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COMMENTS

“Alcoholics Anonymous as Treatment and as Ideology”; Comments on the Article by R. E. Tournier

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Demonstrating scientifically that Alcoholics Anonymous helps alcoholics is about as hopeless as showing scientifically that radical mastectomies cure cancer of the breast.

The rockbottom requirement for such proof consists of random assignment of matched patients to different modalities with a follow-up of the patients over adequate periods and agreement about definition of recovery. Recently, such a study was attempted with regard to radical mastectomy, but the study was so flawed that the conclusions could not be trusted. Surgeons simply will not consent to participate in such a study because they are convinced that radical mastectomy is superior to simple mastectomy, lumpectomy, radiation or any combination or nothing. They are convinced because they have performed the operation on many women and many recover.

This comes under the category of clinical impression, not science. There are a number of histological types of breast cancer, each with a different natural history and outcome. Even those types with the direst outcomes sometimes smolder along for years and the patient may die of old age before she dies of breast cancer.

The same problem exists in evaluating Alcoholics Anonymous. It is inconceivable that believers in the efficacy of A.A. would consent to participate in a randomized study. They have *seen* A.A. work. To deny an alcoholic A.A. would be viewed as close to criminal. There have been a few attempts to compare treatments for alcoholism by random assignment of patients. Results have been inconclusive because many alcoholics have decided in advance what kind of treatment they want and nowhere is there a law that prevents them from seeking out this treatment.

Some treatments for diseases are so effective that controlled studies with random assignment are not necessary. Penicillin for pneumococcal pneumonia is an example. However, with alcoholism it is clear that

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no single approach produces the miraculous cures attributed to penicillin. I personally believe that A.A. works. I personally know alcoholics whom I believe could never stay abstinent, even briefly, without A.A. But I repeat: this is clinical impression, and if the history of medicine tells us anything, it is that clinical impression may not always fit the facts.

I believe that Tournier (1) has written a balanced and sophisticated evaluation of A.A. without diminishing by a jot what I believe both he and I agree upon: A.A. does indeed work with many individuals where nothing else will. I have one little caveat of my own to add; it bears on the controlled drinking controversy.

I can understand the emotionalism generated by this issue, but consider it unfortunate. As I recall, Davies actually had his life threatened when he found in a study (2) that a few alcoholics seemed to manage their drinking with some degree of control. A fanatical attachment to A.A. may be necessary for some members to find A.A. successful for them personally, but as an organization (to the extent it is an organization) I would hope that fanaticism and dogmatism would have little place.

In many A.A. groups, I know personally that they have little place. Not all A.A. members are antidisulfiram, antipsychiatry or antiananything that seems to help. None of these other approaches, in truth, is incompatible with A.A.

Back to my caveat, with which I will close. It has to do with the self-fulfilling prophecy inherent in the drumbeat of repeated assertions that "once a drunk, always a drunk." Translated: if you drink at all, it is inevitable that sooner or later you will go on a gamma-like spree. This is said frequently at A.A. meetings, and doctors often tell alcoholics the same thing. The effect, it seems to me, could easily be that once the alcoholic, for whatever reason, slips and has a drink, a kind of resignation occurs in which he says to himself, "Well, there I've done it! I've had that one drink. I might as well go ahead and enjoy myself and go all the way."

For many alcoholics, the situation may indeed be all-or-none. But for others, going all the way may not be inevitable; and if going all the way does occur, it may result more from a self-fulfilling kind of brain-washing than from some powerful innate force.

Since this is a touchy subject, I must repeat what I said. I send all my alcoholic patients to A.A. During their clerkship in psychiatry, our medical students attend open A.A. meetings as part of their training. I believe A.A. helps many individuals, and I regret very much that we will probably never be able to demonstrate scientifically that what seems self-evidently true is indeed true.

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The success of Alcoholics Anonymous as a social movement and ideology is beyond dispute, and its influence on the alcohol field, as discussed by Tournier (1), has been extremely pervasive. One interesting aspect of the growth of A.A. and its highly committed constituency has been the persuasive force of A.A. members and supporters in generating federal attention to and support for alcoholism treatment services. That support, in turn, has been an important factor in (1) prompting the identification of a broader range of individuals in need of treatment services, (2) supporting research to determine the nature of alcohol problems, and (3) promoting the development of innovative treatment approaches. Paradoxically, the knowledge derived from these activities can now be perceived as threatening the dominance, and perhaps even the viability, of the A.A. organization.

Although some would contend that the issue of alternatives to abstinence is the main source of this threat—surely it has been a focus of controversy—it is our contention that the real source of the threat goes far beyond treatment goals. More specifically, the continued sovereignty of the A.A. ideology is threatened by the rapidly increasing body of knowledge about all aspects of alcohol problems, including the identification of populations in need of services. The problem is most serious since it can be interpreted as intimidating the multitude of recovered alcoholics whose present philosophy of life centers on a rather literal allegiance to A.A. precepts. The threat will not recede, because it is largely founded on empirical evidence. Therefore, some kind of accommodation to these changing times seems imperative if A.A. is to remain viable. This being the case, how then can the viability of A.A. be preserved?

As Tournier has concisely stated, the role and influence of A.A., which have probably far exceeded those ever envisioned by its founders, must be redefined to serve those for whom it is most valuable and to accept the coexistence of alternative approaches. Also, for the welfare of potential members of A.A., it is important to determine the extent to which group membership can serve a treatment function for various types of persons having various types of alcohol problems. Clearly, there are a great many persons who attribute their recovery to joining A.A., but there are untold numbers of others who are reluctant to undergo the A.A. conversion experience. In some cases, this hesitancy may indeed reflect a process of denial or subliminal motivation to continue drinking. In such cases, perhaps alternative methods of treat-

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ment may be found to be more effective in encouraging those individuals to seek help. In other cases, however, such persons may not wish to identify with or accept the A.A. ideology and accompanying changes in lifestyle which seem to be necessary for full participation in the A.A. program. Such a stance need not be judged pathological; it can represent a rational decision. Moreover, there are serious problems involved in attempting to apply A.A. concepts to deal with early problem drinkers, individuals having serious psychopathologies in addition to alcohol problems, the young and various other populations.

In sum, it is ethically imperative that we determine for whom A.A. can be most helpful, for whom it has little value and for whom it may even be detrimental. In the end, evaluations can only benefit clients. If popular assertions regarding the efficacy of A.A. as a treatment are valid, then the results of such evaluations are likely to be supportive and persuasive. Furthermore, well-designed evaluations can be conducted without presenting a threat to the anonymity of A.A. members, as the preservation of participants' privacy and confidentiality is a stringent requirement for almost all current evaluation studies (certainly for all those directly or indirectly supported by federal funds or conducted by accredited programs). If A.A. is to be proselytized as an effective treatment, as has been clearly advocated by many, then its efficacy should be documented with the same degree of scientific scrutiny applied to other treatment programs. Since the A.A. organization has been gathering its own data in massive quantities during recent years, it can hardly be argued that allowing the implementation of soundly designed controlled investigations would violate A.A. traditions. But perhaps the most curious aspect of the present lack of evaluative data concerning A.A.'s effectiveness as a treatment is that there is little reason to believe that the results would be other than positive.

Although the gathering of data regarding A.A. efficacy would meet the ethical necessity of determining what types of persons can benefit most from participation in A.A., it would not resolve the matter of how the organization can remain viable in the face of evidence contradicting certain basic tenets of its ideology. And a viable organization is prerequisite to making its benefits available to new members. One can speculate that there are several ways in which the organization can retain its vitality, but its strengths must be based on those factors which are separate from the accumulating scientific evidence. Similarly, they must be consistent with empirical findings, lest the organization's credibility erode. Some of the many possible ways by which this strengthening accommodation might be achieved are enumerated below:

1. The steps and traditions of A.A. appear to provide a reasonable model of recovery for many and to resist corruption within the organization. Thus, they should be preserved. Perhaps this would best be accomplished by emphasizing a view of the prototypic A.A. alcoholic history and recovery process as an analogy rather than a reification. Admittedly, many A.A. members and advocates already adopt this orientation. However, it is too often the case

that some individuals, especially those working in treatment programs and as counselors, insist on a literal interpretation of the Big Book.

2. The value of A.A. as a nondrinker alliance should be stressed; perhaps the greatest asset of A.A. is that it is an effective social and altruistic fellowship. Regardless of personal values, for the foreseeable future the nondrinker must live in a predominantly drinking society. There is safety and comfort in the fellowship of others who share similar difficulties, values and successes.

3. There must be a recognition in practice that A.A. cannot be all things to all people with all varieties of drinking problems. The target population for A.A. needs to be better specified, and indiscriminate evangelistic recruiting of anyone who has any sort of drinking problem should be discouraged. In particular, there should be no derogation of those individuals, particularly problem drinkers, who choose to follow a different drummer in their attempts to recover. Currently, an individual who has recovered from alcohol problems and is able to drink without incurring adverse consequences faces a colossal task in convincing others of his or her recovery. To a large extent, this popular attitude of suspicion can be viewed as an unfortunate consequence of the pervasive influence of the A.A. ideology. Certainly such individuals are entitled to the same social acceptance and equity as those who achieve a purposeful abstinence.

Perhaps even the aforementioned suggestions will be viewed by some as threatening. Speaking from our own orientation, many of the threats perceived by A.A. members and their defenders seem to be exaggerated or based on misinformation. We and others who have been involved in research which has resulted in empirical findings contradicting A.A. concepts have made extensive efforts to be cautious and judicious in our generalizations. Furthermore, we have explicitly recognized that A.A. plays an important role in the treatment of many with alcohol problems. However, it is now imperative that the populations which can benefit from A.A. be identified and that the over-all treatment efficacy of A.A. be explored—not just as a solitary intervention, but also in combination with other approaches.

For the reasons cited above, we are greatly concerned that the viability of A.A. be maintained. Nevertheless, it seems clear that the strength and credibility of the organization can only be preserved through a recognition by A.A. leaders and A.A.-allegiant treatment providers that while the organization serves a vital function for its members, it cannot continue to do so by excluding other views and treatment alternatives. Such a change in orientation may be difficult to implement, but it is surely preferable to the credibility crisis which is likely to occur in the absence of such changes.

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Andreski (1) and others have documented how frequently social scientists have published sheer nonsense in the name of "science." This is certainly true in the field of addiction, and in 1974 I expressed my concern about the increasing number of "unqualified and inexperienced individuals leaping into the field of alcoholism" (2). My concern has in no way been lessened by reading the Tournier article (3).

Tournier's main theme is that Alcoholics Anonymous has somehow blocked adequate reliance upon other therapies, especially those aimed at "controlled drinking." The author does state that for the gamma alcoholic "controlled drinking is probably an inappropriate goal." If Tournier indeed believes this, it is odd that he cites the work of the Sobells as being significant to his argument. The Sobells explicitly state (4, p. 54) of their experiment in controlled drinking that "all subjects meet the criteria of Jellinek's (1960) gamma alcoholics." Does Tournier then mean that the Sobells are pursuing "inappropriate" goals? Or did Tournier not read the Sobells very carefully? Or does he question their classification of their own experimental sample?

The author fails to clarify his position when he identifies those he considers to be most appropriate candidates for controlled-drinking therapy. He states that abstinence may not be a realistic goal for "non-addictive alcoholics." Most workers in alcoholism treatment would consider this phrase to be a contradiction in terms. An "alcoholic" is today defined by most people in the field as being addicted. In his classic work, Jellinek (5) included under the "genus" of alcoholism several nonaddicted "species." He later regretted having stretched the definition of alcoholism so thin, but he believed himself locked into his earlier terminology. He did indeed then lump together under the term "nonaddictive alcoholics" those species who showed no biological dependence on alcohol. But, significantly, he added (6): "Strictly speaking, the disease conception attaches to the alcohol addicts only." By general agreement the word "alcoholic" is today taken to mean addict, and nonaddicted overdrinkers are referred to as "problem drinkers," "alcohol abusers" or "excessive drinkers." To include these under the category of "alcoholic" would produce an overdiagnosis, making all communication and research meaningless (7). If Tournier is referring to problem drinkers, no reasonable person would deny the possibility that controlled drinking might help their condition.

However, Tournier introduces other dimensions into his thinking that do not leave his opinions so clearly discernible. Apparently as an equivalent of "nonaddictive alcoholics" he uses the phrase "early-stage (nonaddictive) alcoholics." By using the term "early-stage" the author

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obviously implies that there are later stages, and therefore he accepts the concept that alcoholism is "progressive." As he thanks A.A. and the National Council on Alcoholism (N.C.A.) "for leading the battle to define alcoholism as a disease," he seems to accept the disease concept, i.e., addiction, somewhere along the line of the alcoholic's progress. If he implies that late-stage alcoholics are addicted, then an early-stage nonaddicted alcoholic would be one so diagnosed before he or she shows any symptoms of the disease. This is much like diagnosing malaria before the patient has been bitten by the mosquito.

On the other hand, if Tournier is really rejecting the disease concept entirely, he is following the behaviorists' dictum that alcoholism has no biological correlates and is merely a naughty habit. If this is his intent, he has ignored or dismissed the massive and competent research on the medical and biological aspects of alcoholism. It would be nice if the behaviorists' claim were validated and it were reliably demonstrated that alcoholics can be turned into normal social drinkers. If this were the case, we would have millions upon millions of alcoholics conditioned into quite normal drinkers. Since this is not the case, could it be that behaviorists' therapeutic skills fail to match the assurance of their theoretical pronouncements?

It is interesting that Tournier urges controlled drinking when he admits that it is possible to "question the adequacy" of many of the experiments in this area. At the same time, he states that if we are to persist in using A.A. "we must do so as the result of an objective appreciation of its impact." He then demonstrates that no methodology exists for an objective evaluation of A.A. His implication is obvious. Because he lacks the ability to document A.A.'s considerable success, Tournier questions its validity, but he makes sweeping undocumented statements such as "there is a sizable body of evidence which suggests . . . that . . . A.A. [is] limited in its general effectiveness." He does not identify any of this evidence.

Further, Tournier makes a number of far-flung authoritative statements on what members of A.A. think, and these seem to be based on nothing but his intuition. He certainly fails to document these omniscient statements. In fact, Tournier fails to understand the nature, structure, functioning or influence of A.A. He erroneously sees A.A. members as constituting a "lobby" dedicated to "proselytizing" their ideas as "the voice of the alcoholic" and "spokesmen for the victim." In fact, acting as part of A.A., no members have anywhere constituted a "lobby." Far from proselytizing, A.A. policy is based on "attraction" rather than "promotion." In no place and at no time has A.A. claimed to represent all alcoholics. In fact, far from being the tightly organized, efficient, powerful and monolithic organization that Tournier describes, A.A. is a weak confederation of independent chapters. "A.A. has no real government. Each group is free to work out its own customs and ways of holding meetings, as long as it does not hurt other groups or A.A. as a whole" (8). These words are from the General Service Conference Board, which is the closest approximation A.A. has to an offi-

cial voice. This board has no means to discipline members or force them into a united stand. In fact, members of A.A. are notoriously independent in their opinions. Therefore, unless one samples the total A.A. membership, the only way to cite A.A. positions is to cite the General Service Conference Board. All of the board's publications seem to contradict Tournier's opinions of how A.A. members think and act.

Tournier seems to see A.A. as trying to obstruct, block or disrupt all other alcoholism therapies. In fact, the official position is "that A.A. members not criticize, obstruct, or hinder any other efforts to help alcoholics" (9). Further: "Anything that works toward the recovery of the alcoholic is good, and this includes hospitals, rehabilitation centers, state or provincial alcoholism centers, religion, and psychiatry—as well as A.A." Far from claiming to have a monopoly on truth, the board states (9), "Saying 'we know the *only* way to recovery' is an egotistical luxury we can no more afford than we can afford resentments." Indeed, the board sees the alcoholic as needing more than A.A. (9): "A.A. wants to work in cooperation with the professional and all other sections of the community in doing our part in the total circle of help needed around the alcoholic. We can fulfill only one role: providing the A.A. program of recovery."

Tournier objects to A.A. because, he claims, it blocks the identification and early intervention needed to get alcoholics into treatment. If, in his own vocabulary, Tournier means that A.A. members are not personally involved in getting the nonaddicted heavy drinker (i.e., "the nonalcoholic") into therapy, he is correct. "Official" A.A. literature states (8) that "A.A. concentrates on helping those who are already alcoholics." The reason for this, states the same source, is that "no one has discovered a way to prevent" alcoholism. Further, Tournier states that while A.A. "officially" no longer sees a "low bottom" as essential for recovery, that in fact "the survival of such a bias in older members seems to have facilitated its perpetuation in those for whom they have served as role models." This is another of the author's totally undocumented conclusions. In fact, I have recently interviewed a large number of "high bottom" alcoholics, and can assure Tournier that they are not a rarity. The mere fact that there are many young members of A.A. seems to contradict Tournier's statement.

While the formal A.A. literature does not support Tournier's claims, I undertook a quick sampling in Santa Barbara, California, (population under 80,000) to see to what extent other treatment modalities were in conflict with A.A., Al-Anon and N.C.A.—the last two, by Tournier's definition, being identified with A.A. in that they accept alcoholism as a disease. Tournier states that "the fellowship of A.A. is felt to extend to all those who share its philosophy." Obviously, some members of A.A. think the way that Tournier says all members of A.A. think. However, I found no direct or indirect attempts by members of A.A., Al-Anon or the N.C.A. to block reliance on any modality for treatment of alcoholism. Further, within the past 3 months, the A.A. central office referred 21 alcoholics to the residential alcoholism unit in Pinecrest

Hospital, which uses a wide variety of techniques; 5 to the Farmhouse, a residential recovery home; 16 to Detox in San Luis Obispo, a general 15-day program beyond detoxication; and a few individuals to Wings of Love, the Rescue Mission and the Salvation Army. In the same period, the local N.C.A. chapter referred 37 persons to A.A., another 70 to other treatment modalities, and conducted 36 interventions. Many, but not all, members of A.A. have been supportive of this intervention program. On the other hand, members of Al-Anon have been almost totally committed to supporting intervention. Despite Tournier's words, A.A. is not a static, homogeneous, closed-minded organization. Anyone who looks at A.A. objectively will see a varied membership and a dynamic and changing philosophy and orientation that are increasingly becoming more and more open-minded.

It is true, as Tournier observes, that most members of A.A. are opposed to controlled drinking experiments. This stand is not based on whimsy but on a vast shared experience with alcoholism and those who profit from it. As a whole, A.A. members have witnessed endless amounts of suffering, agony and death as a result of their disease. They know that the sanctioned administration of alcohol to alcoholics can produce unending misery and death. Tournier seems to dismiss lightly the idea that one should not "take chances with people's lives" in these experiments because the idea of risk is merely "A.A.-rooted ideology." Those with more experience and concern do not take the danger as lightly. Faillace and his colleagues (10) stated in 1972 that "investigators, when undertaking this kind of research, have to consider carefully the ethics of giving a potential toxin to human subjects, especially when this is not a traditionally accepted form of treatment."

To date we have absolutely no evidence that there exists anywhere an acceptable therapy that can condition those addicted to alcohol to become normal social drinkers. The A.A. experience that abstinence is the only reliable road to sobriety is not only common sense but is backed up by evidence far too massive to be cited here. However, Adolf J. Sullivan, past president of the Association of Labor-Management Administrators and Consultants on Alcoholism, has stated,² for example, that the over-75% success rate of business, industrial and union recovery programs would be impossible if they did not rest on a philosophy of abstinence. The Navy program also uses abstinence as a base for its very successful program (11). Reputable research by qualified individuals usually fails to duplicate studies like the Sobells' or those listed in the "Rand Report" (12). Ewing and Rouse (13) have failed to achieve the success in controlled drinking experiments claimed by the Sobells. In the résumé of their findings, Ewing and Rouse stated, "Based on our experiences with these patients and a long term follow-up, we have concluded that, in our hands at least, further attempts to inculcate controlled drinking by such methods are unjustified." More recently, Paredes (14) is apparently failing to replicate the successes re-

² Personal communication.

ported by the Rand Corporation: "at the present state of our knowledge I would recommend total sobriety." Further, many are concerned by the public news splash achieved by studies like the Rand Report. Such overly optimistic reports, no matter what their intent, are sure to encourage many alcoholics to continue drinking rather than to seek valid help. As far back as 1963, in regard to the Davies study (15), Bell (16) stated: "Until we are in a position to predict who may be able to resume moderate controlled drinking, clinical studies of this kind should be carried on with a minimum of publicity. Otherwise, the health and safety of a great many people could be seriously jeopardized."

Bell raises the ethical issues involved in the whole spectrum of controlled drinking experiments. These issues must be raised. The chances of conditioning an alcoholic into being a normal social drinker seem to be about the same that would be encountered in trying to teach a penguin to fly. Such experiments are a dangerous business, and they do indeed urge life-threatening behavior on alcoholics. If these attempts must continue, I think they should be labeled for what they are: extremely hazardous experiments rather than merely harmless alternative treatment modalities. Any financing or sponsoring agency should insist on adequate safeguards to protect the lives and well-being of the human subjects. It should also be mandatory that such experiments be overviewed by a neutral ethics committee which would not only safeguard the rights, including confidentiality, of the alcoholics, but also check for accuracy of reports on the experiments. This ethics and validating team should have full and unrestricted access to the data and the human subjects themselves for a period of at least 5 years.

I am afraid that my concern with the welfare of alcoholics in such experiments will be dismissed by Tournier as "vilification." Further, he may add that he really does not support controlled drinking for addicted alcoholics but only for his "nonaddicted alcoholics." If so, I do not know why he wrote the article. He could have summed up his thesis by saying, "Therapy for addiction is not necessarily the most appropriate approach for those who are not addicted." On this point, at least, I agree with him completely.

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Tournier (1) is to be commended for bringing this discussion into public scrutiny, though his views may not be acceptable to all. Presumably, he has experienced some scientific or professional rebuff that stimulates him to write so provocatively. Many of us have experienced such conflicts with a strict interpretation of Alcoholics Anonymous and will undoubtedly do so in the future. However, my own views are not so pessimistic, and I do not feel so thwarted by A.A.

In fact, over the years I have found most A.A. members, especially those who work in treatment programs, to be quite receptive to psychiatric concepts. The "bleeding deacons" who accept only the most dogmatic positions are seen rarely today, in my experience. This degree of receptivity, however, requires a courteous and respectful exposition that does not challenge the other person and also allows for the professional's learning from A.A.

When considering A.A. as a treatment, Tournier is correct in stating

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we really do not know its effectiveness. Like most interventions, it is probably very helpful to a third of its members, less helpful to another third and of no help to the remaining third. Bill C. (2) agreed with this in 1965, and surveys by the General Service Board of A.A. (3) do not significantly refute this estimate. Even greater need for modesty is required when we consider that we do not know how this compares with "spontaneous recovery." However, we do not have evidence that other forms of treatment (if it is proper to consider A.A. as treatment) are significantly superior. The "Rand Report" (4) suggests that better results are obtained with a mixture of A.A. and professional treatment than with either alone, in which case they are about equal.

One of the great problems in studying treatment effectiveness stems from our tendency to give every patient a "treatment smorgasbord" which washes out any evidence of treatment specificity. The great unanswered clinical research question is which treatment is best for which patient. Tournier believes A.A. may impede our finding the answer to that question.

My experience with A.A. has varied depending upon the arena. In my involvement with public programs, the "A.A. lobby" has been very strong but not domineering. While the expressed desire for professional input has initially been ambivalent, after trust is established the desire is sincere. Given the problems of political survival, the vocal support of A.A. has been essential to keep programs alive. On occasion I have been concerned when politicians have taken advantage of this support to suggest that only A.A. is necessary (because it is so cheap!). At that point, in my experience, A.A. members have objected to that interpretation.

In the private treatment sector, which is where my major involvement lies, I have long encouraged and relied upon A.A. as an integral part of the program for my patients. I would not make A.A. mandatory, but would urge its acceptance to whoever would listen. It has been unusual, in my experience, to find serious conflict between psychotherapeutic treatment, even disulfiram, and the A.A. program. The point is not to be competitive but cooperative.

As ideology, A.A. has the potential to interfere with the introduction of new ideas since it is very conservative in its views. That is not all bad, because it tends to prevent sudden cultists or unproven techniques from gaining temporary dominance. It is bad, however, if it stultifies innovative thinking. Whatever the ultimate value of "controlled drinking," that segment of the alcoholism treatment field that is strongly A.A.-oriented did not make a very good impression with its rather hysterical response to the Rand Report. However, when I served my four-year term on the Alcohol Research Review Committee of the National Institute on Alcohol Abuse and Alcoholism, I did not sense that basic and clinical research was being hampered unduly by A.A. as an ideology.

It seems to me that there is so much more for us to do and so much more for us to learn about alcoholism that there is plenty of room for A.A. and plenty of room for other ideas and scientific disciplines. I

am confident that when real and solid "truths" emerge, the field will open up and allow them in.

I would urge us not to injure A.A. by demanding it be a scientifically oriented organization. Self-help groups and movements survive by dogma and faith. The scientific method of doubting, testing and self-scrutiny is anathema to such groups. Tournier certainly does not suggest that we change A.A. or abandon it, and with that point I am in total agreement.

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Robert Tournier (1) seems to argue that Alcoholics Anonymous so dominates the field of alcoholism that its teachings have assumed the force of dogma and anyone who proposes an alternative opinion runs the risk of being denounced as a heretic. Among the fundamental teachings of A.A. are that (i) alcoholism is a single condition rather than an umbrella term for a variety of pathological drinking behaviors, each requiring its own type of intervention, (ii) recovery can begin only after the individual has reached a state of despair and has hit bottom, and that (iii) abstinence is the essential first step along the road to recovery. The authority of A.A. persists despite the fact that this organization reaches only a small proportion (perhaps 5%) of those with drinking problems and that its proven rate of success is much lower than is popularly believed. Tournier suggests that the preeminence of A.A. philosophy has the effect of keeping early-stage alcoholics from seeking help, as well as impeding the advance of new treatment approaches, such as the use of conditioning techniques to achieve con-

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trolled drinking. As if frightened by his own audacity, Tournier is careful not to criticize A.A. too severely. He ends his paper by stating that this organization still has a vital role to play but that this should not stifle the development of alternate strategies to deal with the whole range of drinking problems.

A.A. is one of an expanding number of self-help approaches aimed at changing pathological behaviors, such as overeating, underexercising, excessive nervousness, smoking and the misuse of alcohol and other drugs. A number of these groups (e.g., to achieve weight loss or the control of smoking) have expanded into highly profitable, nationwide business enterprises. While many of these self-help organizations have degenerated into quackery or even outright fraud, some seem to do a pretty good job and may well have a higher success rate than that achieved by professionals (2). The development of this "alternative health care system" has been explained as a reaction to the "official system," in which treatment is provided in hospitals and clinics by highly trained professionals, with the patient relegated to playing a rather passive role in his own care.

To my mind, there exist fundamental differences between the professional and lay approaches to the care of a disability. The philosophy (belief system) of a lay group usually develops out of the personal experiences of its founding fathers whose charisma draws people to them. Help (salvation) comes from identifying closely with the group and by assiduously following its teachings. Failure comes from deviating from the established truths, and individual interpretation is strongly discouraged. The scientific approach, by contrast, is to be suspicious of dogma and to seek change through dispassionate testing of hypotheses. The scientist who studies a disease process examines the various forces at work at the same time and measures their relative importance. Treatment, therefore, cannot be applied in a stereotypical way but would vary according to the diagnosis and the needs of the individual patient (3).

When Tournier criticizes A.A. for its doctrinal rigidity, he is really contrasting the scientific and the lay approaches to treatment. In many aspects of health care (e.g., the treatment of infections, cancer, heart disease) the scientific approach is now the dominant force, but it is still less than certain that professionalism and the scientific methods have improved the treatment of alcoholism beyond what self-help groups can achieve. The recent and highly important paper by Edwards and his colleagues (4) makes us question seriously whether the lengthy and expensive treatment approach to alcoholism that is offered throughout the Western world is really better than simply offering the patients some advice. I have little doubt that when the scientific community comes up with a cure for alcoholism, we will rapidly see its adoption and the equally rapid demise of all the dogmas and make-shift "treatments" that now characterize the field. Unfortunately, that day still seems far away.

In spite of all the public information about the evils of alcohol mis-

use and the value of early intervention, it remains a fact that relatively few alcoholics voluntarily seek help until their condition is well advanced and has entered a chronic stage. (Alcoholics can be coerced into treatment at an early stage of the illness, through employee programs or after a drunken-driving offense, but they often show a great reluctance to cooperate.)

Delay in seeking help is, of course, not unique to alcoholics. Hackett and his colleagues (5, 6) have examined patients' delay in seeking help for myocardial infarction or cancer. By using denial and other defenses, a person is able to hide his illness even from his own awareness. When he accepts that he is ill, he may delay even longer before seeking help. Hackett and his colleagues found that patients whose condition is first discovered during a medical check-up are most likely to enter treatment early. Worry and incapacity are also likely to bring them to treatment. However, the advice of a friend or public information efforts seem to be rather ineffective.

Tournier's efforts to explain an alcoholic's reluctance to seek help as a product of A.A.'s dominance is too simplistic. In my view, this delay and denial of illness are the product of a variety of factors, such as the widespread acceptance of alcohol in our society, the lack of a clear distinction between social and excessive use, the pleasure people derive from alcohol, their unwillingness to give up something that plays so important a part in their lives, the reluctance of professionals to confront a person who has a drinking problem, the public image of the alcoholic as a Skid Row bum, and so on. By focusing so heavily on the alleged dominance of A.A., Tournier has failed to note that many other forces are at work and that great areas of ignorance about alcoholism and its treatment remain. There is still a lot of research that needs to be done. I would suggest a closer examination of the psychology of denial and delay to understand why alcoholics wait so long before seeking help. Furthermore, we should look more closely at the similarities and differences between the lay and the professional approaches to care. Most important, since our present methods are not very effective, we should redouble our efforts to understand alcoholism and develop new approaches to care. Change brings uncertainty and even hostility, but this should not deflect the scientist from his task.

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Tournier's thoughtful and provocative analysis of the functions and dysfunctions of Alcoholics Anonymous (1) is a constructive and useful contribution to the theories of social organization, social movements and interest groups. It also has a highly contemporary ring. Another venerable institution is under attack. To A.A.'s credit, to have become a venerable institution in about four and a half decades is indeed an accomplishment.

Comparative and revealing data from an unpublished study conducted in metropolitan Boston² are available to supplement some of Tournier's observations. The findings were derived from an area probability sample of the Boston Standard Metropolitan Statistical Area. The survey instrument was administered in 1975 and 1976 to 1043 respondents in 69 cities and towns. Eight problem areas were identified (alcohol, aging, child behavior, counseling, employment, financial, homemaker and home health). All of the respondents were asked where they would go for help if they or someone else in the family had the problem, whether the problem was present in the family, if present where did they go for help, and finally whether the problem had been adequately resolved. Several findings from that unpublished study bear upon Tournier's paper and will be cited here.

More people (78%) were able to identify sources of help for alcohol problems than for any of the other seven problem areas. More people (61%) identified A.A. as the source they would use for help than any other source for any other problem. The next most cited source, the public employment service, was selected by 29% of the respondents. Of the 1043 respondents, 13% identified alcohol problems in their family, making it the fourth most frequent problem, but only 28% of those so identified sought outside assistance. Only homemaker services were in less demand. Of those who did seek outside help, 34% went to physicians (20% to psychiatrists and 14% to other medical specialists), 23% sought out A.A., 18% private agencies, 10% public agencies and 8% their clergyman.

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² One published report from this study is by Wechsler et al. (2).

Tournier's contention that A.A. dominates the alcoholism field as a method of intervention is partly substantiated. Its superordination in the minds of the general public is overwhelming in both absolute and relative terms, and it is not limited to the alcohol field. Of all eight problem areas studied, only A.A. was named by the majority of respondents as the assistance of choice for a given need. But popularity is not sufficient as is evident from the succeeding items. Few people with alcohol problems actually sought help (28%). In contrast, the most aggressive use was made of outside resources when a child behavior problem was identified; 85% of those affected sought formal assistance. Additional reductionism is possible. Of those few people with alcohol problems who did extend themselves, only 23% actually used A.A. as the primary therapeutic source, or 7% of the total identifying alcohol as a problem. One caution should be noted. As Tournier reminds us, A.A.'s ideology and treatment philosophy may well have permeated the other treatment modalities so that even the conscious choice of non-A.A. treatment sources may not have been honored.

The data dramatically illustrate the distinction between wants, needs and demand. A.A. has more effectively stimulated the imagination of the general public than of alcoholics. Thus Tournier's contention that we need to expand therapeutic alternatives is supported by the data.

The current popularity of A.A. must be seen in a larger context in which there is widespread interest in and support of self-help groups. Mutual aid and support systems are significant components of the caregiving network; A.A. is often cited as a model of this effort.

Tournier also suggests that A.A. has adversely influenced imagination and creativity, negatively affecting early intervention. I would suggest that a more specific identification of A.A.'s sphere of influence is possible than Tournier's generalization. A.A. members currently hold significant policy and administrative positions on the paid staff and advisory bodies of the National Institute on Alcohol Abuse and Alcoholism, state alcoholism authorities, and the National Council on Alcoholism and its affiliates. Similarly the growing use of alcoholism counselors (mostly A.A. members) as significant treatment agents is another measure of extended influence. Significantly excluded from A.A.'s direct influence are the academic and scientific institutions, including, obviously, clinical research, or the many studies of controlled drinking would not have occurred. This free-standing sphere of influence is highly important for it is only by research and experimentation that significant progress will ever occur.

It is probably true that A.A. members have encouraged hostility to conditioning procedures designed to promote controlled drinking. Could it be otherwise? The primary influences on the two founders of A.A. were the Oxford Group movement and William James, especially his *Varieties of Religious Experience*. The result is a spiritually based social movement strongly reinforced by 11 of A.A.'s Twelve Steps. Chafetz and I (3) writing in 1962 noted the biblical underpinnings of A.A.:

"The old testament is the 'Big Book.' Its new testament is the twelve steps and twelve traditions. Its Jehovah is Bill W. . . ."

Can we realistically expect an ideologically based organization, with its principal tenets firmly established in its charismatic founders' writings, to comfortably accept opposing explanations? By definition, all ideologically based groups want to strengthen their membership, expressions of piety aside.

Given these normative requirements, A.A. is not antiscientific—it is ascientific. Only when threatened by a significant breach of its boundaries will it attack—science, clinical research or otherwise. Interest group theory logically prevails.

An equally logical assumption is that as scientific advances occur, new findings will challenge other of A.A.'s fundamental beliefs. For scholars of social movements and for those concerned about preserving the integrity of A.A. as an important means of helping many alcoholics, the controlled drinking research will be only one of many challenges to A.A. Given findings which appear to undermine their early beliefs, some social institutions integrate institutionalized intraorganizational change mechanisms to remain viable. Others either revert into residual roles or fade away. Time will determine which of the alternative routes is chosen by A.A.

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Tournier's thesis (1) is that Alcoholics Anonymous programming is the principal, if not the exclusive, cornerstone of treatment efforts, that such programming fetters innovation, hinders intervention in the early stages of alcoholism and is really only appropriate to addictive alcoholics.

For anyone who has long-term familiarity with A.A. and alcoholism treatment, it is clear that, in certain circumstances, there may be some validity to the author's contention—with two exceptions. The first concerns his use of the concept of "A.A. programming" and the second relates to time frames.

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Although Tournier comments on "A.A.'s nebulous membership," he proceeds to talk about A.A. as if it is a discrete entity and as if there were positions that were representative of the thinking of the entire membership. At times, it is not clear whether he is talking about A.A. members, alcoholism counselors who happen to be members of A.A., the organization known as Alcoholics Anonymous, the General Service Office of A.A., the philosophy of the Twelve Steps of the A.A. program or A.A. methodology (whatever that is).

In noting the issue of time frames, it becomes evident that the position taken by the author would have been more appropriate 10 or 15 years ago. In demonstrating the use of A.A. as the primary therapy in state mental hospitals, he uses statistics from a study which was done in 1966. This was probably accurate then, but does not reflect the situation today. At that time, the patient was either treated "the A.A. way" or was not treated, at least not for alcoholism.

Tournier notes that some treatment programs place heavy emphasis on A.A. attendance, and, in some, attendance is compulsory. His point appears to be that A.A. is used as if its effectiveness were beyond question. In many treatment programs, not only is A.A. attendance required, but so are group therapy sessions, a psychosocial evaluation, a comprehensive history and physical examination, aftercare planning, etc. Each is regarded as one component of effective treatment programming.

The author has taken the position that A.A. is much less effective than has been assumed, and that accurately establishing the number of people reached by A.A. is impossible because of its tradition of anonymity. He goes on to state that the size of A.A. membership in the United States is 400,000 to 600,000. (The General Service Office of A.A. uses an unofficial estimate of over 700,000.) Tournier's contention is that since A.A. has no formal organizational structure, no mechanism exists for gathering information such as membership, demographic data, etc. The General Service Office of A.A. does, in fact, routinely publish such information, most recently in 1978.

Tournier further states that the recovery rate of alcoholics through A.A. is quite low, perhaps as low as 5%. It is not clear how Tournier arrives at this estimate. It has often been stated that only 5% of alcoholics use A.A., but 5% is also the estimate of the percentage of alcoholics in treatment of any kind. The 5% rate as applied to A.A. membership is not a recovery rate but a penetration rate. Given the magnitude of the problem, one must agree that A.A. is not making a major contribution in reaching the majority of alcoholics; however, neither is any other treatment approach or even all treatment approaches combined.

The author points out (referring to one estimate) that even if 57% of the people who attend A.A. recover, this may not be a demonstration of the effectiveness of A.A. as much as of the fact that recovered alcoholics tend to gravitate toward A.A. as a means of sustaining initial recovery, thereby using it as a form of aftercare. This is another way of saying A.A. is effective. Sustaining the original "recovery" is a part

of the ongoing recovery process, particularly when alcoholism is viewed as a chronic illness. Tournier's comment that treatment is best seen only as one incident in recovery, a lengthy process beginning prior to and independent of contact with the treatment program, should be reexamined in light of some more recent information which indicates that the best prognosticator of recovery from alcoholism is continued treatment.

Again, the author characterizes A.A. as it was 15 years ago, as most appropriate for the disenfranchised alcoholic, for whom A.A. became a means of coping with isolation, feelings of loneliness, etc. Although this is still true of some people, most A.A. members today no longer fit the role of disenfranchised. They enter treatment much earlier in the progress of their addiction, before the manifestations of the later-stage symptoms of the addiction, such as loss of job and family, serious health problems, etc.

The comment that the Twelve Steps "as an ideology of recovery" virtually preclude early intervention indicates a lack of comprehension of the Twelve Steps of A.A. and the A.A. philosophy. For example, in the admission of powerlessness, powerlessness is a relative concept. Although it could be applied to the public inebriate who has lost everything, many other A.A. members find that they can apply the same concept to themselves, even though they have lost very little materially. Relinquishing the denial mechanism and becoming successfully involved in A.A. does not require hitting a "low bottom," as the author states. A "bottom" connotes an awareness by an alcoholic of personal helplessness and the need for outside help; it need not be directly proportional to the extent of the alcoholic's problems as a result of drinking. Since "bottom" is a subjective phenomenon, A.A. can and does bring about this awareness earlier in the progress of the illness. Although earlier intervention requires a different methodology for overcoming denial and confronting powerlessness, it is obvious from observing and talking to A.A. members that the despair over having lost everything is not a prerequisite to recovery. As further refutation of the argument that the A.A. philosophy hinders earlier intervention, probably the single most effective force currently available for early intervention is the employee assistance or occupational alcoholism program, most of which are "A.A.-oriented" and many of which are directed by recovered alcoholics who are members of A.A. The premise that unless a person suffers from addictive alcoholism, he cannot relate to the A.A. message or accept A.A. is belied by the fact that many new members of A.A. are very young and, again, have lost very little.

I agree with the author that there is probably no such thing as alcoholism, but rather there are alcoholisms. There has been a homogenization of diverse problems under the rubric of alcoholism, which may at times be counterproductive. Laying this at the feet of A.A., however, is stretching the point. For example, most A.A. members object strongly to the possibility of conditioning for controlled drinking. The thrust to make controlled drinking a successful or legitimate goal

of treatment, as contrasted with the goal of total abstinence, raises a variety of other questions. Even those who indicate that controlled drinking may be possible for some alcoholics recognize that it is not a viable alternative for the majority of alcoholics. It appears to be feasible for only a small minority of alcoholics (if any), and the potential results of unsuccessful controlled drinking are disastrous. Until we can predict with great accuracy those who can return to controlled drinking successfully, we place the majority of alcoholics in a situation with risks far greater than any potential gains from controlled drinking.

Another issue that is rarely addressed is the possibility that non-addictive alcoholics—alcoholics at an earlier stage of the illness, during which there is psychological dependency alone—may develop physical dependence with continued drinking, no matter what psychological intervention takes place. The presence of a physical dependence may be one of the least significant factors in alcoholism treatment. Although there are problems created by the inability to stop drinking once it begins, most alcoholics do stop; in fact, they “stop” continuously. The more serious consequences of alcoholism occur because of the repetitive return to drinking after abstinence. Relapsing is not a function of physical but rather of psychological dependence. Said another way, the problem for the alcoholic is not the bottle, but the belief in the bottle, or the belief in the magic of the chemicals. Since this is the case, even if “addictive alcoholism” were to be magically eradicated, the reduction of the destructive consequences of alcoholism would not be all that significant.

Over-all, the author touches on a number of things that may have some merit, be true of some people, be found in some treatment centers and might have reflected the state of alcoholism treatment and A.A. in 1965. This interpretation of the A.A. philosophy and program is neither in keeping with the way A.A. is used in many treatment centers today nor as it is interpreted by many A.A. groups and individual members. Finally, the author might have provided a more constructive analysis by subjecting A.A. to a phenomenological evaluation.

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