

## **Addiction: Alcohol and substance abuse in Judaism**

By

Kate Miriam Loewenthal

Royal Holloway, University of London  
Glyndwr University, Wales  
New York University in London  
Heythrop College, University of London  
c.loewenthal@rhul.ac.uk

### **Abstract.**

This article outlines a brief history of rulings and beliefs about addiction in Judaism, covering alcohol and substance use and addiction. It examines patterns of use, abuse, dependency and addiction and whether and how these relate to beliefs and practices among Jews. Some conclusions will be suggested about the impact of religious rulings and of other factors on addiction among Jews. Therapeutic practices and organisations will be described.

### **Biblical and rabbinic rulings, past and present: the concept of addiction**

What are and what have been rulings and beliefs about addiction in Judaism concerning alcohol and substance use and addiction?

This article will focus on alcohol and substance use and abuse; it will not be spread to explicitly include the many other forms of addiction and dependency such as gambling, pornography and the internet, which are now said to haunt the Jewish community. Alcohol's appearance in the biblical text places the history of its use to be almost as old as the history of the human race: Noah's drunkenness and its sequelae are significant features of the early part of the book of Genesis (Gen 9: 20-27), and the biblical text has a clearly condemnatory attitude regarding Ham's role in causing this drunkenness. Subsequent Jewish laws and customs are not difficult to discover. Although excessive alcohol consumption is discouraged (for example by officiating priests in the Temple) (Lev 10:9), alcohol consumption for religious reasons is prescribed (for example sanctifying the Sabbath and festivals), wine in moderation is praised as a something that "gladdens the human heart" (Psalms 104:15) and drunkenness on selected (very rare) occasions may even be encouraged (for example for the festival of Purim). Thus Judaism supports and prescribes the controlled use of alcohol [1]. This has been suggested as an explanation for the overall lower levels of alcohol use and abuse among Jews [1-5].

However it should be noted that a genetic basis for alcohol intolerance has also been noted among some Jews [6]. The protective genotype is less common than the unprotective genotype, and among older Jews in Israel, among whom alcohol consumption is low, genotype was not related to a measure of anticipated alcohol consumption. Among younger Jews, genotype did have a protective effect, with anticipated alcohol consumption among the genetically unprotected exceeding the threshold for risky and unsafe drinking [7]. This work suggests that environmental influences promoting higher levels of drinking can be modulated by genetic factors. But where the norms of alcohol consumption are low, genetic factors were unrelated to anticipated alcohol consumption. This implies that Jewish religious rulings, norms and social attitudes about alcohol consumption have probably played at least as important a role in regulating alcoholism as genetic factors. Although genetic protection can

have an effect, only a minority of Jews are so protected, and the effect may only be apparent when group norms of alcohol consumption are high. In the past and among the older generation, genetic protection may not have played a role: norms and customs based at least partly from religious sources were the source of Jewish moderation with respect to alcohol. .

Jewish and rabbinic views on the use and abuse of opiates and other mood- and mind-altering substances have emerged much more recently. These views follow the development of substance abuse in countries with Jewish communities, and also the subsequent outlawing of many forms of substance abuse. There has been some suggestion that Jews played some role in the scientific and legislative response to substance abuse; this will be described.

There are no biblical references to the use of such substances, in contrast to alcohol which is frequently referred to. The use of opiates and other addictive substances without medical prescription and supervision is now illegal in most countries, and this is a comparatively recent historical development. Opium use has been known for at least two thousand years, and was widespread and problematic in eighteenth-century China, when the substance was controversially imported from India by British merchants to raise funds to buy the tea to which the British had developed a strong attachment. Laudanum, diluted opium, was a popular over-the-counter panacea in nineteenth-century Western society. It was widely used for pain relief, to soothe cranky babies, and cheerfully endorsed as a means of enhancing creativity and literary sensitivity among the educated classes. The best-known of many famous users was Queen Victoria [8,9]. With respect to other well-known substances, Freud was an enthusiastic cocaine user [10]. Mariani wine (diluted cocaine) was said to be used by and endorsed and used by popes in the nineteenth century, and Coca Cola's original secret ingredient was cocaine (removed in 1903). The most addictive opiate, heroin, was derived from morphine, and innocently (naively) marketed at the beginning of the 20<sup>th</sup> century by Bayer as a substance that could wean opium and morphine addicts from their addiction. There was some strong disapproval of opiate use in some quarters – Gladstone was a noted opponent – but generally, opiate use was socially acceptable. However by the late nineteenth century there was concern about the effects of both alcohol and opiate use and abuse on the workforce [9]. In the Western world, legislation simply controlled the sale and consumption of alcohol, whereas the sale and consumption of opiates became illegal.

However the early twentieth-century introduction of legislation designed to make the sale and use of addictive drugs illegal did not stop the spread of potentially addictive substances. As in China nearly 200 years earlier, the spread was ensured by compulsive demand from addicts enabling stupendous profit margins to providers. It has been suggested [11] that medical scientists played a major role marginalising and repressing drug addicts in the early twentieth century. German and Russian medical writings in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries constructed drug addiction as a social problem related to modernity, capitalism - and Jewishness. These writings had an anti-semitic tone, making Jews responsible for addiction among other social and economic problems. Jewish scientists attempted to respond to these allegations, addressing the issue of addiction, constructing projects for social change, also for improving Jewish health, and generally trying to reshape Jewish identity. The overall effects were the marginalisation and repression of drug addicts. In Vassilyev's view [11] anti-semitism and the Jewish scientific response played an important role in developing current policies towards drug addiction, in spite of the lack of effectiveness of these policies.

The above account contextualises current perspectives of drug use as illegal and morally wrong. 120 years ago, although there was some disapproval, the “problem” of drug addiction

was not apparently as serious and as widespread, or normally defined as problematic, and so we cannot meaningfully search for pre-20<sup>th</sup> century rabbinic opinion.

Current rabbinic opinion centres around two fundamental general principles in Jewish law. First, that life and health must be protected. The health risks of excessive alcohol consumption and substance abuse mean that no rabbinic authority will be found to condone these behaviours, although medically-sanctioned use for health and life-saving are of course rabbinically sanctioned. There is also an important principle that Jews should obey the laws of the country they live in (where these do not conflict with Jewish law) : *Dina d' malchusa dina* – the law of the land is the law (incumbent on Jews) (see the Talmud e.g. Baba Kama 113a, Baba Basra 54b,). The importance of self-control has been endorsed by many rabbis, and extended into the widespread rabbinic endorsement of Twelve Step programmes [12 -14]. Among secular professionals, addiction is currently recognised as a disease (for instance by the American Medical Association and the American Psychiatric Association).

The rabbinic view offers a shift of emphasis: though rabbinic sources regard addiction as something over which control might be achieved, addiction would appear to straddle the divide between wrongdoing and illness: sin/wrongdoing and insanity are both regarded as spiritual illness (*choli nefesh*).

Parallels have been drawn between Maimonides' laws of repentance (*teshuvah*), R. Yonah of Gerona's Gates of Repentance, and the Twelve Steps [12]. There are marked similarities, Glass argues. The Twelve Steps and the rabbinic guides to repentance all advocate acknowledging ones failings and taking a careful inventory, asking for forgiveness, making reparation and resolving not to repeat the failings. But there are differences between the Twelve Steps and Jewish views on repentance: the Jewish sources take it as given that the Jew is a believer, whereas the Twelve Steps involves becoming a believer. The possible difference might be resolved by the view that belief and faith must be in a continual process of strengthening and development by all people, addicts or not, Jewish or not. A further possible divergence between the Twelve Steps and Jewish views is that in Jewish eyes the Twelve Steps could appear to advocate over-reliance on divine power, including the abdication of responsibility [12]. However it has been argued that generalised faith in divine power is consistent with Judaism, and certainly does not mean abandoning free will and personal responsibility [12]. Indeed, as mentioned above, there is general rabbinic endorsement for the Twelve Steps approach to alcohol and substance addiction [12-14].

Complementing all this is a rabbinic view that those who become addicted are (through no fault of their own) particularly prone even before they start to imbibe alcohol or illicit drugs. An orthodox rabbi working with addicts in a Jewish rehabilitation facility, endorses this view, arguing against viewing addiction as the result of moral failing or as a mental illness and strongly supporting the spiritual approach behind [15].

Another suggestion, from a group working in an orthodox Jewish rehabilitation centre, is that addicts suffer from splits, for example between affect and logic: here there is a divorce between (mis)behaviour and feelings of responsibility [16]. For example feelings - cravings to use illicit drugs - "taking over" even though the individual knows all along that what they are doing is wrong. In the Jewish rehabilitation centre, Jewish teachings are used with the Twelve Steps to enable spiritual awakening, direction and control. Twerski is an orthodox rabbi and a psychiatrist, working with substance addicts. He also points to splits and contradictions in the behaviour and thinking of addicts, permeating the sense of self-worth,

for example the eminent specialist – a substance addict – who was terrified when delivering a public lecture for fear that he would be criticised, even though he was an internationally respected expert in his field [13].

So far, we have seen that traditional Jewish religious sources support the controlled use of alcohol. Since substance addiction is a relatively recent phenomenon, there are no traditional religious sources on this but there is current widespread rabbinic interest and activity focussed on support and therapy. The most noteworthy feature of this interest and activity is a general endorsement of the Twelve Steps approach to recovery from addiction.

We turn now to the question of the extent to which alcohol and substance abuse have occurred and do occur in Jewish communities.

### **Prevalence**

There are particular difficulties in discovering the prevalence of alcohol and substance abuse and addiction in the Jewish community. Chief among these is denial. For example, in 1962, it was reported that alcoholism and drug addiction were “entirely absent” in the Jewish community in the USA [17]. 33 years later there was a 1995 report of zero prevalence of alcoholism in an epidemiological study of stress and psychiatric disorder the UK Jewish community [18]. These reports may well indicate the existence of some denial.

A further difficulty in estimating prevalence is that studies vary in whether they report point prevalence, lifetime prevalence, or prevalence over some other period. They vary on whether they report on use, dependence, abuse or addiction, and on which substances are investigated.

Awareness of Jewish alcoholism in the USA began to develop in the 1970s, and the possibility of dual dependency was acknowledged in the 1980s. However support groups in the 1980s were finding it near-impossible to book accommodation for their activities in synagogue premises: there was continued denial of the existence of addiction in the Jewish community [12].

In 1997 massively lower prevalence of alcohol abuse/dependency was reported among Jews in the USA compared to those with other religious preferences. For instance lifetime prevalence was 11.1% (men) and 3.4% (women) among Jews, compared with 28.7% and 8.5% [19] among those of Christian background. Some recent studies have reported a rise in both alcohol and recreational drug use among younger Jews [7,19]. Some or all of this reflects a genuine increase, which may in turn be driving a need to report problems and seek help, which may be reducing denial.

15 or 20 years ago users of the UK Jewish drugsline were peripheral to the main Jewish communities: users were described as marginal individuals [21]. Now users are reported to come from throughout the community, including the orthodox and strictly orthodox. There may have been Jewish addicts who would not have used a Jewish drugsline for fear of their problems becoming known in the community. This fear may have reduced in the previous two decades.

Few or no studies of substance abuse have been reported among the American Jewish population, with no national prevalence data [22]. However there are Israeli data: the lifetime prevalence of reported illicit drug use in Israel is 13%, while about 1% of Israelis meet the

DSM-IV criteria for drug abuse/dependence, which is similar to that reported in the USA [20]. Prevalence estimates in the USA range from 2-6% [23]. There are reports of a number of trends and group differences in illicit drug use in Israel. For example there has been growth in the number of drug-related offences since the 1960s, and in reported drug use, a possible decline in “hard” drug use accompanied by a growth in the use of inhalants. Groups with higher rates of illicit drug use include immigrants, men, the secular, and victims of terrorist attacks [20].

Lower lifetime and current rates of substance abuse are reported in Israel than in France among adolescents, but among adults, lifetime prevalence is similar in the two countries.

These rather variable reports and estimates are the survivors of the methodological difficulties and variations mentioned above. We can provisionally conclude that:

- Alcohol and illicit drug addiction do currently occur in Jewish communities and rates are said to be rising.
- Rates may have been lower than in other groups but it is difficult to be confident about prevalence since denial is said to have occurred in the past and may still occur.

### **Community beliefs and attitudes**

There are about 13 million Jews worldwide, about 0.2% of the world’s population. About 5 million Jews are in Israel, 6 million in the USA, and the remainder mainly in Europe (chiefly Russia, France and the UK) with some in South Africa, Australia and elsewhere. In Israel and the UK, about a quarter of affiliated Jews consider themselves (strictly) orthodox, about 60% traditionally orthodox and the remainder non-orthodox. In the USA the proportions of strictly and traditionally orthodox are lower, and the proportions of non-orthodox (Reform and Liberal) are higher. Numbers of unaffiliated Jews are hard to estimate, but may be relatively low. Among the orthodox, there is strict observance of the dietary, marriage and other laws relating to religious observance. Most strictly orthodox live in religious communities and send their children to Jewish religious schools. Exposure to the media is limited – television, cinema, theatre, fiction reading and internet use are tightly restricted and controlled. Jewish community cohesion is high especially among the orthodox. Community beliefs may be relatively homogenous and the influence of religious leadership relatively strong. Although alcohol and substance abuse have risen in recent years, community boundaries have delayed these trends. Traditionally orthodox Jews normally have orthodox leaders, but individual religious practice and belief can vary greatly and community boundaries are much more permeable than among the orthodox. Media use is unrestricted by rabbinic prohibitions. Although community boundaries and religious leadership have less impact among traditional and non-orthodox Jews, and media use is not restricted, there can be a strong sense of community, with strong social ties, and factors such as respect and groups norms are likely to influence alcohol and drug-related behaviour – and its reporting.

Until relatively recently, those who initiated and worked on the UK Jewish drugsline (Rabbi Aryeh Sufirin, Chava Sufirin and others [21, 25] ) reported that community beliefs reflected the conclusion that substance abuse and indeed alcohol abuse were not problems in the Jewish community, but they were seen as problems in the host society. Jewish community members believe that “we are supposed to be better” Jews hold more pejorative beliefs about alcohol use than do Protestants [26], and excessive drinking was considered to be an out-group characteristic by the Jewish community [1]. Jews reported negative stereotypes about

drinking and drunkenness among the rest of (non-Jewish) society, while people of Protestant background were more likely to say that alcohol enabled relaxation and a reduction of worry and tension [3]:

*'It's something that non-Jews do generally therefore it is frowned upon in the Jewish community' (Jewish man);*

*'If you do go to the pub, you expect that there will be a lot of drunk people around and beer flying' (Jewish woman);*

*'It can lead to abuse or to violence...it can cause husbands hitting wives...destroying furniture, things like this...attacking wives and children' (Jewish woman);*

In contrast:

*'People want to enjoy themselves and perhaps put problems to the side' (Protestant man);*

*'I find a drink might relax me' (Protestant woman);*

*'It drowns your problems' (Protestant woman).*

When the existence of addiction within the community came to the attention of some community social service agencies and leaders, attempts to set up services and to educate children via community schools met with denial that there were problems that needed addressing [21]. Parents were reluctant to allow their children to be exposed to information about the dangers of substance abuse because it believed that children would not otherwise learn about the existence of recreational drugs; having informative sessions might “put ideas into their heads” [21]. One orthodox rabbi stated that he “would be surprised if parents of teenage kids were willing to admit that there is even a need to teach their children about it”. Aryeh Sufrin, working on addiction support, said that recreational drug use probably took longer to penetrate the Jewish community, particularly the strictly orthodox (chareidi) section, but that security and stability have been eroded over the past two decades – with an accompanying growth in recreational drug use and abuse. Moreover exposure to media is somewhat greater than in the past, and addiction can be conveyed as a glamorous problem in the media. Substance and alcohol abuse, gambling and other addictions are now significant problems [25]. But denial that the community has a problem is still evident. Fear of stigmatisation is evident in this community and there is reluctance to admit to both communal and individual difficulties, whether these relate to alcohol or drug abuse, mental or even physical health:

*“People can't know I'm struggling” (Drugline user) [25]*

*“I wonder what type of families need this? Is it just those who can't cope? I might feel ashamed to ask for such help?” (Orthodox Jewish woman talking about community support services in general [27].*

*“One problem is stigma and the related problem of confidentiality. In a small closed community like this, these are difficult issues”. (Co-ordinator of a Jewish community support group) [27].*

A salient feature of stigmatisation – for whatever reason it occurs – is that it is believed to affect the chances of all family members gaining admittance to the more prestigious religious educational institutions [25], the marriageability of family members [28], and possibly employability in some religious communal roles.

Chava Sufrin, as experienced community support worker reported that the prevalent belief about causes of addiction among lay members of the Jewish community is that it is self-inflicted, not a disease [25]. However if a family member is known to be addicted, then family members will feel guilt, shame and self-blame, often alongside a paradoxical but

common initial response is to blame everyone and everything else. Eventually with effective support, families will usually assume responsibility for supporting their addicted relative. However the belief that addiction is a disease may be held by some users. This belief makes users resistant to programmes such as Cognitive Behaviour Therapy (CBT) or the Twelve Steps programme in which beliefs and habits must be controlled and changed [25].

Of course many or all of these beliefs may be held in other religious and social groups, but some may be particularly marked in Jewish communities. In particular, denial has been widely noted, although said to be decreasing.

Signs that community denial is being eroded include a recent edition of a popular orthodox-Jewish women's magazine on addiction, which included strong assertions that the Twelve Step programmes for alcohol and substance and other forms of abuse are not only kosher for Jewish use, but are the most effective and appropriate [29]. Other articles gave attention to ways in which "co-dependents" (typically spouses) might alter their behaviour and attitudes [28-31], and all advocated the importance of strengthening connections to the divine and becoming aware of the spiritual strength that comes from this [32].

In summary, collective beliefs and attitudes are slowly changing from denial that alcoholism and drug addiction are problems for the Jewish community. As it becomes evident that these problems are apparent – perhaps particularly among the younger generation – denial is becoming less total. Stigmatisation is still a problem and may inhibit help-seeking.

### **Relations of religious rulings to behaviour in the community**

There is negligible systematic study of the ways in which religious rulings on alcohol and substance abuse actually affect behaviour. Some of the possible effects have been alluded to and there are others.

First, there is some evidence that rabbinic rulings are followed by many, with respect to many behaviours. To take some obvious examples, kosher food shops and restaurants, synagogues and religious educational institutions, ritual baths and many other institutions and businesses are well patronised indicating the observance of the dietary laws, and prescriptions regarding prayer, religious study and other behaviours are commonly and normatively observed among the orthodox. As noted, over half of the Israeli and UK Jewish populations are strictly or traditionally orthodox, and aware of many rabbinic recommendations. Specific examples include the observation that beliefs about the causes and treatment for depression were generally reported to follow rabbinic guidance [28], and the observation that orthodox Jewish women reported strenuous efforts to follow rabbinic guidance to avoid idle gossip and speaking badly of others [33].

Overlying this general tendency – especially among the more orthodox - to follow rabbinic guidance is a marked tendency to develop and maintain a perfect image and reputation. This may help to keep some doing the right things and might partly account for the possible lower prevalence of addiction among Jews, but it also helps to account for denial.

Denial has been widely noted, and failure to acknowledge addiction issues prevents or delays help-seeking. A facet of denial is the belief that the Jewish community or religion "protects us from the scourge of drugs, alcohol or gambling". As described by one rabbi, this

dangerous belief “makes dealing with the issue more difficult as people are lulled into a false sense of security”.

Rabbi Aryeh Sufrin who initiated the UK Jewish drugsline noted enormous difficulty even ten years previously in being allowed to speak to Jewish school children about the dangers of recreational drugs [21]. Initially many schools and parents felt that to allow such information to be offered would be to put ideas into the heads of children/teenagers. Jewish drugsline workers indicated that to an increasing extent they were being allowed and welcomed into Jewish schools to improve awareness [21].

Another very striking effect reported was the lack of distinction made by orthodox Jewish drug users between more and less significant failings. Thus is that if one someone has committed a minor religious transgression, they may be in danger of branding themselves as an outcast, henceforth allowing themselves to enjoy all kinds of forbidden indulgences. So for instance one might allow himself to try a non-kosher candy – and from then on might-as-well try marijuana and other substances. This can be a common path into substance abuse in the orthodox Jewish community [25].

It can be suggested therefore that observance of rabbinic rulings by many may help to account for the possible relatively low prevalence of alcohol and substance abuse. But the downside of this is the need to maintain a perfect image and the readiness with which individuals and communities have been practising denial. Stigmatisation is also a feature of community beliefs. The realisation that alcohol and substance abuse do happen in the Jewish community has facilitated the support now generally offered by communal leaders for preventive educational programmes and religiously-appropriate treatments.

### **Organisations, centres and helplines.**

It is often acknowledged that minority groups – including Jews – may feel more comfortable in treatment programmes that are sensitive to cultural and religious values [27, 28].

A number of helplines, and residential and non-residential addiction treatment programmes have sprung up in the last two decades, offering support to Jews (and sometimes to others). These include:

- Norwood (formerly Chabad) Drugsline, London UK  
<http://www.norwood.org.uk/Page/Norwood-Drugsline>
- Gateway Rehabilitation Center Pittsburgh USA  
<http://www.gatewayrehab.org/>
- Beit T’shuvah Synagogue Recovery Center, LA, California, USA  
<http://www.beittshuvah.org/>
- Chabad Residential Treatment Center, Los Angeles, CA, USA.  
<http://www.chabadrehab.com/>
- Jewish Recovery Center, Florida, USA  
<http://www.chabadrehab.com/>
- Jewish Center for Addiction: Prevention, Help and Hope, Chicago, USA  
<http://www.jcfs.org/node/91>
- Addiction helpline, Torah and the Twelve Steps: JewishDrugRehab.org  
<http://torahtwelvesteps.org/>

- JACS: Jewish alcoholics, chemically dependent persons and their families: friends and associates encouraged and supported to explore recovery in a nurturing Jewish environment.  
[www.jbfc.org/JACS](http://www.jbfc.org/JACS)

Many of the Jewish rehabilitation centres and agencies above involve orthodox rabbis as central figures. These rabbis have a strong sense of mission: they do not seek specifically orthodox Jewish clients; they do offer Jewish spiritual teachings (sometimes kabbalistic) and some practices to clients as appropriate, in the expectation that these will inject a spiritual dimension and sense of purpose into the lives of their clients. Beit T'shuvah for example takes approximately one-third of its clients from those who have been ordered to take treatment somewhere, and who have elected to go Beit T'shuvah; one-third are there as an alternative to a prison sentence, and the remaining one-third are entirely voluntary. The Twelve Steps are often endorsed and followed.

Expectations are often said to be fulfilled but quantitative outcome studies are still awaited.

## Conclusions

Addiction is stigmatised in Jewish community, as it emerges from decades of denial that alcoholism and drug abuse are not Jewish problems. Rapid social change and electronic communication are factors that have contributed to the increased consumption of alcohol and recreational drugs within the Jewish community, including enclave strictly orthodox (chareidi) communities. Responses include educational initiatives to alert school children to the dangers of recreational drug use, and helplines and treatment programmes, both residential and non-residential. The Twelve Steps approach is widely supported, and generally argued to be consistent with Jewish spirituality.

## References

1. Barry Glassner, and Bruce Berg. "How Jews avoid alcohol problems." *American Sociological Review* 45 (1980): 647-664.
2. Kate M. Loewenthal, Andrew K. MacLeod, Susan Cook, Michelle J. Lee, and Vivienne Goldblatt. "Beliefs about alcohol among UK Jews and Protestants: Do they fit the alcohol-depression hypothesis?" *Social Psychiatry and Psychiatric Epidemiology* 38 (2003): 122-127.
3. Kate M. Loewenthal, Andrew K. MacLeod, Susan Cook, Michelle J. Lee, and Vivienne Goldblatt. "Drowning your sorrows? Attitudes towards alcohol in UK Jews and Protestants: A thematic analysis." *International Journal of Social Psychiatry* 49 (2003): 204-215.
4. Charles R. Snyder. *Alcohol and the Jews*. Carbondale and Edwardsville: Southern Illinois University Press, 1978, 244.
5. P.P. Yeung, and S. Greenwald. "Jewish Americans and mental health – Results of the NIMH catchment area study." *Social Psychiatry and Psychiatric Epidemiology* 27 (1992): 292-297.

6. Michael V. Osier, Andrew J. Pakstis, Himla Soodyall, David Comas, David Goldman, Adekunle Odunsi, Friday Okonofua, Josef Parnas, Leslie O. Schulz, Jaime Bertranpetit *et al.* "A global perspective on genetic variation at the ADH genes reveals unusual patterns of linkage disequilibrium and diversity." *American Journal of Human Genetics* 71 (2002): 84–99.
7. Baruch Spivak, Amos Frisch, Ziyona Maman, Efrat Aharonovich, Donald Alderson, Lucinda G. Carr, Avraham Weizman and Deborah Hasin. "Effect of *ADH1B* genotype on alcohol consumption in young Israeli Jews." *Alcoholism: Clinical and Experimental Research* 31 (2007): 1297–1301.
8. Martin Booth. *Opium: A History*. New York: Thomas Dunne, 1996, 381.
9. Frank Sanello, and William T. Hanes. *The Opium Wars: The Addiction of One Empire and the Corruption of Another*. Aurora, IL: Sourcebooks, 2002, 336.
10. Howard Markel. *An Anatomy of Addiction: Sigmund Freud, William Halsted and the miracle drug Cocaine*. New York: Pantheon Books, 2011, 314.
11. Pavel Vasilyev. *Poisons of Civilization, Remnants of Capitalism, or Jewish Disease? Drug Addiction in Russian and German Medical Texts from the 1870s to the 1930s*. Munich, Germany: Grin Verlag, 2010, 72.
12. Carol Glass. "Addiction and recovery through Jewish eyes." In *Addiction and Spirituality: A Multidisciplinary Approach*, edited by Oliver J. Morgan and Merle Jordan. Danvers, MA: Chalice Press, 1999, 235-247.
13. Abraham Twerski and Craig Nakken. *Addictive Thinking and the Addictive Personality*. Center City, Minnesota: Hazelden, 1999, 288.
14. Kerry M. Olitzky, and Stuart A. Copans. *Twelve Jewish Steps to Recovery, 2nd Edition: A Personal Guide to Turning From Alcoholism and Other Addictions-Drugs, Food, Gambling, Sex*. Woodstock, VT: Jewish Lights Publishing, 2009, xxiii 113.
15. Shais Taub. *G-d of our Understanding: Jewish Spirituality and Recovery from Addiction*. Jersey City, NJ: Ktav Publishing, 2011, 186.
16. Charles D. Blakeney, Ronnie F. Blakeney, and K. Helmut Reich. "Leaps of faith: the role of religious development in recovering integrity among Jewish alcoholics and drug addicts." *Mental Health, Religion & Culture* 8 (2005): 63-77.
17. Kate M. Loewenthal, Vivienne Goldblatt, Tessa Gorton, Guy Lubitsh, Helen Bicknell, Deborah Fellowes, and Amanada Sowden. "Gender and depression in Anglo-Jewry." *Psychological Medicine* 25 (1995): 1051-1063.
18. Leo Srole, Thomas S. Langner, Stanley T. Michael, Marvin K. Opler, and Thomas A. C. Rennie. *Mental Health in the Metropolis: The Midtown Manhattan Study*. New York, NY: McGraw-Hill, 1962, xii 428.
19. Itzhak Levav, Robert Kohn, Jacqueline M. Golding, and Myrna M. Weismann. "Vulnerability of Jews to affective disorders." *American Journal of Psychiatry* 154 (1997): 941-947.
20. Yehuda D. Neumark and Hadar S. Schwartz. "The epidemiology of drug use and dependence in Israel." In *Psychiatric and Behavioural Disorders in Israel: From Epidemiology to Mental Health Action*, edited by Itzhak Levav, Jerusalem: Gefen Publishing House, 2009, 131-148.
21. Arieh Sufrin, and S. Mervish. "The road to addiction." Paper presented at the Jewish Mental Health Forum Seminar, London, June 2014.
22. Shulamis L.A. Strauser. *Ethnocultural Factors in Substance Abuse Treatment*. New York: Guilford Press, 2002, 447.
23. Marc Galanter, and Herbert D. Kleber. *Substance Abuse and Treatment, Fourth Edition*. Arlington, VA: American Psychiatric Publishing, 2008, 595.

24. Cecilia A. Essau and Franz Petermann *Developmental Psychopathology: Epidemiology, Diagnostics and Treatment*. Amsterdam, The Netherlands: Harwood Academic Publishers, 1997, xv 479.
25. Chava Sufrin. "Supporting addiction in the Jewish community." Unpublished interview, London, March 2014.
26. Shoshana Weiss, and Michael Moore. Perception of alcoholism among Jewish, Moslem and Christian teachers in Israel. *Journal of Drug Education* 22 (1992): 253-260.
27. Kate M. Loewenthal, and M. Brooke Rogers. "Culture sensitive support groups: how are they perceived and how do they work?" *International Journal of Social Psychiatry* 50 (2004): 227-240.
28. Joan E. Bayes, and Kate M. Loewenthal. "How do Jewish teachings relate to beliefs about depression in the strictly orthodox Jewish community?" *Mental Health, Religion and Culture* 16 (2013): 852-862.
29. Zalman Nelson. "An addict in the family." *N'Shei Chabad Newsletter* 43 (June-July 2014): 52-56.
30. Abraham Twerski. "When kindness is misguided". *N'Shei Chabad Newsletter*, 43 (June-July 2014): 58-59.
31. Shais Taub, "Should I be my husband's mashgiach?" *N'Shei Chabad Newsletter* 43 (June-July 2014): 60-63.
32. Deb Hirschorn. "Addiction and the Neshamah. *N'Shei Chabad Newsletter* 43 (June-July 2014):64-65.
33. Lewis Glinert, Kate M. Loewenthal, and Vivienne Goldblatt. "Guarding the Tongue: A thematic analysis of gossip control strategies among orthodox Jewish women." *Journal of Multilingual & Multicultural Development* 24(2003): 513-524.