

## *Original Paper*

# Natural Recovery and Supportive Community Networks

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Received: March 5, 2021

Accepted: March 13, 2021

Online Published: March 20, 2021

doi:10.22158/jpbr.v3n2p7

URL: <http://dx.doi.org/10.22158/jpbr.v3n2p7>

### ***Abstract***

*The natural recovery process of “maturing out” appears to be an active process of renewal and growth, leading to transformative growth that involves the individual’s body, mind, and spiritual dimensions. If spontaneous or “maturing out” recovery accounts for about 4 to 18% of the alcohol and other drug (AOD) challenges to the field of behavioral health treatment, how does one effectively partner with the other 82% who have alcohol and other drug issues? To answer this concern, we must ask a few more questions. (1) What developmental factors influence growth? (2) What social determinants of health enhance recovery? (3) What is a supportive community network? and (4) What constitutes evidence-based practice? When one only looks at the biological reasons for behavioral health challenges, the assumption is that getting well and overcoming deficiencies is a function of the individual rather than the system of care. This kind of narrow perspective has contributed to a behavioral health delivery system that continually struggles to provide an integrated, comprehensive care model. This restrictive thought process undermines individuals’ confidence to change and is unduly dismissive of community leaders’ efforts.*

### ***Keywords***

*natural recovery, social determinants of health, evidence-based practice*

Study after study appears to conclude with the same research findings that substance use begins in one’s early teens and concludes with a group of individuals changing their pattern of substance use or abuse in their mid to late 30’s. (Heyman, 2009; Dawson, 1996). A Harvard Medical School report indicates that most people who successfully stop substance use for a year or more do it alone, without any treatment program or “support group”. The Harvard report also notes that some heroin addicts

break their addictive habits in an average of eleven years and that at least 50% of alcoholics eventually become drug-free. However, only 10% are ever treated for substance abuse (Harvard Letter, 1995).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) National Epidemiologic Survey of 43,000 individuals with alcohol and related conditions concluded that:

*About 75 percent of persons who recover from alcohol dependence do so without seeking any kind of help, including specialty alcohol (rehab) programs and AA. Only 13 percent of people with alcohol dependence ever receive specialty alcohol treatment (NIAAA, 2017).*

Cahalan's (1970) drinking practices study noted that drinking problems decrease in men after age 50 and the amount of alcohol consumed also decreases. Cahalan, Cisin, and Crossley (1974) found that approximately one-third more individuals had problems drinking in a period before their three-year study period than during the study period itself. Their results suggested a tendency toward "*spontaneous remission*" of drinking problems. Goodwin, Crane, and Guze (1971) found that approximately 18 percent of the alcoholic felons had been abstinent for at least two years on an eight-year follow-up with individuals who received no treatment. Lemere (1953) reported long-term abstinence in eleven percent of untreated alcoholics over an unspecified interval. Kendall and Staton (1966) reported 15 percent abstinence in untreated alcoholics after a seven-year follow-up. Kissin, Platz, and Su (1970) reported a 4 percent one-year improvement rate in untreated lower-class alcoholics. Imber et al. (1976) described a follow-up of 58 alcoholics who received no treatment for their alcohol dependency. For this group, the abstinence rate was 15 percent at one year and 11 percent after three years. In the 2012 National Drug study, an estimated 23.9 million Americans aged twelve or older were current (past month) illicit drug users. This estimate illicit drug use represents 9.2 percent of the population aged 12 or older. Illicit drugs included marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used non-medically (SAMHSA, 2021).

Most of the studies mentioned above suggest a natural or "*spontaneous*" recovery rate for alcohol and other drugs of at least one-year duration is about 4-18 percent. Although there may be differences in how natural recovery occurs, the phenomena have persisted from the original studies in the 1960s and '70s into the 21st century. This phenomenon is characterized throughout the whole spectrum of alcohol and other drugs: alcohol, marijuana, heroin, binge eating, smoking, sex, and gambling (Building Common Ground, 1999).

The natural recovery process of "*maturing out*" appears to be an active process of renewal and growth leading to transformative growth that involves the individual's body, mind, and spiritual dimensions—generally, it is not a passive activity. Maturing into adulthood takes time, motivation, and a supportive environment embedded in an understanding community. The process of recovering from years of behavioral health challenges can take decades. Peele (1999) indicates that the advantages of

the “*maturing out*” approach is that individuals come to see that “*recovery*” is a natural process that is more likely than not to occur if they make real progress in key areas of their lives. Key social determinants of life (health) tend to involve work, school, friendship, recreational and physical activities, citizenship, including volunteering, engaging in the political process, and other aspects of civic life, and participating in spiritual and religious activities (Salzer, 2006; Scoles & DiRosa, 2018; Scoles, 2020). Peele (1999) believes that one’s addiction is not lifelong and all-powerful; rather, it is something with which ordinary people with a proper support network can manage. It appears that a “*supportive community network*” can help people in early recovery find additional strength, hope, and motivation to pursue a path of health and transformation that will put their behavioral health challenges into a more manageable life process resulting in less stress and anxiety.

### **Natural Recovery**

Natural recovery is a recovery that occurs without treatment or traditional AA or NA support groups. (NIAAA, 2012). According to Horvath and associates, there are four key elements in any successful natural recovery process:

- 1) **Humility:** It is commonly used to mean “*modesty, lack of pride*” (concerning one’s achievements), and an informal transcendent egolessness.
- 2) **Motivation:** It becomes clear over time that the benefits of change outweighed the costs of remaining addicted. This realization provides one with enough motivation to make needed changes.
- 3) **Sustained Effort:** Recovery requires a sustained effort. Many people who fail in their first recovery effort under-estimated how much commitment, resilience, and stamina it would involve. and
- 4) **The restoration of meaning and purpose:** Recovery must be built around experiences that give one’s life meaning and purpose. To succeed in recovery, something else must fill that void.

If spontaneous or maturing out recovery accounts for about 4 to 18% of the Alcohol and Other Drugs (AOD) challenges to the field of behavioral health treatment, how does one effectively partner with the other 82% who have alcohol and other drug issues? To answer this question, we must ask a few more questions. (1) What developmental factors influence growth? (2) What social determinants of health enhance recovery? (3) What is a supportive community network? and (4) What constitutes evidence-based practice?

#### **(1) Developmental factors**

Many developmental approaches to an individual’s behavioral health challenges have been fueled by clinician’s training, which in Western culture is based on Freud, Piaget, Maslow, Erickson, etc. Historically, the battle between the Western ego and the Eastern psyche was a struggle that initially united but eventually destroyed Sigmund Freud, Alfred Adler, and Carl Jung. Carl Gustav Jung, a Swiss psychiatrist, was Sigmund Freud’s junior by nineteen years. Their close personal relationship lasted from 1906 to 1913 (Gary, 1988). Though Sigmund Freud (1856-1939) distinguished himself as an intellectual, it was Alfred Adler (1870-1937) and Carl Jung (1875-1961) who moved the emerging

mental health field toward a reevaluation of the meaning of life. Adler's view of human nature—that we shape our own destiny rather than merely being determined by our childhood experiences—was historically considered heretical by Freud. It was Adler who felt that what we believe happened in our life is our reality. Adler's social interest concept and striving for superiority introduced psychology to developing the “*life force*” or spiritual dimension in therapy (Adler, 1979). Adler, who died almost two years before Freud, and parted with his mentor and teacher in 1911, had a significant influence on what we know today as the Cognitive Therapy of Aaron Beck (1976) and the Rational Emotive Therapy of Albert Ellis (1973).

Carl Jung, who also disagreed with Freud on many substantive issues, supported the perspective that “*the journey in front of us was far more important than the path behind us and that we are more than our past. We are creators of our future*” (Ansbacker, 1974). Unlike Freud, Jung de-emphasized man's nature as a biological, instinctive drive and introduced the idea of a cultural and collective unconscious, which contains information from the history of humanity with both spiritual and religious needs (Jung, 1968). According to Jung, middle-aged experiences are more important than our early childhood recollections, and our “*psychic birth*” does not occur until adolescence, which is marked by dramatic physical and emotional development, such as hormonal changes, completing our education, finding a career, getting married, etc. (Storr, 1983).

During the first half of life, the ego dominates our existence: we establish our lifestyle, and we live among the struggles of our mundane existence. In the second half of life, different issues appear to emerge. In the first half of life, we struggled towards achievement, and in the second half of life, we move towards integration. (Singer, 1994). The Eastern developmental emphasis on self-awareness and self-analysis is balanced well with the outward ego-consciousness of the West. The Western psyche struggles with the Eastern concept that the way to overcome pain, anxiety, and depression, etc., is to live through the process of life (Clark, 1994). In the West, we “soften” our suffering from drugs and alcohol and forget that the journey is more important than the destination.

Human growth theory not only helps a person develop a better sense of one's conscious identity, but it also has an obligation to explore the deeper meaning of one's existence. The more one feels his/her beliefs, values, and thoughts are generated outside of oneself, the more one gives those directed activities the power to control his /her life. The objective in life is to create a balance between personal mythology (inner self) and ego complexes (outer self) so that the psyche (soul/spirit) can take command of one's life rather than having the spirit constantly be a stepchild to science (Fowler, 1981; Wilber, 2006). Since much of one's training is related to developmental deficits as a primary cause of adult behavioral health challenges, one needs to ask if we add a spiritual path that embraces a faith/spiritual perspective will it change the way practitioners treat behavioral health challenges?

Fowler's Stages of Faith Development (1981) and Ken Wilber's Integral Spirituality (2006) are just a few recovery paths that allow the introduction of a developmental perspective of spirituality that can

complement the bio-psycho-social perspective. James W. Fowler (1981) developed a series of stages of faith across the life span. His work builds on Jean Piaget, Erik Erikson, and Lawrence Kohlberg regarding psychological development in children and adults. Fowler defined faith as a set of assumptions of how one is related to others and the world one lives in throughout their life. The assumptions are based on one's ability to trust, commit, and relate to the world. Ken Wilber's Integral Spirituality (2006) stages of spiritual development reflect a perspective that embraces spirituality, culture, and consciousness. Wilber correlates his stages with Fowler's and thus presents an integrated model of spiritual development. Ken Wilber begins with a very primitive mind, which evolves into the third level of development in which the individual is egocentric and self-protective. Wilber believes this is the same as Fowler's Mythic-Literal Stage (pre-adolescence).

According to Fowler and Wilber, in the mid to late twenties, a person realizes that faith and, to some extent, truth needs to be discovered and not delivered to the individual. The concept of blind faith is a serious debate with the evolving Self. During this developmental stage, the individual begins to move away from a person's primary identification and expands to a worldview. It becomes more of a citizen of the world. The individual becomes "*world-centric*". It is obvious, however, that some people never reach this level at all. Wilber's developmental level corresponds roughly to Fowler's Individual-Reflective stage and our rational level (usually mid-twenties to late thirties).

During the early '40s, a person begins to bring concepts together and look for common ground instead of difference (ecumenically or pluralistic faith). This is when the individual realizes that there are many paths to seeing one's reality. This worldview helps change the individual to have more compassion for others and become heavily involved in social causes. This can be a time for more idealistic thinking. According to Wilber, a person can include mystical or cosmic experiences (Wilber, 1977, 1999). What is significant about all development (psychological and spiritual) is that no matter how far one evolves, we retain our previous stages' ancient vestiges. Like the process of recovery and life, one needs to confront one's Shadow and continually work to humanize it (Jung, 1968). The Shadow is instinctive and irrational, is prone to psychological projection, in which one's personal inferiority is recognized as a perceived moral deficiency in someone else. Through the Shadow's humanizing, we gain resilience and begin converting our life (Wilber, 2000, 2001). The humanizing of the Shadow is fostered not just by an all-inclusive appreciation of our human growth and development (body, mind, and spirit) but also gains support and encouragement from a supportive community process that fosters resilience and demands evidence-based treatment that compliments one's culture.

## **(2) Social Determinants of Health (SDoH)**

The behavioral health field is engaged in expanding the conventional medical treatment model of care, which emphasizes diagnosis and subsequent treatment, to the more comprehensive and inclusive population health model. The goal is to redirect the focus on healthy social determinants thereby reducing health inequities and disparities among different population groups. The lack of improvement

in social determinants (SDoH) belies our ability to improve a community's health (Michener et al., 2016). Studies have found that increases in income, educational opportunities, and accessible housing have the largest positive effect on one's health. Social spending, not health care spending, is significantly associated with improved mortality rates (Koh et al., 2020).

Positive therapeutic healing will be accomplished by addressing the above social determinants that influence many lifestyle choices. Therefore, from a behavioral health perspective, a population health focus would best be defined by the clinician's advocacy effects to intervene upon and influence these complex social, behavioral, and environmental factors affecting the individual members of diverse populations within the communities they serve. This shift to a more holistic healing model can be successful by creating a transformed care system for adults with health challenges. The realization that the old, entrenched behavioral health care delivery methods are not working has provided an impetus for this movement. The social determinants of health (SDoH) focus on the social, environmental, and cultural concerns impacting children, adolescents, and adults who are members of diverse populations within our society (Koh et al., 2020). "*Where we live, work, learn, and play is as significant as our genetic code*" (Michener et al., 2016, p. 24).

With its focus on acute disorders, the current behavioral health system continues to be inadequate in helping our communities and its members develop healthy lifestyles. Thus, professionals in varied disciplines, psychiatry, education, psychology, social work, nursing, etc., are seeing greater evidence that a person's individual health cannot be separated from an individual's community health (Koh et al., 2020). Moreover, a lack of attention to these social determinants contributes to the overall "*community pathology*" and low rates of therapeutic success (Scoles & DiRosa, 2018; Scoles, 2020). Thus, from a community health perspective, healing the community heals the individual, understanding that one inherently does not exist without the other. Social exposures to factors such as high-crime and drug-infested areas, domestic/partner violence, and poor access to parks or playgrounds, transportation, quality education, social services, and mental health care create an overwhelming impact on lifestyle choices. Therefore, from a behavioral health perspective, a population health focus would best be defined by the advocacy effects to intervene upon and influence these complex social, behavioral, and environmental factors by actively working to engage community organizations, families, schools, and individuals in efforts to create and shape positive and healthy environments in which all members can thrive (Scoles, 2020).

Clinical practitioners have been moderately successful in treating individual disorders. Still, they most often are ignorant to and neglectful of the interplay between one's individual "*pathology*" and the community within which one resides. The recognition that an individual's health is linked to a community's overall health is the missing link to a consistent, efficient healing process. Without practitioners engaging in a comprehensive evaluation of the concomitant social determinants of health (SDoH) to which communities and its members are exposed, a long-term successful solution to the

individual's behavioral health challenges can be nearly impossible. Incumbent upon the field of behavioral health is the obligation to influence an individual's therapeutic choices toward making healthy lifestyle changes while remaining active in their communities. Professionals must simultaneously help shape the community perspective of what changes need to occur within and among their existing micro and meso systems to foster more positive and healthy lifestyle factors for all residents who reside within a neighborhood.

### **(3) Supportive Community Networks**

Support groups like AA and NA typically portray testimonials as validity for their recovery approach should not be confused with evidence-based treatment. Self-help groups are a fellowship of like-minded individuals who share their lives to give hope and encouragement to a process that values sharing life experiences to balance the body, mind, and spirit. The practice of developing and maintaining relationships that form social networks that help each other is critical to building recovery capital (Granfield & Cloud, 2001). For many, self-help meetings reinforce positive lifestyle changes and help build resilience that reflects the best of the theory and practice of cognitive-behavioral therapy and the general field of positive psychology. Central to all stories of recovery is the theme of personal empowerment and transformation. All self-help programs are based on a voluntary commitment to change. Some believe that the greatest weakness of the 12 Step Programs-its dogmatism-is possibly also its greatest strength. The 12 Step Programs give highly vulnerable people a more faith-based and less scientific support system. One is hard put to fault the kind of personal support that so many recovering alcoholics and other drug addicts have derived from what is commonly referred to as the Fellowship. Supportive communities, like AA and NA, encourage a more resilient perspective on life events. Over the past 60 years, many different community-based self-help groups have evolved to give encouragement, support, and understanding to individuals who face lifelong adversities from various traumas. Many fellowship groups have borrowed heavily from the Twelve Steps of Alcoholics Anonymous. Many support groups outline a way of living related to chemical use and abuse issues but provide a spiritual path to a more positive life worth living. As stated in the original tenants of the Oxford movement, the flow to a successful, positive life is centered on one's ability to: (1) make an examination of conscience, (2) review one's personal defects, (3) make restitution to people we hurt, (4) resolve to help others in need, and (5) find a spiritual space to practice our newfound wisdom. The above five tenants were originally developed from a Christian perspective, but they are positive principles reflected in all faith-based organizations (Scoles, 2019; Ash, 1993).

Delgado and Delgado (1982), reflecting on culture and the healing process, reported four significant resources that constitute a natural community-based support network:

- 1) The use of extended family, which will enhance the social and emotional support network.
- 2) The use of folk healers, who utilize culturally specific methods, facilitates the healing of emotional, spiritual, and physical ailments.

- 3) The use of faith/religious institutions offers additional social and psychological support services, emergency assistance in a crisis, and spiritual advice.
- 4) The use of merchants and social/civic clubs, which traditionally are neighborhood-based, could provide a wide variety of social activity and support.

The challenge facing a comprehensive community support network is a need for one's community to embrace a paradigm shift that will facilitate the change toward a holistic model of recovery and resilience that embraces the spiritual dimension, not just as a part of the self-help movement but as a part of an integrated model of psychological and spiritual health that complements the biological and genetic foundation of people in need. Many social factors may be influential in which pathways people take. Treatment and recovery systems need to offer multiple recovery pathways so that people can take the pathway that suits them best (Elms et al., 2018).

#### **(4) Evidence-Based Substance Abuse Treatment**

Substance abuse treatment and recovery in the United States appears to be more of a struggle between a personal individual process (recovery) and wellness, which evolves a comprehensive support network perspective. Both movements need to be integrated into one unified process of related activities. The first movement is treatment renewal. Led by front line service providers to reconnect treatment to the process of long-term recovery and rebuild relationships between treatment organizations, local communities, and local recovery support groups. The second movement, the recovery advocacy movement, rose in reaction to the re-stigmatization, de-medicalization, and re-criminalization/penalization of AOD problems in the 1980s and 1990s. The goals of this second movement include reaffirming the reality of long-term addiction recovery, celebrating the legitimacy of multiple pathways of recovery, enhancing the variety, availability, and quality of local/regional treatment and recovery support services, and transforming existing treatment into "*recovery-oriented systems of care*" (White & Kurtz, 2006).

To bring the above two movements together, The Substance Abuse and Mental Health Services (SAMHSA) provides a working collaborative definition of the guiding principles of recovery and treatment renewal that attempts to deal with these complex behavioral health challenges. The guiding principles assume that no single factor can predict whether a person will become addicted to drugs. The risk for addiction is influenced by a person's biology, social environment, age, or development stage.

Besides the inclusion of spirituality into the mainstream of human development and the focus on a caring community support network, substance abuse treatment must clearly demonstrate that behavioral health challenges listed as improved exceeds the 4 to 18% of individuals who would recover without any intervention. Without evidence-based protocols, one cannot legitimately claim to be successful just because they have matched the "*maturing out*" or "*spontaneous remission*" phenomena associated with recovery. As practitioners, we should all be concerned about "*evidence*" that consists merely of testimonials, self-published pamphlets or books, or items from popular media shows. Generally,



complex behavioral health challenges require complex solutions.

A transformed healthcare system must embrace the concept that individuals' health is affected by the overall community's health. The "*pathology of the individual*" cannot be separated from the "*pathology of the community*"; they coexist and commingle. Provider agencies exist within the community. They are members of the community and therefore have a responsibility to improve the community's overall health. A counselor cannot just live in his/her office and be an effective change agent. He or she must embrace therapeutic strategies that support and empower the community. Evidence-based behavioral health interventions, such as Cognitive-Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT) and trauma-informed initiatives like the Sanctuary Model as well as many other therapeutic strategies are compatible with an approach to healing that supports community concerns by helping individuals and their families develop effective ways for coping with cravings and avoiding high-risk situations, exploring the positive and negative consequences of continued drug use, and recognizing situations that might put one at risk for use. In Cognitive-Behavioral Therapy (CBT), strategies are based on the theory that learning processes play a significant role in developing maladaptive behavioral patterns like substance abuse. By applying a range of different skills, one learns to stop or dramatically reduce drug use and address various other problems that often co-occur with substance abuse. A central element of CBT is helping individuals identify related problems and develop self-control through effective coping strategies. In Dialectical Behavior Therapy (DBT), people learn interpersonal effectiveness, distress tolerance/reality acceptance skills, emotion regulation, and mindfulness skills. The Sanctuary Model helps children who have experienced the damaging effects of interpersonal violence, abuse, and trauma. Trauma includes substance abuse, eating disorders, depression, and anxiety. The model is intended for use in a variety of settings, such as residential treatment, public schools, domestic violence shelters, homeless shelters, group homes, outpatient and community-based settings, juvenile justice programs, substance abuse programs, parenting support programs, and other programs assisting children (SAMHSA, 2007).

Effective treatment services, like the above strategies, embrace a holistic approach that integrates well into a comprehensive social support network perspective geared toward (1) the elimination of stress in the overall community; (2) being attentive toward environmental factors such as divorce, death, and illness; and (3) supporting and providing opportunities for better housing, increased employment opportunities and positive family activities. Without attention to these social determinants of health, one will continue to live in a static environment or a neighborhood in decline, which becomes a toxic wasteland for individuals, their families, and their community (Scoles, 2020).

The key to how individuals, families, and communities work together, and change has more to do with a collaborative and healing environment that embraces and integrates various therapeutic catalysts into their lives. Therapeutic catalysts were originally applied by Prochaska, and DiClemente, to individual therapy.

The therapeutic catalysts applied to community processes are:

- 1) **Consciousness Raising**—a community that provides increased information about life challenges and how their community can combat unhealthy neighborhood processes.
- 2) **Environmental Reevaluation**—a community that assesses how one's challenges affect their neighborhood's personal and physical environment.
- 3) **Emotional arousal and dramatic relief**—a community that engages different community partners to work on behavioral health challenges by providing services that lead to healthy solutions.
- 4) **Self-Reevaluation**. A treatment setting reflects the community's needs for clarifying values and challenging beliefs or expectations of the community in which they work.
- 5) **Self-Liberation**—Choosing and committing to action plans or believing in the ability to act and positively impact their community.
- 6) **Counter Conditioning**. Encouraging and supporting community alternatives for anxiety caused by disruptive community members.
- 7) **Helping Relationships**—Focusing on being open and trusting about challenges with people who care about their community. Interventions should include pastoral or other spiritual counseling, self-help groups, social support, etc.
- 8) **Stimulus Control**—a community that avoids or counters stimuli that elicit destructive behaviors. Interventions could include avoiding high-risk cues and avoiding situations that may be stressful and traumatic.
- 9) **Reinforcement Management**—Rewarding one or being rewarded by others for making positive changes to one's community (Prochaska & DiClemente, 1984, 1986).

The need to view “*pathology*” from a broader wellness transformative function is particularly relevant to behavioral health challenges and the development of resilience and protective factors in children and adolescents. It helps people recognize the larger worldview they must create and make a part of their new reality. This new worldview system brings a different perspective to an otherwise nearsighted life during mental health or alcohol and other drug challenges. Singer (1991) states that Jung saw the transpersonal perspective as

*A view that sees the world as a series of interconnecting, interacting, and mutually influencing systems. This approach to human beings is in the context of the wider world, including the invisible world of spirit...the only way the spiritual world can manifest is through ordinary people in the visible world (Singer, pp. 142-143).*

The evolving field of behavioral health requires not only an individual who possesses a comprehensive therapeutic worldview but also, as White and Kurtz (2006) indicate, a constellation of knowledge and skills that counselors, lay helpers, and recovery coaches (as well as community leaders) need to perform related to integrated community-based services. The nine guiding principles of recovery that support the above assumptions and give credibility to the development of a comprehensive support

network perspective that can impact the 82% of individual's negative environment and exposure to drugs of abuse, which will create an atmosphere for change are based on the following recovery attitudes and behaviors:

- 1) Recovery should be person driven.
- 2) Recovery occurs via many pathways.
- 3) Recovery is holistic.
- 4) Recovery peers and allies must support.
- 5) Recovery is supported through relationship and social networks.
- 6) Recovery must be culturally based.
- 7) Recovery must be supported by addressing trauma.
- 8) Recovery involves individual, family, and community strengths and responsibility.
- 9) Recovery must be based on respect.

When one only looks at the biological foundation for behavioral health challenges, the assumption is that getting well is a function of the individual rather than the community care system and its disparities. This kind of narrow perspective has contributed to a behavioral health delivery system that continually struggles to provide an integrated, comprehensive care model. It also undermines individuals' confidence in their ability to change independently and is unduly dismissive of nonprofessional helpers' efforts (Humphreys, 2015).

The need for a diagnostic nomenclature, which attempts to explain life in a singular dimension, primarily physical and mechanical, with minimal consideration to one's spirituality, was necessary if psychiatry's emerging profession was to become established as a part of medicine. Although psychiatry has tried to merge biomedical and psychosocial perspectives in diagnosing mental disorders, the language does not sufficiently disguise its biomedical bias. Surely psychiatric labels help us converse with our professional colleagues and comply with managed care requirements (reimbursement agents). Still, the person in front of the therapist is more than a label and greater than modern science (Scoles, 2019).

In conclusion, one cannot separate a positive comprehensive healing process for individuals, families, and communities from (1) positive developmental factors that influence growth, (2) social determinants that enhance health, (3) strategies that supportive community networks, and (4) programs that demonstrate evidence-based practice.

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