

REACHING OUT TO RECOVERING JEWS

A Professional Partnership With The Jewish Community

ARLENE KAHN

*Coordinator, Task Force on Addictive Behavior
Jewish Family Service of Southern Middlesex County, New Jersey*

AND

ARTHUR J. FRANKEL, PH.D.

*Associate Professor
Rutgers University School of Social Work, New Brunswick, New Jersey*

There is a growing awareness that many Jews are dealing with active addictions to drugs and alcohol, and many more are recovering. Jews generally will not seek out traditional addiction services, which do not deal with the unique issues faced by recovering Jews. This is particularly true of the 12-step programs, in which professionals are usually not allowed to participate. A Jewish Family Service in New Jersey developed a partnership with the recovering Jewish community and helped over 600 people dealing with addictions come together to share the support that is uniquely needed by recovering Jews.

There is a commonly held belief that Jews do not have problems with alcohol or drug abuse. Traditionally, being Jewish and being alcoholic have been thought to be mutually exclusive.

Yet, the reality is that there have always been Jewish alcoholics and drug users. The Bible is replete with references to drunkenness and admonitions against tarrying too long over the wine (Spiegel, 1977). In fact, Noah was considered one of the first alcoholics. In addition, there are suggestions in the Bible that the ancestors of the modern Jews were copious drinkers (Keller, 1970). After the return from exile and the acceptance of the Torah, drunkenness began to be frowned upon. Drinking became a way to celebrate rituals, religious celebrations, and life-cycle events: four glasses of wine at Pesach, one glass of wine to usher in Shabbat, wine to consecrate a wedding and to celebrate a young person's Bar or Bat Mitzvah, and prescribed drinking at Purim.

The toast "L'Chaim" means that wine, even today, is used to celebrate health and life. Wine itself is sacred and has its own blessing (Keller, 1970).

Yet, to be drunk, and especially publicly drunk, was a betrayal, a "shanda" or shame. The stigma of public drunkenness meant that those Jews who did drink to excess did so quietly and in a closeted way. Snyder (1958) notes a popular song among Jews, "Shikker is a Goy" (A drunkard is a Gentile), demonstrating Jewish identity as connected with sobriety. Although this value offered some protection against alcoholism in the past, it has increasingly contributed to the denial of alcoholism and drug use within the Jewish community today.

ALCOHOL AND DRUG USE BY JEWS: RESEARCH STUDIES

The first studies to call attention to alcoholism among Jews were those of Bales (1944, 1946) and Snyder (1958). They studied the qualitative differences and the differential incidence rates in drinking practices of Jews and non-Jews. Bales reported that the

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function of drinking for the devout or Orthodox Jew was symbolic and communicative. Drinking among religious Jews was ceremonial, was sanctioned within the context of religious and ritual observance, and was psychologically dissociated from the "effect" of alcohol on the individual. Bales felt that the use of drinking for religious observance accounted for a low rate of alcoholism among Jews and hypothesized that the decline in the number of Orthodox Jews accounted for the recent increases in rates of alcoholism among Jews in America. He also suggested that Jews had a high rate of addictions to other drugs, citing a study by Bailey (1922) that found, of the American draftees rejected in World War I for psychiatric reasons, Jews had a higher rate of drug addiction than any other ethnic group.

Snyder (1962) studied Jewish drinking patterns, rather than alcoholism per se. He particularly noted the significance of "in group-out group" relationships in Jewish drinking practices. He found that drinking occurred more frequently when Jews were with other Jews, but that intoxication occurred more often in settings that were predominantly Gentile, such as in the military and in college, where there was a certain degree of assimilation. The Jewish men he interviewed believed that Jewish identity was related to sobriety. They felt that the closer a person identifies with Judaism, the more likely he is to derive a sense of worth from being a Jew and therefore the less likely to do something that will make him a non-Jew; namely, becoming drunk.

Information on the incidence of alcoholism and other drug use among Jews today is more anecdotal than statistical. As many as 10.5 million adult Americans are estimated to show signs of alcoholism or alcohol/drug dependence (NIAAA, 1990). Every addicted person seriously affects four to five significant others. In other words, with adults being roughly half of the population, approximately 1 in 10 people in this country

who drink or use drugs will become alcohol or drug dependent, or about 5% of the total population. There are also indications that up to half of alcoholics are addicted to other drugs as well (NIAAA, 1990).

According to the 1990 National Jewish Population Survey (Kosmin et al., 1991), there are approximately 5 1/2 million Jews in America. Extrapolating from the NIAAA data, it is reasonable to assume that over 250,000 Jewish adults are chemically dependent, with close to one million or more Jewish people being affected by the disease of chemical dependency.

Support for this estimate of alcohol/drug addiction in the Jewish community comes from an analysis of social service usage by American Jews based on the 1990 NJPS (Winter, 1992). Six percent of Jewish households sought help from a Jewish agency for alcohol or drug problems. This number did not reflect those who had these problems but did not seek help or those who had addictive problems and sought help elsewhere.

Rabbi Abraham Twerski (1986), a psychiatrist and addiction expert, has also suggested that, even if the incidence of pure alcoholism among Jews is lower than in other groups, it is more than compensated for by the existence of a large number of Jews who are dependent on or addicted to other mind-altering chemicals, such as sedatives, tranquilizers, or opiates. Jews as a group tend to mix drugs, using marijuana, alcohol, amphetamines, cocaine, and other drugs. One study reported that, among frequent drug users in college, the use of three or more drugs, excluding alcohol, was more prevalent in Jewish students (39%) than in non-Jewish students (26%) (Daum & Lavenkar, 1986). In areas that are densely populated with Jews, Jewish attendance at Alcoholics Anonymous meetings is quite high. In New York in one AA meeting that has an average attendance of 100 people, 50% of the participants are Jewish. Pills Anonymous meetings in New York are between 30% to 50% Jewish (Twerski, 1986).

Cocaine use is another area of concern. Of 427 respondents to a survey by the National Cocaine Hotline during January through April, 1985, nearly one-fifth (18%) were Jewish. In a private cocaine abuse treatment program at the Regent Hospital in Manhattan, approximately 60% of the first 300 treatment applicants were Jewish (Levy & Blume, 1986).

USE OF TREATMENT RESOURCES BY JEWIS

The myth that Jews are not alcoholic or drug addicted has contributed to a "double denial." There is first the denial of any addictive problem. This denial is common to most addicted people and their family members. Then there is the second denial that "if I'm Jewish, I can't be alcoholic." This second denial is supported by the last 200 years of Jewish history and tradition during which there has been a belief that somehow Jews are virtually immune to this disease. It is therefore likely that Jews who do have a problem with an addiction take longer to recognize it and that their disease is often more advanced before they seek help.

The reluctance to seek help for alcohol and drug problems is an area of serious concern for the Jewish community. A recent national survey of experts in Jewish drug addiction reports their judgment that Jewish people avoid traditional alcohol and drug treatment resources (Frankel et al., 1991). Typically they are the last to use the best treatment resources available, such as AA, Al-Anon, other 12-step programs, rehabilitation centers, and outpatient programs. They do not know to call upon governmental councils on alcoholism and other drug agencies for information and referral. Instead, they reportedly tend to go to psychiatrists or other physicians, and their problem may be mislabeled as depression, anxiety, or a physical condition. Jews most often go to Jewish physicians, and there is every reason to believe that they adhere to the same stereotypes and denial

about Jews and addiction as do other Jewish people. If the result of consulting a physician is a drug prescription for a pain killer, Valium, or Zanax, the addiction and the denial are exacerbated.

Some Jews experiencing alcohol or drug symptoms may consult their rabbi, the Jewish Family Service, or the Jewish Community Center. Rabbis are not often trained in diagnosing drug and alcohol addictions, the symptoms of which often look like those engendered by other personal, marital, or family problems. In addition, even if a rabbi suspects an addictive problem, he or she may not be aware of the proper referral network that can help Jews with addictions.

Neither are social workers in Jewish Family Services and Jewish Community Centers always trained in recognizing the signs and signals of addiction. Because they may not see large numbers of addicted clients, many are undertrained in how to diagnose, refer, or treat someone with an alcohol or drug addiction. Many are unfamiliar with 12-step programs and do not know how to refer to and use them to the best treatment advantage. In addition, many Jewish communal workers share the same history of denial regarding alcohol and drug abuse in the Jewish community.

A corollary to the myth that Jews can't be alcoholic is that those Jews who do recognize that they have an addictive problem often feel that "if I acknowledge that I'm alcoholic, then I can't be a very good Jew." They may feel different, may be alienated from other Jews, and may disaffiliate from the Jewish community. Those who do seek support in AA, Narcotics Anonymous, and other 12-step groups are often further alienated from the Jewish community because of the Gentile culture of most 12-step programs.

Twelve-step programs are derived from Alcoholics Anonymous, which was founded in 1934. A few years later its founder, Bill Wilson, and Dr. Bob Smith wrote the Twelve Steps, which is a self-help frame-

work stressing personal responsibility and belief in a higher power. Millions of people over the last 50 years have joined AA, as well as other similarly designed self-help groups, such as Narcotics Anonymous and Overeaters Anonymous.

All 12-Step groups are organized along a similar framework. No individual speaks for a group or the organization as a whole; meetings are publicized by an intergroup committee made up of volunteers; and no professionals are involved and no professional treatment is offered. Often, a key figure in the helping process is the sponsor, a designated recovering person who helps new members. Sponsors are available 24 hours a day to support their fellow members in times of stress and to help them understand the 12 steps. At meetings a recovering speaker tells his or her story, followed by discussion or sharing (Elliott, 1987).

For recovering Jews, because of the Gentile culture of AA, joining that organization is likely to provoke conflicts with their Jewish identity. Most 12-step meetings are held in churches, which feel alien and disloyal to many Jews. It may be the first time a Jew has ever been in a church, and many Orthodox Jews consider it a sin to be in a church. The spiritual emphasis on a higher power feels non-Jewish to many Jews. Even though AA asks each person to define individually his or her own higher power, having the meeting in churches, with their many references to Jesus as God, makes AA feel Christian. Most meetings end with the Lord's Prayer, which is from the New Testament. In addition, those Jews who are agnostic feel alienated by ending meetings with such prayers or by being asked to invoke a higher power as a support in their recovery. Finally, the language of AA sounds Christian to Jews. Such concepts as "turning our will over to God," calling on a higher power, and belief in our powerlessness are not part of the language that Jews hear in their families, synagogues, Jewish Community Centers, or in other places where Jews congregate.

TASK FORCE ON ADDICTIVE BEHAVIORS

New Jersey has a population of 450,000 Jews (Jewish Federation, 1990). Applying the projections described earlier, there may be over 22,500 addicted Jews in the state. Most of these Jews have families, which makes the number of Jews affected by drug and alcohol problems much higher.

It became clear to the professional social workers at the Jewish Family Service (JFS) of Southern Middlesex County that the addictive problems and the recovery needs of the Jewish community were not being addressed adequately. These problems were different from most other problem areas in Jewish communal work because professionals have traditionally been excluded from the most successful form of support for people recovering from drug and alcohol addictions — the 12-step programs. Nevertheless, the JFS staff developed a Task Force on Addictive Behaviors in 1985, with its first goal being the assessment of the needs and addictive behavior of New Jersey Jews with drug and alcohol problems. This Task Force was made up of volunteer professionals and laypeople interested in dealing with the issues of Jews and addictions. During the first three years of the Task Force's existence, three major projects focused successfully on the problem of Jewish addictions: a videotape program entitled "Jews and Addiction: When L'Chaim Is Not To Life" (Kahn, 1990); a national needs assessment research project to determine professional Jewish attitudes about the level, severity, and impact of Jewish addictions (Frankel et al., 1991); and a state-wide group of recovering Jews called The New Jersey Forum For Jews in Recovery.

In the first phase of the Task Force's work, a network of volunteers was formed to help link newly recovering people with existing alcohol and drug treatment resources. Through this process, contact was made with a number of recovering Jews in 12-step programs who felt that these

programs did not address satisfactorily the issues of being Jewish and being a recovering addict. Under the auspices of the Task Force, these recovering Jews were brought together and the Forum was born.

The first Forum project was sponsorship of a series of 1-day retreats for recovering Jews across New Jersey. These retreats were called "Share-a-Day." They were advertised through synagogues and newspapers, but mostly by word of mouth at 12-step meetings. Member of the JFS staff played a facilitative role at the meetings; otherwise, they were involved only when they were specifically invited to participate on a panel or give a presentation. Rather, the entire program was planned and conducted by the recovering Jews in the Forum.

Each Share-a-Day began with a keynote address by an invited speaker, who was a recovering Jew with long-term sobriety. After that presentation, participants broke up into small workshops on a variety of topics led by recovering Jews in 12-step programs. Discussions focused on how Jews feel being in a religious/ethnic minority in 12-step programs; understanding the 12 steps in a Jewish context; how their Jewish identity, culture, and spirituality related to their addiction and their needs in recovery; and what new programs might meet the needs that were uniquely felt by recovering Jews.

Confidentiality was protected during the Share-a-Days in much the same way as in 12-step programs. Only first names were used, and no process records or tape/video recordings of any Share-a-Day were kept. However, participants have reported that discussions have been lively, with a great deal of self-disclosure going on in the small groups. Participants have included not only those recovering from drug and alcohol addictions but also Jews who have reported addictions to food, gambling, and a variety of prescription drugs.

From 1989 to 1991 there have been six Share-a-Days with over 600 recovering

Jews attending. Each Share-a-Day has shown excellent attendance. The most recent Share-a-Day had an attendance of 75 recovering Jews from ten counties across New Jersey.

The success of the Share-a-Day program in New Jersey has a number of important implications for agencies serving the Jewish community. First, it is clear that there are a large number of recovering Jews in 12-step programs and that the issue of their being Jewish and in recovery is not being met in many of these programs. Second, providing a forum for the recovering Jews to discuss the unique issues of their recovery with members of their community is a direct service to this group that is not being provided elsewhere. Third, bringing together so many recovering Jews in one place gives them an organizing voice that could have an impact on the entire Jewish community. For example, some of the ideas that have come out of the Share-a-Day discussions include developing more comprehensive recovery support programs addressing the theme of Jewish spirituality and ethnicity; outreach and publicity to identify and involve isolated recovering Jews who are not affiliated with any religious institution; planning specialized Share-a-Day programs to reach adolescents who are addicted; reaching out to the thousands of recently arrived Soviet Jews who have been resettled by Jewish agencies throughout New Jersey; and identifying synagogues where 12-step meetings could occur. The Forum Planning Group, in conjunction with the staff of the JFS Task Force on Addictive Behavior, is presently working on bringing some of these ideas to fruition.

The JFS of Southern Middlesex County clearly tapped a wellspring of enthusiasm and need when its staff facilitated the Share-a-Day program. By mobilizing and supporting a totally volunteer group, hundreds of New Jerseyites have found a forum to explore their unique issues as recovering Jews. There is every reason to

believe that this service could be replicated in every state. In addition, by providing recovering Jews a forum to share their experiences, it also gives Jewish social service professionals a way to facilitate more comprehensive services to addicted Jews, and very importantly, a means to directly involve the organized Jewish community in the process.

One of the reasons that the Share-a-Day program was successful is that the professionals at the JFS of Middlesex County clearly took a "back seat" in the organization and development of the Forum. Although 12-step programs exclude non-recovering professionals from their groups, the intervention model reported here shows that it is possible for JFS professionals to work with Jewish "12 steppers" in the development of programs that better meet the unique needs of recovering Jews in the American milieu.

There are at least three possible hypotheses explaining how JFS professionals became as involved as they did with the recovering Jews in the Share-A-Day programs. First, the success of this partnership may have been dependent on the facilitative skills of the professionals and their ability to form person-to-person relationships, rather than looking at those recovering as "clients." In addition, the legitimacy of JFS in the Jewish community may have helped support the work of the Task Force in coordinating Share-a-Days with synagogues and Jewish Community Centers. Second, Jews may be more accepting of professionals in general than other groups and thus were more able to use the professional support offered. Third, the fact that the Task Force on Addictions was made up of paid and volunteer professionals, as well as those recovering from an addiction, probably gave this partnership legitimacy in the eyes of the recovering Jewish community.

There has not yet been any formal evaluation of the program, for several reasons. Confidentiality has been an

important issue for participants, and in the first stages of this project it was deemed inadvisable to attempt systematic evaluation efforts. Because Share-A-Day participants used only their first name, it was difficult to track attendance. However, written suggestions were elicited from participants, which guided future programming and indicated the general enthusiasm for the meetings.

The Forum is continuing to plan more day-long retreats. The informal evaluations collected from participants have suggested the development of more focused Jewish content relating to alcoholism and drug addiction. Group members have requested that more rabbis and rabbinic interns attend and lead workshops and that workshops deal with less general recovery issues and offer more specific Jewish content, such as 12 Psalms for 12 steps, the Jewish view of *Tshuvah* (repentance) and recovery, and mysticism and Judaism. In addition, there are plans to sponsor a dance for Jews in Recovery, as well as Jewish holiday celebrations. The program is expanding and sharpening its Jewish focus, as that is the vital missing piece in traditional 12-step programs.

An offshoot of the retreats has been a smaller group that formed independently for the purpose of exploring issues of Jewish spirituality in recovery. It is called "Chaim v'Tikvah" (Life and Hope). It meets Sunday evenings in a synagogue, and its members explore Jewish literature, invite rabbis for discussion, and have their own self-help meeting.

Other agencies in the Jewish communal field should further test the hypotheses raised in this demonstration project in developing support for recovering Jews. The experience of the Jewish Family Service of Southern Middlesex County in New Jersey suggests there is a widespread need for such support and that it is possible for professionals to join in a partnership with those recovering from addictions who are dealing with issues unique to their experience as recovering Jews in America.

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