Unraveling the Mystery of Personal and Family Recovery

An Interview with Stephanie Brown, PhD

By William L. White, MA

IN RECENT YEARS, THERE HAVE BEEN growing calls to shift the organizing center of the addiction and mental health fields from pathology and intervention paradigms to a recovery paradigm and to begin this evolution with a recovery-focused research agenda. Dr. Stephanie Brown is a pioneer who has advocated this focus on resilience and recovery. I consider her developmental models of personal and family recovery as among the most important in the modern era of addiction treatment. In this interview conducted in late 2010, Dr. Brown talks about her life, her work and her legacy.

Bill White: Stephanie, your Master's thesis at California State University and your doctoral dissertation at the California School of Professional Psychology both focused on alcoholism. How and when did you decide on this focus of study?

Stephanie Brown: I entered graduate school for my Master's within a month of recognizing my own alcoholism and beginning my recovery in March, 1971. I was steeped in the beginnings of my own deep self-exploration, as I had already been in psychotherapy for the previous year. So, I brought to my Master's program a combination of traditional psychotherapy, peer-supported recovery, and a desire to be fully credentialed at the Master's and Doctorate levels. My own childhood development under the influence of parental alcoholism, along with the shock and relief of recognizing my own alcoholism, prompted my Master's thesis, a study of the teenage daughters of male alcoholics, and led to the larger question that

has guided my work: "What happens to people when they stop drinking?"

Bill White: In 1985, you published the book, *Treating the Alcoholic: A Developmental Model of Recovery*, that set forth the developmental perspective that has informed much of your work.

Stephanie Brown: *Treating the Alcoholic* was a translation of my doctoral dissertation, now further confirmed by our patient work at Stanford. It outlined the stages in a developmental process and the tasks of treatment for the patient and the therapist at each stage, a radical way of thinking about alcoholics and alcoholism at that time for both the addictions and the mental health worlds.

I suggested that alcoholism and alcoholism recovery is an ongoing process, not an event, and outlined four general stages in this continuum. These are now widely known as active drinking, transition, early recovery and ongoing recovery. Today, we say active addiction; drinking/using transition and abstinent transition, the move from active use to abstinence; early recovery, which centers on new development of self; and ongoing recovery, which is the stabilization of new behaviors, a new identity and a whole new self.

Bill White: When first reading this work, I was struck with the simple but profound idea that, as people shifted from one stage of recovery to the next, treatment approaches need to shift in tandem with these transitions.

Stephanie Brown: That's right. In my view, mental health professionals at that time did not understand addiction, and in fact, were often doing more harm than good in their approach to treating alcoholics. Mental health theories worked against an understanding of the developmental process of healthy growth. Even today, many difficult experiences of recovery can be misinterpreted as "pathology" instead of a normal part of healthy recovery development.

Bill White: You were very involved in the early Adult Children of Alcoholics (ACOA) movement. How do you look back on that movement today?

Stephanie Brown: With great warmth and affection. We came together as a group of individuals who had all begun to focus our professional work on the needs of children of alcoholics or adult children of alcoholics. We became NACoA, the National Association for Children of Alcoholics. There were initially about 15 of us, all professionals, and all, or most, self-identified adult children. We were all responding to our own emotional children of alcoholic selves in a desperate need to "make real" and to name the truths of our lives—the reality of growing up with alcoholic/addicted parents.

The social movement lasted a good 10 years, and then its major themes were picked up by academic research which in the 1990s, validated our original findings. The social movement quieted, as social movements do, waiting until their "cause" is integrated and institutionalized in the culture or forgotten. Fortunately, this social movement survived and is now well-integrated in mental health and addiction.

Bill White: What do you think are some of the most important contributions of this movement?

Stephanie Brown: Most important was the naming of reality, the power of the label—children of alcoholics, adult children of alcoholics—because that label identifies parental alcoholism as a key source of a child or adult's development. It says that living with parental addiction will have an influence. The COA and ACOA movement highlighted the interpersonal nature of individual development and the difficulties adults brought from their childhood into their adult experience. It also provided a clear link to the emerging broader mental health field of trauma. Twenty-five years later, all of these contributions are part of theory and practice in both mental health and addiction.

Bill White: Your book, *A Place Called Self: Women, Sobriety and Radical Transformation*, deeply touched many people.

Stephanie Brown: At the time I wrote *A Place Called Self*, I was deepening my understanding of the role of paradox in recovery. Hazelden asked me to explore some of these paradoxes from the perspective of recovering women. I reviewed the stages of development and reviewed the significance of surrender—of hitting bottom, of powerlessness. Then I addressed the question, "How can women accept their powerlessness when the culture is pushing them to claim their power?" I believe that's where the paradox comes in: that women, just like men, come to understand their fundamental humanity in the powerlessness, in the realization that we are all ultimately dependent—we find the power in powerlessness.

Bill White: In 1999, you published a book with Virginia Lewis, *The Alcoholic Family in Recovery*, that transformed my own understanding about family recovery from alcoholism.

Stephanie Brown: That book came at the end of a 10-year research project that Virginia and I undertook in 1990 to study the process of recovery for the family. I had always wanted to know what happens to the whole family when the drinking of one or both parents stops. We asked the same main question I had asked previously: is the process of recovery for the family similar to the process for the individual, and do the stages of active addiction and recovery I identified for the individual hold true for the family? We discovered pretty quickly that these stages do hold true and that they are a good guideline for understanding what happens with recovery growth following abstinence.

We realized we needed a different kind of model to understand the processes

involved for the family. So, we developed a matrix in addition to the linear, sequential stage model. Through the matrix, we included domains of experience along with the stages of family change. The domains of experience allowed us to look at the environment and family system in addition to individual experience. The environment includes the context and atmosphere of family life in which we all live every day, but rarely think about or acknowledge. We looked at the atmosphere, the mood, the tone, the feeling, the emotional experience of living within the addicted family as it transitioned into recovery and beyond. We quickly identified trauma as an organizing theme for the change process.

Bill White: Yes, you used the phrase "trauma of recovery" that stunned me when I first read it.

Stephanie Brown: By 1994/95, we were well into analyzing family data and clearly saw that the experience of trauma, so starkly evident during active addiction, continues in the beginnings of recovery. Most people expect that when the drinking stops, everything is going to be fine, and it isn't. It isn't for the individual, and it definitely isn't for the family. New kinds of problems actually emerge with recovery, totally unexpected because no one knows what to expect with abstinence, and the family members do not know how to operate without the drinking.

The family system in active addiction achieves homeostasis by adapting to the pathology of addiction. That leaves the family in the beginnings of recovery without structure to nurture and support the health of family members or the family as a whole. There's a vacuum in the system, which often creates more trauma—new trauma—which we labeled the "trauma of recovery." Clearly, this vacuum is a time when the family needs much greater external support to help "hold" them in their new recovery process. The transition from exiting formal treatment to achieving stable family functioning is still a huge vacuum for many families. We found, sadly, shockingly, that children are often more traumatized in the beginnings of recovery than they were during active addiction.

Bill White: You've proposed that the roles, rules, rituals and other homeostatic mechanisms that allow the addicted family to function must collapse and be replaced in the recovery process, and you've recently talked about the need for what you call scaffolding that can support the rise of a new family process. What happens if families don't have that kind of scaffolding?

Stephanie Brown: Most families in recovery have not had that scaffolding, which means external structures of support. In the early days, family members were viewed as "support people" for the addicted person, an extension of "codependent" family dynamics. In essence, they were expected to become the "scaffolding" for the newly recovering addicted person. It's only recently been recognized that family members need their own separate recoveries as individuals, and that they must "detach" from their unhealthy involvement with the addicted person. This is of course what Al-Anon teaches. Family members can be supportive of others' recovery as long as they have their own, and that their own individual recovery comes first.

Families who participated in "family programs" during the '80s and '90s were provided some degree of "scaffolding" during the course of that treatment, but not much because they were not the "identified patient." As many told us in the research, they felt important before the addicted person entered treatment but unseen as soon as the addicted person was in treatment. Structural supports, including education, recovery planning, and support people, were only available to the addicted person post-treatment.

There were some pioneer programs, such as the children's program at the Betty Ford Center in Palm Springs and a few family programs that provided education and support for family members' recovery. But there is a vacuum in understanding the need for continuing focus and services to address the primary needs of all family members in transition and early recovery.

Bill White: It poses the question of what the ideal scaffolding would be like that could support recovery.

Stephanie Brown: I think we understand much better today that the family encounters a vacuum on entering recovery with or without formal treatment or outpatient therapy. This vacuum within the family, and the same kind of vacuum in the community—the neighborhood, town, city, work, school and social environments—is a significant problem. Current treatment ideas and formats could be extended into something quite wonderful. The treatment center could expand its focus to include the care of families and extend their responsibility beyond what is now included in treatment into a process of sustained continuing care for the families they serve. As people leave treatment, there would be a much stronger "hand-off" to professional and peer-based supports, including alumni groups and mutual aid groups. The idea of a recovery coach is growing now, which I think will be a tremendous help to individuals and families. The notion of a recovery coach emphasizes the necessity for continuing care and reduces the "dropping off the cliff" experience that has previously characterized family experience.

Bill White: From your studies, Stephanie, how long does that support need to be provided to families?

Stephanie Brown: I would say a minimum of a year. I envision an apprentice approach following the model of AA. People who use the supports will pass on their experience to newcomers leaving treatment centers, on referral from a therapy experience, or simply entering recovery on their own. It's probably the

case that most people who find recovery have not been in formal treatment programs or even any kind of therapy. Thus we need to conceive of "community supports" as a loosely organized network separate from any one treatment center or person.

Bill White: When I first read the book you and Virginia Lewis co-authored, you talked about family recovery following treatment, not in terms of days or months, but in terms of years. None of us in the field at that time had that kind of vision.

Stephanie Brown: I think that's correct. That's where the developmental perspective is helpful. The normal process of recovery for the individual and family is not all forward progress. Normal development is back and forth, not always just straight ahead growth. Periodic problems, or even ongoing struggles, are normal and expected as part of healthy growth, so they should not automatically be interpreted as a problem with recovery. Not only do individuals and families look and feel worse at the beginning of recovery and as they move forward, but the process itself—a deepening of memory and emotional understanding—will often create pain and conflict that can be misinterpreted as pathology rather than part of a growth process.

Bill White: You've had an opportunity to consult with many treatment programs in the development of family programs. How would you describe the state of family treatment and recovery support today?

Stephanie Brown: Treatment centers are still primarily focused on the addicted individual. They have not been able to add a family focus that allows family members to also be viewed as identified patients. They still are looking at the family as appendages to the addicted person, which is a huge problem in my perspective.

Bill White: Your work has enhanced understanding of the intergenerational nature of alcohol and other drug problems. Have you envisioned how such intergenerational cycles might finally be broken?

Stephanie Brown: I think we've started to name and describe what happens in addicted families across generations, which is helping us understand family addiction and the complexities of family recovery. And I think we are poised to move beyond our current focus on the genetic and neurobiological influence on intergenerational transmission of addiction to include exploration of the larger psychological and social processes involved. We need more family research to understand these aspects of the transmission process and the kinds of family and community support processes that can influence these cycles and positively disrupt them. We need to help families who have intergenerational vulnerabilities understand family addiction processes and integrate recovery as an integral part of the family lifestyle and identity. We will not always prevent addiction because we don't know how to prevent it. But by intervening and supporting healthy family systems, we may someday be able to have an earlier, bigger impact on prevention.

Bill White: Have you found any evidence that children in recovering families who go on to develop a problem themselves have a better prognosis for recovery?

Stephanie Brown: Yes. We were so lucky to interview a number of families in which the adult children were already in their own recoveries. Their parents had entered their recoveries when these young people were still children and adolescents; we could see and hear the impact on them of experiencing recovery while they were still young and living at home. We did see generational recovery, but we need more research and more subjects to confirm our findings.

Bill White: Treatment administrators lament that they can't provide family programming because no one's paying for it. What kind of supports could be provided to families that wouldn't be contingent upon either public or private funding?

Stephanie Brown: We need to move toward community models to support families—the use of alumni on-site during active treatment, the use of alums and volunteers after treatment. The idea of volunteers is not new, but it needs to be valued, promoted, updated, and organized. I also think it would help if treatment centers could deeply understand the concept of the family as patient and build volunteer networks from this basis.

Bill White: You're describing the role of the treatment professional as not the first line of support, but as the safety net. That's a radically different view of the role of the treatment center and the private therapist.

Stephanie Brown: I don't think we're going to proceed otherwise. For treatment centers to lead the provision of family support, they must move beyond a fixation on money and billable services and look to how family support can be mobilized in the larger community. The fee-for-service system cannot provide an adequate level of family support over the course of the family recovery process. Professionals are vitally important at key points in an ongoing process. But they are parts of a bigger picture. We need to raise the value we give to peer-based and other no-fee supports.

Bill White: You've been recently applying the concept of recovery to our whole culture, suggesting among other things that we as a culture are out of control, have lost our sense of limitation, and are prone to all manner of excess.

Stephanie Brown: American culture was formed in the 1600s with a basic belief in the power and entitlement of the individual. American identity and American character were formed on a sense of privilege. Americans saw themselves as the chosen people, entitled to this new land and to the rest of the

continent. This identity is similar to the kind of personal identity and beliefs that form with addiction—grandiosity and entitlement without limit. The addict believes "I am not an addict; I can control my use, and I can have what I want." In essence, "limits don't apply to me."

Westward expansion proceeded through the 1700s and 1800s and the beginnings of the 20th century. But by the 1950s, the end of territorial expansion occurred, and colonialism became unpopular. The United States was faced with the reality of geographical limits for the first time, but we did not have a national or cultural identity that accepted limits. Then along came cyberspace—a new territory without limits. As far as we know, cyberspace is indeed unlimited, but human beings quickly had to face human limits: we cannot go as fast or as endlessly as cyberspace and technology. Human beings must come face-to-face with human limits.

But instead, in the last 20 years, our culture has become out of control. The beliefs in entitlement, the grandiosity of no limits, and the realities of loss of control now characterize American cultural identity and behavior. I'm writing about a culture addicted to speed—going fast—driven by its denial of limits and a belief that we are always moving forward. There must be only progress and only success. We need to slow down, but slowing down is failure. This is just the tip of the story.

Bill White: From what you have described, it seems like there might be a real appetite for this recovery concept within the larger culture in the coming decades.

Stephanie Brown: Absolutely. In the last three months, the *New York Times* and other news sources have been full of articles describing the out of control culture. The popular press is picking up on this "new idea" and it will soon be, I hope, a serious subject of concern. I see that the principles of addiction apply to the whole culture, and an understanding of recovery can help us face it and deal with it. The "American way" is to slow down temporarily, to get control, and then jump back on board to ride the wave of "the next big thing." This is the same dynamic that occurs with addiction: try to get control until you can be out of control again.

Bill White: You and I are at a stage in our careers where it is natural for us to think about legacy and the most important things we can do to serve the field in the time we have remaining. What are your priorities as you look forward?

Stephanie Brown: The book on speed, which has been very difficult to write, is still in process. It is very important to me, so I plug along. I am more naturally an academic writer, so I have struggled with this book to find the voice and the central threads to translate complicated theory into an accessible, popular work. I don't have an agenda beyond finishing this book, although I do hope to continue to contribute to the greater integration of mental health and addiction theory and practice over time. Sometimes, facetiously, I say that one of my greatest achievements of these last 40 years is to have passed the point when I could die young. That really says it. I am one of those fortunate people who got to recovery, and it has blessed me ever since.

Bill White: Stephanie, thank you for all you've done for the field, and thank you for this very engaging interview.

Stephanie Brown: Thank you so much, Bill. It's been absolutely wonderful.

To the Reader: *The complete interview with Stephanie Brown is posted at www.williamwhitepapers.com.*

William White *is a Senior Research Consultant at Chestnut Health Systems and author of* Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices.