prayer.[3]This point is also made implicitly in the Connors et al. chapter, which describes mixed results from two key studies on spirituality and recovery. Specifically, better substance use outcomes at follow-up are described as being associated with (1) only 2 of 8 spirituality measures (i.e., daily spiritual experiences and purpose in life) in Robinson et al. (2007, in Connors et al., this section), and (2) only 5 of 13 spirituality measures (i.e., forgiveness of others, purpose in life, serenity, existential well-being, and religious practices) in Connors et al. (2003, in Connors et al., this section). Notice that the large majority of these measures fail to map onto traditional forms of religious involvement; rather, they seem to reflect a combination of (potentially secular) sense of purpose and general healthy functioning. Robinson and Johnson likewise describe results from two studies factor-analyzing spirituality scales and finding quite different results for the different factors (Kendler et al., 2003, and Johnson et al., in press, in Robinson and Johnson, this section). Robinson and Johnson also describe disparate results for religious support and religious coping in relation to alcohol use and well-being and for meaning and meaning seeking in relation to recovery from alcoholism. Galanter makes the point that despite evidence associating spirituality with health benefits, spiritual indoctrination sometimes has negative effects. He also discusses Kendler et al.'s (2003, in Galanter, this section) finding that religious devotion—but not institutional religious conservatism—buffers the impact of stressful life events.[4]

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[3] Findings for prayer, however, should be balanced by evidence that church attendance is actually one of the stronger and more consistent predictors of lower mortality and other positive mental and physical health outcomes (see Gartner, Larson, & Allen, 1991; Hummer, Ellison, Rogers, Moulton, & Romero, 2004; Powell, Shahabi, & Thoresen, 2003). Thus, it seems likely that prayer per se (rather than religious behavior generally), if anything, is linked to worse outcomes.

[4] Interestingly, Galanter (this section) further argues that the nature of spirituality is culture-bound. One would imagine that spirituality's effects are similarly culture- and context-dependent.

It is not news that "spirituality" can have very different effects depending on what exactly is measured. Gorsuch (1995) distinguished between a nurturing, supportive religiousness (which is protective against substance abuse) and a restrictive, negativistic, and ritualistic religiousness (which is not protective). Similar distinctions have been made between "intrinsic" (functionally positive) and "extrinsic" (functionally negative) religiosity (Allport, 1979; Donahue, 1985; see also Robinson and Johnson, this section.) The work described above suggests further functional distinctions (e.g., between types of religious behaviors). Although the tendency remains for spirituality researchers to speak in generalities, this section's evidence is, I think, a call for specificity in measurement and interpretation. Mixed effects such as we see here suggest that investigators target specific aspects of spirituality rather than spirituality generally; clearly articulate what they have measured; and approach generalizations with caution. Readers should likewise attend to measurement issues in interpreting and summarizing prior work. Investigators should be particularly clear and particularly careful to avoid over-generalizing when investigating aspects of spirituality that are only distally related to lay conceptions of spirituality/religiosity, such as purpose in life, since such findings could be easily misinterpreted and misapplied. So, it is better to describe the effects of forgiving others (if that is what is measured) on recovery than the effects of spirituality on recovery (which could imply associations between, for example, religious involvement and recovery). Absence of such clarity could lead to confusion and seriously stalled progress. In short, for many cases the category of spirituality may not be functional. Particular dimensions of spirituality might be better targets for research attention.

Related to this first theme is a second, which, briefly, concerns an interest in the mechanisms of action behind spirituality's effects. Several chapters offer proposals on how spirituality might work. Pearce and colleagues devote substantial attention to this issue, arguing that spiritual involvement may affect both general mental health and recovery outcomes by influencing social support processes; meaning making; the acceptance of uncontrollable life events; hopefulness; and altruistic behavior. The issue is addressed more obliquely in the chapter by Connors, which does not discuss mechanisms specifically but does describe spiritual experiences in AA that are presumably linked to recovery, including humility, serenity, gratitude, hope, and forgiveness. Connors and colleagues also highlight potential roles for helping others in AA and for the development of mutually beneficial social relationships. Galanter suggests that spirituality relieves dysphoria by helping people attach meaning to experiences they cannot fully understand (and particularly, negative experiences) and by affecting people's expectations that they will be helped (analogous to the placebo effect). Galanter further suggests that psychotherapy works via these same mechanisms, also capitalizing on the development of a supportive relationship. Hsu and colleagues argue that AA and mindfulness meditation share some mechanisms of action, including self-efficacy, thought

suppression, and social support. Finally, Zemore and Pagano encourage causal modeling to determine potential roles for variables including social status, self-esteem, social bonding, and sense of purpose in helping's effects on outcomes. Despite some differences, these chapters collectively stress individual's core needs for mutually beneficial social relationships ("mattering" to others), a positive self-view, meaning, and hope. (Needs for a positive self-view and hope were discussed already in connection with AA's "spiritual disease" concept.) An important step for further research will be to formally test causal models relating aspects of spiritual involvement to both mediators of this kind and outcomes. Theoretical development and testing should be informed by, and inform, research addressing which aspects of spirituality are beneficial, for what outcomes, and when. Theoretical development will thus impel and respond to solutions to the measurement problems described earlier. Causal testing should also help to confirm causal (vs. spurious) associations for aspects of spiritual involvement, and perhaps most important, inform nonspiritual interventions targeting key psychosocial mediators.

4. Applications: Cautions

In closing, I address the potential for applications of the current research. Galanter points out the potential benefits of integrating spiritually grounded techniques into general and addictions-focused psychiatric practice. Indeed, evidence for the efficacy not only of AA but also of other spiritually inspired techniques (such as mindfulness meditation) in recovery suggests a value for doing so.

Many providers are a step ahead of these recommendations and have already integrated twelve-step principles and practices into both private and publicly funded treatment programs. Some programs, such as a subset of the VA system (Moos, Finney, Ouimette, & Suchinsky, 1999) and all Minnesota model (McElrath, 1997) and California social model (Borkman, Kaskutas, Room, & Barrows, 1998) programs, are inherently twelve-step oriented. These programs host AA and NA meetings on-site; take clients to off-site twelve-step meetings; and include twelve-step activities in their curricula, such as weekly groups on AA's steps. Most of such programs have homework and discussions on readings from key AA texts, including AA's basic manual, the *Big Book* (Alcoholics Anonymous, 2001); the *Twelve by Twelve* (Alcoholics Anonymous World Services, 1991), which explains AA's twelve steps and twelve traditions; and *Living Sober* (Alcoholics Anonymous World Services, 1975), covering practical tips for discarding drinking-related habits. At social model programs, alumni involved in AA and NA also offer to sponsor new clients (Barrows, 1998). Typically (but not always), treatment groups are led by recovering staff, many of whom are AA and/or NA members. However, integration of the twelve-step model with the treatment industry extends far beyond these specific programs: In 1997, 93% of treatment

facilities in the United States reported utilizing the twelve-step approach and 83% held twelve-step meetings on-site (Roman & Blum, 1997, p. 24). It is not clear how many of these programs offer/ed secular alternatives. This is particularly significant because clients are often coerced, to a greater or lesser degree, to attend treatment: The large majority (around 70%) of treatment clients rate the courts and Employee Assistance Programs (EAPs) as significant influences on their decisions to enter treatment (Roman & Blum, 1997, p. 16).

There are several problems that seem to attach to integrating spiritually oriented interventions, such as AA, into addictions treatment. I explore some of them here. This exploration is not meant to deter programs and individuals from using AA or other spiritually based programs, since both offer substantial promise. The hope is to generate awareness and discussion around potential limitations.

1. *Spiritually focused interventions have the potential to alienate nonbelievers, who may consequently be deprived of treatment.* It is important to recognize that addictions treatment incorporating explicitly spiritual or religious ideology may be avoided by individuals who are not spiritually inclined or who do not wish to have their spiritual beliefs questioned. We know that AA, while impressively effective for those who stay involved, has a very poor record of attracting and retaining members (Kaskutas, Turk, Bond, & Weisner, 2003; Kelly & Moos, 2003; Tonigan, Bogenschutz, & Miller, 2006) and that this problem has something to do with AA's spiritual/religious focus: Agnostics and atheists show *much* lower involvement in AA than the religious and spiritual (Kaskutas et al., 2003; Tonigan, Miller, & Schermer, 2002). We also know that addictions treatment programs in the United States show similar problems in attraction and retention (Carroll, 1997; Pekarik & Zimmer, 1992; Weisner, Greenfield, & Room, 1995). It may be that the former helps explain the latter, as we have already shown that the majority of treatment programs in the United States are closely intertwined with AA. This possibility needs to be addressed empirically. Until then, treatment providers and researchers should be aware of potential effects for the use of spiritually oriented programs on a program's *attractiveness* to clients. Still, it may likewise be argued that nonspiritual interventions are alienating to spiritually oriented clients. If so (and again this is an empirical question), this needs to be evaluated as an important factor in decisions surrounding program curricula.
2. *Spiritually focused interventions may bring risks when, rather than targeting thoughts and behaviors directly related to an addiction, they aim for wide-ranging changes in core belief systems and behaviors—some of which may be harmless or even better left intact.* Some spiritual interventions, including AA, attempt to change members' drinking and drug use by way of changing core elements of their belief systems and behavior

patterns. The AA member is expected to complete the Twelve Steps having had a "spiritual awakening," which is typically understood as a dramatic, even miraculous, change in attitude (that is, conception of self and reality) stemming from "completing" all Twelve Steps (acknowledging powerless, developing a relationship with a "higher power," confessing, praying or meditating regularly, and so on; see Alcoholics Anonymous, 2001, p. 25). Further, sobriety in AA is sometimes understood to be maintained only by indefinitely maintaining certain behavior patterns, including "carrying the message to other alcoholics" (that is, helping others), communicating with "God," and lifelong meeting attendance. These are significant life changes. Is this kind of dramatic reworking really necessary for sobriety? Probably not for everyone with a substance abuse problem. Yet, calling for such fundamental changes may bring costs. One cost might be a high potential for general noncompliance; if the treatment is difficult and threatens one's basic mode of living, people may be inclined to avoid it. Another cost could be the loss, with compliance, of some coping strategies, patterns, and relationships that were previously adaptive. For example, an individual who attends AA seven days a week might lose time for other activities and friends that once contributed to his/her sense of well-being. Certainly there are cases where fundamental changes are necessary to address an addiction, and certainly some fundamental changes are basically good. The point is simply that, for each individual, the *need* for intrusive interventions should be carefully evaluated, given their potential costs. Treatments should take care to respect the integrity of individuals and the successful strategies that they have developed for living. Further, specific components of an eclectic and intrusive program should, insofar as possible, be evaluated for efficacy in relation to the cessation of addictive behavior. If individual components are not evaluated in this way, there is potential for corruption (e.g., the development of "addiction" programs with a secondary aim of conversion). Of course, these concerns also apply to secular interventions that aim at changing core beliefs and behaviors, particularly when those beliefs and behaviors are not obviously or empirically linked with addictive behaviors. It should also be said that some spiritually based interventions may provide a religious or spiritual *context* for change in behavior without viewing the individual's core beliefs about the world as targets for change; those programs do not face the same risks as articulated above.

3. *Coercing people to participate in religiously oriented programs violates their First Amendment rights.* Use of public funds for the promotion of religion is unconstitutional, and for good reason: Individuals of all faiths and none must be equally served by public institutions, and no religious faith must be given precedence over another. Further, theism of any kind has always qualified as religion under the First Amendment; courts also consider religious any practices that most people would view as

religiously significant, such as prayer (Honeymar, 1997). By this definition, AA's emphasis on the higher power concept and on prayer makes it a religious—and not a spiritual—organization. Accordingly, at least nine state and federal courts have now heard cases on mandated AA, and the unanimous conclusion has been that coercion to attend AA and other twelve-step groups is unconstitutional because of these groups' religious nature. This means that criminal justice officers (and theoretically any agents of the government) can be sued for damages within the applicable districts. Other spiritually based interventions should, and likely will, be evaluated against the same standards. These decisions recognize that attempts to involve a person in any intervention that could be *felt to be* religiously coercive should be carefully evaluated. Earlier I suggested that AA members can approach spirituality in AA from extremely different angles and may not accept theism at all. While this is true, again, other people may feel AA to be religiously coercive, and their experiences are also valid. Still, it is helpful to remember that it is not AA—but the absence of secular alternatives to AA—that has been deemed unconstitutional: Court rulings on mandated AA have emphasized that coerced attendance is permissible as long as individuals are offered viable secular alternatives (see also Honeymar, 1997, on the constitutional imperative to offer alternatives). This is an important point. It implies that, to remain consistent with the First Amendment and the principles it represents, public programs need to incorporate alternatives to AA and twelve-step-oriented treatment, since otherwise they are effectively coercing their clients (who may not be able to attend other programs) to attend "religious" programming.

The current section suggests that spiritually focused interventions, of which AA is a good example, offer potential as effective treatments for addiction. Researchers need to think carefully about what the implementation of such interventions means, however, in the context of public treatment and in relation to treatment access and delivery; the individual's autonomy and overall welfare; the individual's constitutional rights; and societal welfare. The issues are complex, and the promises and pitfalls of any treatment will vary as a function of the specific treatment and its target population; hence, decisions regarding treatment options may be difficult.

One conclusion emerging clearly from this introduction is that public programs offering spiritual programming should offer clients viable secular alternatives as well. Offering clients secular alternatives would help minimize many of the risks I discussed above, since those clients who would not be well served by programming with explicitly spiritual/religious content could receive services appropriate to their needs and desires. Offering clients alternatives would also be a firm statement of respect for clients' First Amendment rights and general autonomy. So, any program emphasizing twelve-step principles

in its groups and encouraging twelve-step meeting attendance should offer attractive, secular alternatives to these activities, including provisions to attend secular mutual help groups such as Life Ring. Unfortunately, it is not yet clear whether AA has any parallel for efficacy among the secular mutual help groups. Whereas research indicates very positive results for individuals who become involved in AA in the context of formal treatment (see Tonigan et al., this volume), research on the efficacy of AA's secular alternatives is virtually nonexistent (cf. Brooks & Penn, 2003). Research on alternatives to AA is an important research priority.

Programs committed to spiritually oriented programs might also consider facilitating involvement in those interventions in such a way that individuals feel they are not being coerced, religiously or otherwise, to accept beliefs and practices unrelated to their addiction. A twelve-step facilitation program developed by Kaskutas and colleagues called Making AA Easy (Kaskutas & Oberste, 2002) is a useful resource here, since it emphasizes (for example) a liberal interpretation of the higher power concept, finding a meeting that fits rather than trying to adapt to the meeting, and within reason, taking what works and discarding the rest. People can be taught to carefully evaluate AA's material and practices just as they might evaluate what they learn in a university setting, some of which may be informative and some of which may fail to suit the needs of a given person at a given time.

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