

White, W. L. (2013). Journeys in recovery research: An Interview with Dr. Lee Ann Kaskutas. Posted at www.williamwhitepapers.com.

Journeys in Recovery Research: An Interview with Dr. Lee Ann Kaskutas

William L. White

Introduction

If the history of early addiction recovery research is ever written, the name Lee Ann Kaskutas will figure prominently in that history. Dr. Kaskutas is one of the first researchers to specialize in the study of recovery, with particular reference to models of peer support spanning social model recovery support programs through her studies of Women for Sobriety and Alcoholics Anonymous and her present landmark study on how people in recovery define and understand recovery. I had the opportunity in August 2013 to interview Dr. Kaskutas about her research and some of the questions it has raised and answered. Please join us in this engaging conversation.

Early Career

Bill White: Dr. Kaskutas, could you share the story of how you came to specialize in scientific research on alcoholism recovery?

Dr. Lee Ann Kaskutas: Well, I was in a completely different career path. I was in high-tech marketing, travelled a lot, met a guy and fell in love, and didn't want to travel so much. I got this idea that if I went to night school in the middle of the week, then I would not have to be gone from Monday to Friday on these exhausting business trips. There was a class on Wednesday evenings at the Extension Program at the University of California, on the cultural foundations of alcohol and drug policy. It was the first letter of the alphabet in the listing for classes on Wednesday so I took that class. When I turned in my final paper on alcoholism in women, my professor said, "I don't know who you are in those navy blue suits and pearls coming to this class, but you should change whatever it is you do for a living and get a PhD in Public Health doing alcohol and drug research." And I thought: "Whoa, me, a PhD?" I'm a high-tech marketing person, but I thought about it. I was on airplanes a lot because of the travel so I was able to study for the GREs and I did very well. So, even though I was an older woman, I got into UC Berkeley School of Public Health. That's how it all began.

Bill White: That's quite a story. I recall you once saying that in your early career as a researcher, you received advice from others in the research community not to focus on the study of AA and other frameworks of recovery. Did that typify attitudes towards AA and alcoholism-related recovery subjects in the scientific community at that time?

Dr. Lee Ann Kaskutas: Yes it did, and it stayed that way after I got out of school and for the first half-dozen or so years. The sea change was when the Project Match study results were published. It had a twelve-step facilitation condition that was almost like a control group for the

other two behaviorally oriented treatments, cognitive behavioral therapy and motivational enhancement. What they found, to many people's surprise, was that there were not differences between the three treatment approaches in outcomes pertaining to how much people drank, but, when they looked at abstinence outcomes, the twelve-step facilitation condition did better than the other two. With that finding, twelve-step-oriented treatment became a legitimate area of study. That's when the field started to change.

Alcohol Research Group

Bill White: Could you describe the circumstances that brought you to The Alcohol Research Group?

Dr. Lee Ann Kaskutas: Well, that too goes back to that Wednesday class at the Berkeley Extension. We had to do a research paper and the professor told us about the different libraries that were available for use by Berkeley students, and one of them was the library at The Alcohol Research Group. The Alcohol Research Group at the time was in an architecturally protected old house right off campus, and in the basement, they had this fantastic alcohol library and a wonderful alcohol librarian, Andrea Mitchell. I just fell in love with going to this quiet place and reading. They had everything you could ever want to read about alcohol, from old prohibition tracks to old leather-bound newspapers. I just fell in love with the library and that's what led me to ARG. I knew I wanted to work there.

Bill White: For those readers who are unfamiliar with ARG, could you describe what it does and what it was like to work there?

Dr. Lee Ann Kaskutas: Yes. It was loosely affiliated with UC Berkeley and some of the ARG scientists had adjunct professor appointments in the School of Public Health, so there were students constantly coming and going. Then there were the core researchers who, back in the day, did not have to spend all their time writing grants. They had a big center grant that they renewed every five years. They did a big national survey of the nation's drinking, and they did other ancillary studies evaluating alcohol problems and alcoholism treatment at the community level.

Every Tuesday was the advanced alcohol research seminar that was part of the public health training program at UC Berkeley, and that was held at the ARG facility. As a student, you'd get to see famous people in the flesh, whose articles you had read, like Robin Room. And there would be these exciting intellectual discussions around the edges of the seminar. Eventually, I weaseled my way in to having a job as a research assistant.

I remember the day I got that job: I had interviewed with my old boss at the International division of IBM and he had offered me quite a nice salary if I would come back after I got my degree. I got an offer the same day from ARG to work on the alcohol warning label project for all of \$9.50 an hour. I remember thinking, "Yeah, I'm going to take the \$9.50 an hour." My husband, everybody that knew me thought for sure I was going to go back to the jet-setting, high income lifestyle that I had before—but I got hooked on that wonderful library and those exciting intellectual discussions. They were unlike anything I'd ever experienced and I wanted more. I wanted to be a part of it.

Bill White: Were ARG researchers free to choose their own areas of research at that time?

Dr. Lee Ann Kaskutas: More than they are now. They could do more historical think pieces and policy pieces. Over the years, funding has become more competitive and the direction of the institute [National Institute on Alcohol Abuse and Alcoholism] has embraced advances in biotech, medical advancements, and pharmacology. It's become harder and harder to justify the importance to the nation of just doing things that are innovative and significant but not mainstream epidemiological or highly professionalized approaches.

Bill White: You mentioned that your earliest research involved the issue of warning labels on alcoholic beverages. How did that research start and what were some of the conclusions you drew from that work?

Dr. Lee Ann Kaskutas: Well, it started as what you could call a “natural experiment” that happened when Congress mandated that warning labels be put on alcoholic beverages. NIAAA got together with researchers at ARG to come up with a study design that would determine whether warning labels changed peoples’ knowledge, attitudes, and behaviors in relationship to drinking and drinking in various circumstances, such as drinking during pregnancy or drinking while driving. ARG was subsequently funded to compare peoples’ knowledge, attitudes, and behaviors before the warning labels appeared on the containers versus afterwards. We found that there was a change in knowledge and attitudes, but that knowledge was already pretty high. It was much harder to discern if there were any resulting changes in behaviors.

Another thing that I learned from that study was just by looking at what the label said, I noticed that it said something very different in tone and tenor to women compared to men. For the pregnancy warning, it said, “According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects;” whereas the other messages avoided the word ‘should’ and were more educational/informational, less of a mandate—for example: “Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery, and may cause health problems.” I thought, “Well, they seem to be pretty willing to tell women what to do. What’s that about?” That led me to look at the research underlying the Surgeon General’s warning about drinking during pregnancy. I did a critical literature review that found that the recommendation wasn’t really based on the kind of science that would be expected today—or that would have been expected then if it were men’s drinking that they were going to be constraining.

Women for Sobriety Studies

Bill White: It seems like that early research bridged toward your studies on Women for Sobriety (WFS). How did your WFS studies begin?

Dr. Lee Ann Kaskutas: I originally got to study Women for Sobriety through a class at Berkeley when I was getting my doctorate. Like an anthropologist, I attended WFS meetings for months and months and months and got to know the group. And then I wrote a paper about it and I developed a questionnaire that I would use in a fictional study. It was, again, for a course.

The reason I ended up studying Women for Sobriety and doing the first ever membership survey of that group was that my house burned down. I was in the process of doing a

dissertation on alcohol control policy. On the floor of my office at home, I had these piles of articles with a slip of paper on top of each pile, telling me what that pile of articles was about. When my house burned down, I lost all of those articles.

I did not have the moral fortitude to go back to the library to stand at the Xerox machine to get those hundreds of articles. So I thought, “Well, what am I going to do for a dissertation? I’ve done this qualitative work on Women for Sobriety. I’ve got this questionnaire I did for a course. Maybe they’ll let me actually implement the survey if I can figure out a way of doing it with no money.” That’s how I came to study Women for Sobriety. It was an accident—a nice accident as it turned out.

Bill White: What are some of your most vivid memories of your time with women in WFS?

Dr. Lee Ann Kaskutas: It was the openness that their meeting structure allowed. They allow crosstalk, unlike AA meetings and twelve-step meetings, and they allow advice-giving. That format seemed to allow the women to go whole-hog with their stories. There was a lot of patience to let people dominate at the time if the women felt that someone was in need to talk, talk, talk. They would sort of surrender their time and let whoever needed it most have more time.

I remember this one story of a woman who had never really gotten drunk but drank all the time and hid her alcohol in the washing machine. Men would never wash the clothes so that was a safe place for the wife to put the alcohol. It speaks to a time in history, really. Another memorable result is from my survey, which showed that over a third of WFS women also currently went to AA. That told me that even though the women were getting these good things from Women for Sobriety, they weren’t getting enough. They needed something else and that something else was coming from AA. Women went to WFS for support and nurturance, for gender-specific support, for a safe environment that was less formulaic and encouraged more thinking and feedback, and for the program’s positive emphasis on self-esteem and lack of negatives (many did not like the “drunkalogues” in AA). AA was seen as an insurance policy against relapse, and women cited a need for more meetings, which AA’s wider availability offered them.

Bill White: I remember being surprised when I first read your report of that. On the surface, WFS and AA have such different foundational concepts of recovery. I could not see how women could weave those together in a way that made sense.

Dr. Lee Ann Kaskutas: I think they made sense of it in a common sense kind of way. Women for Sobriety offered them something they weren’t getting in AA, and AA offered them something they weren’t getting in WFS. And they were smart. When they went to AA, they didn’t say, “Oh, I go to this other group. I’m not saying it’s an easier, softer way, but it gives me something I don’t get here.” Just like the atheist in AA doesn’t go around saying, “Oh, I’m an atheist, but I use the twelve steps every day in my life.” They do that, but they just don’t talk about it. I think women in WFS are just as wise in using the flexibility that both programs allow them to get their needs met.

Bill White: The early work you did with Women for Sobriety branched into studies of gender-specific addiction treatment. Could you talk about that later research?

Dr. Lee Ann Kaskutas: Yes, I always have been cautious about anything that divides the world into a fixed number of groups, like twelve astrological signs or two genders, and I was always suspicious of whether women's needs in treatment really were that different than men's and whether there was a need for gender-specific treatment. And in our studies of AA members, we would hear that everybody's the same. You're just an alcoholic. It was with that view that I took on the issue of gender-specific treatment. I did a randomized trial, comparing women who were randomized to go to a women's only program versus randomized to go to a mixed gender program. And what I found was that they did equally well in both programs.

Now what that tells you isn't that you don't need women only programs; it tells you that you need choice. Just like the issue of Women for Sobriety versus AA. It's not that AA is better or WFS is better; it's that some people feel they need a choice and that choice is important to them. If people aren't going to go to AA because they don't like it, then they need the choice of alternatives. If women aren't going to go to a mixed gender program because they don't think they can talk about their problems in front of men, then they need that option. So it is a question of utilization rather than a question of efficacy.

Social Model Programs

Bill White: Beginning in the mid-1990s, you had the opportunity to work with Dr. Thomasina Borkman and others to evaluate social model programs in California. What did you find that distinguished the social model programs from other approaches to addiction treatment?

Dr. Lee Ann Kaskutas: Well, first off is the language that you just used in your question. Those social modelists did not think they delivered treatment. They would go to the mat, fighting with the feds and the state funding agencies to say, "No, we are not treatment organizations. We are recovery organizations. We do not do treatment. We provide an environment in which people can recover." And they danced on the head of that pin. At the time when I came to study it, I thought these people were nuts to be fighting a battle about language when they were going to lose it because treatment was what people were going to fund. That was the way it was. So the difference in philosophy reflected in that language is one big difference.

Another difference in the social model approach was their eschewing of paperwork. They did not want to fill out diagnostic questionnaires about patients because they thought that recovery was self-directed and that alcoholism was self-diagnosed. That was another pin whose head they were dancing on, and I thought, "Boy, this is a losing battle. Why would you want to fight that? Of course, you have to do paperwork." But they felt that the paperwork compromised the very basis that they thought represented what recovery was all about. They didn't want to spend ninety percent of their time in the office with the door closed filling out paperwork. They wanted to be in there with the clients. They didn't call them "patients." They called them "clients."

Bill White: You did studies that compared outcomes of social model programs with traditional models of alcoholism treatment. What did you find in those comparisons?

Dr. Lee Ann Kaskutas: Well, I did two different kinds of studies in that regard. One was a qualitative study where a multi-disciplinary team of researchers actually lived in the programs.

They didn't sleep there, but other than that, they lived in medical model and social model programs and then went to their car every hour and made notes. We analyzed those notes and came up with two special issues of the *Journal of Substance Abuse Treatment* and *Contemporary Drug Problems* that talked about how the two models were different in such areas as recovery planning versus treatment planning, and the alumni groups and the volunteerism that you saw in the social model. I was very fortunate to get a clinical trial funded by NIAAA and another by NIDA.

I did two trials for this—medical model (both inpatient/residential and outpatient) versus social model. We randomized people to these different kinds of treatment and then evaluated later the degree of improvement by the treatment condition. What we found when we analyzed the outcomes is that there were no differences in outcome between the people treated in the social model versus the medical model programs except for the ones treated in the one program that we had discontinued due to poor quality of care, in which the outcomes were worse. This told me that the two models of treatment provide the same level of efficacy and that quality can really be an issue within social model programs. It also got me thinking about the performance monitoring debate in the field, and I realized that good observation of what happens in treatment is probably as good if not better than the fancy performance monitoring tools and criteria that the field is substituting for that qualitative judgment of quality based simply on observing treatment.

Bill White: As part of that, you developed an instrument to measure fidelity to the social model of programs claiming to use the social model approach. How did you see the degree of social model fidelity evolve under the broader changes that were going on in the alcoholism treatment field?

Dr. Lee Ann Kaskutas: We were able to do a before and after study of that. I just was fortunate enough to have given questionnaires with the social model philosophy scale instrument over a ten-year period so we could look before and after to see how the social model was changing. We saw some huge, drastic changes that really made sense when you understood what had happened in the treatment system in the United States. These changes included the increased percentages of counselors who became certified, the increased amount of time spent on record-keeping, and the replacement of recovery language with treatment language. Another thing we found was that early on, social model programs did not have a reception area—a desk that people had to pass through in order to enter. They didn't think that was good for an environment of recovery and that you needed to be able to voluntarily come and go without that type of gatekeeper. And over the years, more and more programs, as they achieved funding, created reception areas to screen people. All of these were important changes in drifting from the original social model.

Bill White: Today there is this surge of interest in recovery management and recovery-oriented systems of care and peer recovery support services. Do you see these as a reincarnation of much of the social model programs?

Dr. Lee Ann Kaskutas: Yes. And I see some of the same warning signs that were there all along in the social model versus medical model world that I was studying in the '80s and '90s.

One thing that was a problem then and is a problem now is this hierarchy of counselors where you have people with MFCCs making more money and getting more respect than someone who has—what we call in California—a “CADAC,” which is an alcohol and drug

addiction counseling certification that many people in recovery go through. I think that recovery management and recovery-oriented systems of care are going to face challenges because of the strong professional and medical forces, and the quality control issues, which arise from this hierarchy. There's a good and a bad of the hierarchy, and it'd be really nice if we could take the wisdom that can come from the quality issues that certification gives you without the craziness of a hierarchy that says the knowledge that these people with masters' levels have is better than the knowledge that someone with twenty years in recovery has.

AA Studies

Bill White: Let me take you to your work on the study of Alcoholics Anonymous. Early studies of AA were often criticized for their lack of methodological rigor. How would you characterize the quality of AA research in the past ten to fifteen years?

Dr. Lee Ann Kaskutas: Well, it's a little bit better, but most of it is still based on treatment samples, by which I mean opportunistic studies that are recruiting people when they come into treatment and following them when they leave treatment and looking to see how they're doing to show that treatment works. Part of that ends up with some wise researchers asking about AA and NA and concluding that it seems to help if you go to AA.

The major challenge in this research is that you can't randomly assign people to AA. There was one study that did that, done by Diana Chapman Walsh, then at Harvard. She randomized people to AA versus medical model inpatient treatment and found that the medical model had better outcomes than the AA only treatment. But there was a problem with that study: what do you think the people in the inpatient treatment program were getting? They were being told to go to AA, so even this study was not a pure randomization. There was a confounding, if you will, across the study conditions. You couldn't stop the people in the medical model condition of that study from going to AA after they got out of treatment. And you couldn't force the people who'd been randomized to go to AA to actually go there. So, it's really very hard to do good studies of AA that follow the gold standard of randomized trials that we have with medical treatment in the United States.

Bill White: What conclusions have you drawn from your own studies about the relative effectiveness of AA as a framework for long-term recovery?

Dr. Lee Ann Kaskutas: What I found is that if you look at people's AA participation over a number of years, you find a group that goes to a lot of AA in their first year in recovery. Within the people who go a lot that first year, you see some people continuing to go to a lot of meetings for 5 years (let's call them "high" AA), and you see another group that cuts their meeting-going over time to where it's almost nil at the study endpoint ("declining"). Then you see another group that never really went to a lot of AA meetings, but they stuck with it the whole five years at a modest attendance rate ("medium"). Then you see another group that really didn't go much at all ("low"). At the 5-year follow-up, 46% of those in the "low" group were abstinent, compared to about two-thirds being abstinent among the "medium" group and among the "declining" group. For the "high" group, 79% were abstinent at year 5. So this tells me three things: (1) yes, ongoing high levels of meeting attendance yields the highest rate of abstinence; (2) many people seem to be able to figure out how much AA they "need" over time, and it isn't

always a lot, forever, since we saw similar rates of abstinence regardless of being in the “declining” or the “medium” group; and (3) some people really do seem to be able to achieve abstinence without much AA exposure. This really speaks to the issue of people deciding how much they need and figuring that out and then wanting to stay sober, getting reinforcement from the good things that come with recovery and still maintaining their meeting level attendance at the level that they decide they need.

Bill White: A special level of interest of yours and some of your ARG colleagues is the effects of AA helping on recovery outcomes. Could you describe what you found in some of your studies about the influence of helping on recovery outcomes?

Dr. Lee Ann Kaskutas: Yes. If you look at the different kinds of helping activities that people in AA get involved in, you’ve got stuff like listening to another alcoholic, giving them advice about how to stay sober, how to work the program, and then you have other kinds of helping like watching somebody’s dog when they have to go to a medical appointment, bringing food to someone who’s sick, volunteering to be the umpire for your kids’ softball team, or working as a volunteer somewhere. What we found was that people new to recovery spent a lot of time doing the recovery-oriented helping. You don’t see a lot of the dog-sitting, babysitting, feeding the sick, and volunteering. But with people with five or more years in recovery, we saw an increase in those broader helping activities in the community. They’re morphing their helping into the broader community, which I really love because it speaks to this stigma of being an alcoholic and that recovery is linked to the kind of volunteering that we as a nation would hope people would do. You know, they’re being good citizens, which is something that the Betty Ford Institute Panel a couple years ago said was an aspect of recovery.

Bill White: One of the challenges that treatment programs have long faced is how to best link treatment to recovery mutual aid. You’ve done some work on developing a protocol for that called, “Making AA Easier.” Could you describe MAAEZ?

Dr. Lee Ann Kaskutas: Yes. And I need to describe it in tension with the other approaches to twelve-step facilitation that exist and that have been proven to be effective. These other approaches are effective, but they are very different than what *Making AA Easier*, MAAEZ, is. I have some definite opinions about what treatment programs should and shouldn’t do in terms of linkage to AA, and I’ve gotten some real push-back from AA scholars whose work I enormously respect who don’t agree with me on my positions. I don’t think we should ask AA to do anything for any study. And I don’t really think we should ask AA members to put their names on a list of volunteers that a treatment program can call and ask them to meet somebody at a meeting, even though those have been found to be effective linkages. They’re only effective for people in new recovery. They haven’t been found to be that effective in people who are the recidivists, which is most of the people in treatment. I really think scientists need to stay the heck away from trying to tell AA what to do and trying to exploit the AA community in its service.

I also feel strongly that treatment programs can’t do as good a job of teaching people how to work the steps and what the AA program is about as the AA members can do. So, it was with that mindset that I developed *Making AA Easier*. The whole focus of MAAEZ is not to get people to go to a lot of meetings. It’s not to get them to work the steps. It’s not to get them to buy into the program. It’s to get them to be genuinely comfortable with the people that they’re going

to meet at those meetings and get them comfortable with sitting in the meetings and hearing what they are inevitably going to hear. The homework assignments in MAAEZ include things like get to a meeting early and talk to somebody. Another homework assignment is to get a telephone number of an AA member and call them. Another is to ask somebody to be your temporary sponsor. I feel that this is conceptually quite different than having the treatment program be the one to enlist the aid of AA members to help the client engage in AA—which seems to work for newcomers, but not for recidivists. Recidivists benefit from doing it on their own.

Another interesting thing is that MAAEZ participants were more comfortable speaking at meetings than those in the control condition, even though MAAEZ had not had homework assignments that asked them to say something at a meeting they attended. There is something about just getting comfortable with the fellowship, with the people in the program, which seemed to engender being able to participate actively in a meeting.

I think that recovery, to stick, needs to be self-directed. People need to be able to reach out to the people in AA and feel comfortable in those chairs; the MAAEZ sessions and homework assignments help achieve that.

Bill White: Lee Ann, where can our readers get more information about *Making AA Easier*?

Dr. Lee Ann Kaskutas: Well, the manual that they use to lead the group is available for free on our website at www.arg.org (to be exact: <http://arg.org/downloads/arg/MAAEZ.Manual.pdf>). They could also e-mail me (lkaskutas@arg.org) and I'll send them the manual.

What is Recovery Study

Bill White: Your latest major study is one that I think will be one of the most challenging and illuminating of your career. Could you describe this study for our readers?

Dr. Lee Ann Kaskutas: Yes, and the tactic I take with the study will not surprise those who've read this far in the interview. Several government agencies and expert panels have been convened to come up with definitions of recovery. I was on one of those expert panels, and when I was invited to the panel, I thought, "Wow! Why are experts defining recovery? What do we know? You need to ask people in recovery to define recovery." But, turns out, that was a minority opinion. So I wrote a grant arguing that we needed to go to people who were living recovery in order to know what the heck it was. I was fortunate to get a grant funded to do a web-based survey of how people in recovery define recovery.

The study has several phases, beginning with qualitative interviews with many people in recovery in which we said, "Hello. How do you define recovery in your own words?" We then turned those early findings into items we put on a web survey that 9,000 people have now completed. They include people who go to AA, people who don't go to AA, people who go to Women for Sobriety or Life Ring, and people in natural recovery. We have people who don't even use the term "recovery"; they say, "I'm recovered" or "I'm in medication-assisted recovery," or "I used to have an alcohol or drug problem, but don't anymore." What we're doing now is analyzing data from the survey to publish the results. We also received supplemental funding to recontact the respondents who gave us permission to contact them for follow-up studies. Six thousand of the 9,000 agreed to do this, so this will be the largest longitudinal study of recovery ever to happen! We will update our study website as soon as we can, to share those

results with our study participants, study partners, and the interested public. Our website is <http://WhatIsRecovery.org>

Bill White: What were some of the major obstacles that you faced conducting this study?

Dr. Lee Ann Kaskutas: I'm really sorry to have to say it, but it does need to be said: The biggest obstacle was dealing with the AA community. You can tell based on what I said before about MAAEZ and the social model that I did not feel comfortable going to AA meetings to recruit for the study. But we had AA members, "friends of the study" I would call them, who didn't agree with that. They wanted to go to meetings and make an announcement at the meeting about the study. I wanted to recruit ten thousand people, so why would I turn down that kind of help, right? Well, I didn't turn it down, but I also didn't sanction it. I really begged them to be cautious and respectful and to mention the study after the meeting rather than during the meeting. This part went really well, so I guess I was wrong about being against this form of recruitment.

On the other hand, another AA-related recruitment effort was disastrous! AA has this website where you can attend online AA meetings, and chat rooms where you can also post comments. I had been told by another AA researcher that I ought to contact them since other studies had in fact recruited participants using that site. So, against my own better judgment, desperate to follow all possible avenues for reaching representative groups of individuals in recovery, I reluctantly went to the webmaster, explained my study, and asked if I could put a notice on their site. I got his approval to make a several-sentence statement about the study on their site (which included a link to the "What is recovery?" study's website). Within hours of that statement being approved by them and put on the web, I started getting really caustic, negative comments posted on their site. People were saying that the study was a violation of the Traditions... that nobody needed to come up with a definition of recovery... that people in recovery know what it is and that's good enough. I talked to the webmaster about it, and he decided to try one more time to explain the study because he thought it was worthwhile. Of course, a few comments were posted defending the study; but in the end, the caustic comments and what-not were such that they took my post off the site. This was a discouraging low point of the study for me.

Bill White: Which really underscores the challenges of doing this kind of research. Is it too early to be able to say what the profile was of the people in recovery who participated in the study?

Dr. Lee Ann Kaskutas: About twelve percent of participants came from alumni groups of treatment programs. Sixteen percent came by word of mouth. Twelve percent came from self-help groups: people in AA, Women for Sobriety, Life Ring, etc. who heard about the study and told their friends about it. Twelve percent came from recovery organizations, like the Vermont Recovery Organization. A quarter of the sample came from social media and Faces and Voices of Recovery, and another quarter came from unknown sources. In terms of ethnicity, we got primarily white people, which I hated because we really tried to work with Hispanic groups and Hispanic TV. We worked with African American church groups and radio programs and just didn't do a good enough job to reach the people of color who are in recovery. I'm very disappointed in myself by that. Half of the people said that alcohol was their drug of choice. In terms of pathways to recovery, we have a lot of people who have gone to treatment, others who have only gone to 12-step groups, as well as people who didn't go anywhere ("natural

recovery”), and people on medication-assisted recovery. We will be putting this information up on our website any day now (<http://WhatIsRecovery.org>).

Bill White: What do you see as the potential import of the study?

Dr. Lee Ann Kaskutas: Well, I’ve lost hope that anything I publish will really make a difference. But with that caveat, I would hope that word would spread via presentations that I give and that others give who know about the study, and from our study website, that people in recovery really are the kind of people that you want your son to marry or the one you want to be on the bench as a judge and that there is long, long, long-term recovery out there. I hope to shine a light on people who are long sober and not just sober but living this changed life. I’m hoping that it will reduce the stigma, although it might sound arrogant for me to say that, for which I apologize to the readers.

Career Reflections

Bill White: You’re one of only a few scientists who have been able to make a career focused on recovery-related research. How were you able to accomplish this?

Dr. Lee Ann Kaskutas: Boy. Could good luck be the answer? But you’d say, “you’ve done a lot of studies—how could you have been lucky all those times?” So, I must be doing something right. I don’t know that I have the distance from it yet to really know. I can tell you what characterizes my work. I don’t know if that’s why I’ve been able to get funded to do this creative research. I just don’t *do* things that are not interesting to me or that I don’t think need to be studied. There’s a lot of stuff I could get funded to do, but I haven’t written those grants because I just don’t want to do that with my life energy. So I just stick with trying to do what I am interested in doing in the most creative, innovative way I can. There are so many wonderful, significant, innovative ideas that I haven’t yet been able to explore. That just breaks my heart because I know that they would move the field forward. I do feel lucky that some of them have gotten funded.

I think that what characterizes my studies is that they’re crazy hard to do with ridiculously difficult samples to recruit, and they require both qualitative and quantitative research and multi-disciplinary teams. I have benefited enormously from my NIH project officers at NIAAA and NIDA; these are people who make recommendations about and oversee research grants. My project officers have appreciated that my research studies are significant and innovative but are also very hard to pull off, and they have gone to bat for me more than once. I really do sympathize with treatment professionals and the ways of doing this thing called treatment or recovery. I try to keep the people on the front lines in the back of my mind with every sentence of the grants I write.

Bill White: What aspects of your work have been most personally meaningful to you as you look back over your career?

Dr. Lee Ann Kaskutas: I think it’s when the providers come up to me and thank me for my work. It’s nice to know that researchers read my papers and that key people in government agencies maybe read my papers. (You never know about that one.) I hope that the providers,

when they hear about the studies I've done—on AA's effectiveness, the social model, MAAEZ, or recovery—feel that this work matters.

Bill White: What people have been most influential in shaping the content of your work and mentoring your work?

Dr. Lee Ann Kaskutas: Well, Robin Room would come to mind as number one. Second would be Connie Weisner. Other influences would be Mike Hilton, who is now at NIAAA, Keith Humphreys, with whom I collaborated in my early career, Rudy Moos, whose work is awesome, and Thomasina Borkman and Tom McLellan. I don't always agree with everything those people say, but they have been important influences.

Bill White: What advice would you have for an upcoming professional who wanted to pursue recovery-related research?

Dr. Lee Ann Kaskutas: To keep the science strong and to avoid couching their findings in advocacy positions. If they find themselves making a sentence with their mouth that's not based on science, then they need to make it their business to go and find out whether what they're thinking is true before they go around saying it. I think if they stay close to the science and keep their ear to the ground understanding the realities of the system in which the treatment field has to function, they have a chance. Whenever I drive by these treatment programs, I always am reminded of the struggles going on in there with clients who are not always going to be motivated. Inside those buildings, counselors and others are doing what some would call "God's work." It's important that research scientists work respectfully with those helpers and their clients.

I know I just said that young researchers need to stick close to the science. But at the same time, they need to be critical readers and consumers of the science, making sure that they are 100% confident that the methodology used in the study they are reading was sound, that the results are sufficient in magnitude and staying power to warrant their confidence and enthusiasm, and that the idea can truly be integrated into the delivery system.

In preparing for this interview, I asked two people whom I have mentored whether there is anything I ever told them in the advice-giving department that stuck with them as helpful. One woman said that she valued my advice about having a back-up plan in case something didn't turn out because that made her realize that it would be ok if something failed. She also appreciated my support for more radical ideas (like studying treatments that go against the mainstream or digging into an established literature whose conclusions don't make common sense). Another woman said that she had appreciated my advice that she shouldn't forget to take the road less travelled if she felt passionate about what she was doing. But these kinds of innovative, against-the-grain studies we're talking about, they have to be stronger methodologically because they will come under the magnifying glass even more than mainstream study ideas.

Bill White: Do you see the emerging environment as one with increasing interest in recovery research?

Dr. Lee Ann Kaskutas: I don't know. Given President Obama's health care reform and parity for behavioral health care, it could be. There are powerful lobbies for the more medicalized and

professionalized side of what we call recovery; I think it is going to be an uphill battle still to expand recovery research. The science really has to be strong, and it has to occur in the context of the reality of the nation's limited resources. I hope we can remember the volunteerism that comes from AA involvement. We're seeing in our study of recovering people that there is something out there for the nation if we can get people into recovery. If people can get themselves into recovery, it could make this country a better place and help recovery get on the map in a bigger way, in turn reducing the stigma associated with having had an alcohol or drug problem.

Bill White: As a final question, do you have a short list of studies that you would really like to do before you finish your career?

Dr. Lee Ann Kaskutas: There really aren't, but there is a list of studies I'd like to see *other* people do. One thing that I have never gotten involved in is the criminal justice population. They have so much against them and they're asked to do so much by society to re-enter. I wonder if there's a way of making MAAEZ for them so that when they are getting ready to get out of prison, they could go through a MAAEZ that was customized for them that would help them become genuinely integrated into the twelve-step community. I don't think MAAEZ would necessarily work for them the way it is right now. That's an empirical question. I'd like to see somebody study that, see what needs to be changed, and change MAAEZ for this population. I'd also like to see a way of making MAAEZ be available as a stand-alone treatment for people who are just not going to go to treatment for whatever reason. Just have them go to six 90-minute MAAEZ sessions and then evaluate its effects.

Bill White: Dr. Kaskutas, thank you for taking this time to review some of the highlights of what has been a wonderfully productive career.

Dr. Lee Ann Kaskutas: Bill, thank you for this opportunity.

Acknowledgement: Support for this interview series is provided by the Great Lakes Addiction Technology Transfer Center (ATTC) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.

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