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Alcoholics Anonymous as Treatment and as Ideology[1]

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SUMMARY. *It is proposed that Alcoholics Anonymous's continued domination of the alcoholism treatment field has fettered innovation, precluded early intervention and limited treatment strategies.*

SINCE its founding in 1935, Alcoholics Anonymous has come to dominate alcoholism both as ideology and as method, and has successfully established itself as the primary representative of alcoholics and recovered alcoholics in our society. A.A. has come to serve as a major vehicle for defining alcoholism and alcoholism treatment in this country, and, in conjunction with the National Council on Alcoholism (N.C.A.), members of A.A. have become perhaps the most important lobby advocating the now generally accepted disease concept of alcoholism. As a result of four decades of effort, A.A. has acquired a moral ascendancy which has enabled many of its members to be preeminently successful in asserting a claim to be the voice of the alcoholic, a claim which has never been effectively challenged. So successful have A.A. members been in proselytizing their ideas that their assumptions about the nature of alcohol dependence have virtually been accepted as fact by most of those in the field. It is significant that when Pattison et al. (1) seek to define the traditional model of alcoholism, they regard A.A. and interpretations of A.A. perspectives as being among the most important influences in the field and add to the list only Jellinek's disease model.

A.A. has come to dominate treatment as well, not only as a philosophy but also as a method, for A.A. programming has be-

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come a cornerstone of virtually all contemporary rehabilitation efforts. While it is difficult to document the extent of A.A.'s involvement in treatment, particularly because of its rather nebulous membership, some indication of the magnitude of its role can be seen in the results of a nationwide study (2) of state hospitals carried out in 1966. A.A. was used as a primary therapy instrument in 88% of the institutions surveyed (second in frequency was group psychotherapy, used in 78%) and as a follow-up modality in 82% (second in frequency were local clinics, used in 47%). While there are a great many reasons for this overwhelming reliance on A.A. for treatment and follow-up, many of which are probably a function of the willingness of A.A. volunteers to aid in the delivery of services to others, it is important to note that A.A.'s traditional role in the treatment of alcoholism has been legitimized by the fact that in an area where documentable recoveries are rare, A.A. alone has appeared to succeed.

What I would like to offer is a caveat about the current role of A.A. in the field of alcohol dependence. While A.A. is currently the method of choice for treating alcoholics, while it appears to have succeeded in leading untold numbers of alcohol's victims to abstinence, and while it has served and will continue to serve as an inestimably important source of support to those seeking to remain abstinent, I propose that its continued domination of the field and its members' claim to be spokesmen for the victim have fettered innovation, precluded early intervention and tied us to a treatment strategy which, in addition to reaching only a small portion of problem drinkers, is limited in its applicability to the universe of alcoholics.

Alcoholics Anonymous and Treatment Strategy

Given the overwhelming use of A.A. and the frequency with which phrases like "the only therapy used is A.A." (3) or "A.A. attendance is . . . compulsory" (4) or at the very least "attendance at A.A. meetings is encouraged" (5) occur in the descriptions of rehabilitation programs, one could conclude that A.A.'s effectiveness is established beyond question. On the contrary, there is a sizable body of evidence which suggests not only that A.A. is limited in its general effectiveness but also that there are a great many persons with a great many different kinds of alcohol problems for whom A.A. is simply inappropriate.

It is often argued, of course, that A.A.'s effectiveness as a treatment modality is irrelevant, since A.A. is not a treatment but a philosophy of recovery. In principle this is quite true, but in practice A.A. is so often used as a mode of treatment that the demurrer is academic. It is this predominance of treatment by A.A. that makes the issue of evaluation of its effectiveness so very important, for if we are to persist in the use of what one of the discipline's leading experts (6) calls "probably the single most effective method of treatment we have," we must do so as the result of an objective appreciation of its impact rather than as a result of its tradition of use and of the persuasiveness of its proponents.

Evaluation of A.A. is hampered by ideological and methodological problems. On the ideological side, the feasibility of assessing A.A.'s impact is questionable because of the multifaceted nature of the A.A. effort (7). To quantify, or to attempt to quantify, A.A. performance is to obscure the fact that the penetration of A.A.-inspired techniques into other treatment efforts and the equally indeterminant impact that A.A. has on persons who are never considered members but whose recovery is facilitated by contact with A.A. make it far more effective than can possibly be demonstrated by a simple enumeration of successes and failures (8).

Even if one grants that evaluation can be undertaken, the effort is rendered virtually impossible by a host of methodological problems, the most significant being a lack of uniform criteria for recovery[3] and an inability to define the membership of a movement as amorphous as A.A. It is impossible to establish accurately something as seemingly straightforward as the number of people reached by A.A., primarily because the tradition of anonymity precludes a reliable enumeration of membership. In addition to problems posed by anonymity, difficulties derive from the fact that, to the degree to which the fellowship of A.A. is felt to extend to all who share its philosophy, there are no clear criteria for membership. Since A.A. has no formal organization, no mechanism exists for gathering such information. In a situation such as this, assessment of A.A.'s impact, necessary though it may be, is little more than an exercise in speculation.

One result of the imprecision of data on A.A. membership is that one can with equal facility use them to "prove" almost any-

[3] BAEKELAND et al. (9) have discussed treatment goals and outcomes in their critique of treatment methods.

thing. One can argue, for example, that in spite of a large and indisputably growing membership the recovery rate of alcoholics through A.A. is quite low—perhaps as low as 5%. This assessment can be based on the probable size of A.A. membership (400,000 to 600,000 in the United States) in relation to the total number of alcoholics in the country, which has been put at 9 to 10 million. The obvious fallacies of this method of estimation are two. In the first place, only a portion (inestimable in size) of the total number of alcoholics has been labeled as "alcoholic" and thus been made subject to treatment efforts. Hence, the denominator is actually much smaller than 9 to 10 million and the success of A.A. much more significant. Second, such a ratio totally ignores the impact of A.A.-derived programs on persons who are never numbered among its membership.

One can as easily define the universe within which A.A. operates as consisting only of those who are ready to seek help and ready to seek the special kind of help that A.A. offers. One estimate (10) sets the size of this group at perhaps 530,000 and, in assuming some 350,000 recoveries through A.A., claims a 67% success rate, which, given the magnitude of alcohol problems in our society, represents a rather limited impact.

Most claims that A.A.'s effectiveness is significant are flawed by sampling biases, for most ignore persons who, having failed to find help through A.A., drop out of its activities and out of the potential sample. Leach and Norris (8), for example, report a 46.3% "sober from first visit" rate based on a 1971 A.A. General Service Board survey of members attending meetings and willing to complete questionnaires. In what is perhaps the most comprehensive assessment of alcoholism treatment methods to have appeared in recent years, Baekeland (11) cites a 34.6% improvement rate based on a study of A.A. members who have attended at least 10 meetings. Admitting an intrinsic sampling problem, particularly in a probable exclusion of patients having a poorer prognosis, he concludes that one must "take with a grain of salt claims of very high success rates."

None of these arguments are particularly compelling, and all obscure a more basic issue, for none speak directly to the role played by A.A. membership in the recovery process. Even if one accepts an estimate as high as 67% as valid, and it is rather difficult to do so, it is not a demonstration of A.A.'s effectiveness, but may suggest only that recovered alcoholics gravitate toward A.A. as

a means of sustaining a recovery already begun, and may thus use it as a form of aftercare.

An assessment of factors relating to treatment outcome seems to support this view. A number of studies (e.g., 12, 13) have found that the ability to sustain abstinence prior to entering treatment is among the most important criteria for treatment success. Other studies have found that improvements in social and occupational functioning (abstinence, occupational adjustment, marital satisfaction and the like) are not associated with A.A. attendance (14) and that, in general, treatment is best seen as only an incident in a lengthy process of recovery which begins prior to and operates independently of contact with a treatment program (15).

The major impediment to universal use of A.A. as a treatment modality is its inappropriateness to the situations of many of those to whom it is applied. A person who is alienated from family, peers or community and is using alcohol as a means of coping with isolation and with feelings of loneliness will probably be helped by A.A. (16), for A.A. can provide a therapeutic milieu within which persons with spoiled identities can reestablish social ties with others similarly stigmatized. On the other hand, to the extent to which a person's alcoholism represents an escape from frustration, from problems with which he cannot easily cope, A.A. has much less to offer, particularly if a person is characterized by neither gregariousness nor a high level of affiliative need (17, 18). For such persons, the A.A. experience is likely to be nonproductive.

None of this should be taken as deprecation of the importance of A.A. to those for whom it is appropriate and its importance, when used as an adjunct to other kinds of treatment, in facilitating recovery. It is to suggest, however, that the continued commitment to A.A. as the primary treatment of alcoholics should be reexamined.

Alcoholics Anonymous and Early Intervention

The dilemma created by the ready acceptance of A.A. as an ideology of alcoholism goes beyond its limitations as a treatment modality, for one could suggest that the commitment of many of the professionals in alcoholism treatment to A.A. and particularly to the Twelve Steps as an ideology of recovery would virtually preclude early intervention. The problem is that the A.A. philosophy, oriented as it is to a concept of alcoholism based on the experiences of addictive alcoholics, is simply not predisposed toward

serving the needs of early-stage (nonaddictive) alcoholics. The A.A. message, particularly its insistence on an admission of powerlessness as a prerequisite to recovery, is of limited significance to this group.

While acceptance of the Twelve Steps is in no way obligatory for participation, the basic message is nonetheless that alcoholics cannot hope to escape their predicament until they abandon their illusions of control and accept the label "alcoholic" with all that it implies. Such an admission can, of course, be expected from persons whose circumstances have fostered complete disillusionment and who have been forced to abandon the elaborate rationalization and denial mechanisms with which they have been able to conceal their problems from themselves and those around them (19, 20). Such disillusionment seems to be a virtual prerequisite to successful participation in A.A., but it is possible only for those who have reached what A.A. members call a "low bottom."

The implications of such an orientation are unfortunate. While clearly consistent with the experiences of a large proportion of A.A.'s membership and with an A.A. belief in despair-as-prerequisite-to-recovery, this orientation clearly suggests that there is no possibility of recovery without despair. To the degree to which this is part of A.A.'s vocabulary of motives, and it clearly seems to be, and to the degree to which it affects treatment of early-stage alcoholics, A.A.'s potential for effective intervention in their problems is seriously limited (21).

For an early-stage alcoholic, A.A.'s approach may well serve as a barrier to recovery, for insofar as an alcoholic retains a conviction of control (justified or otherwise) and has not experienced all of the personal and social consequences accompanying addictive alcoholism, he will be able neither to relate to the A.A. message nor to accept A.A. as a solution to his problem (22). This is not to suggest that disillusionment cannot occur in an early-stage alcoholic. It is simply not as likely that it will, and an early-stage alcoholic therefore will not be particularly motivated to seek the kind of help that A.A. offers.

It must be noted that while A.A. has "officially" moved away in recent years from a perspective linking a "low bottom" with a readiness to accept rehabilitation, 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.

Alcoholics Anonymous and Innovation

A final issue is more speculative, for it involves not what is but what might be. We need certainly thank A.A. and N.C.A. for leading the battle to define alcoholism as a disease, for as a result of their efforts, alcoholism is no longer considered (at least by most professionals) to be a symptom of immorality or weakness, but is accepted as a specific disease meriting specific intervention. The results of this redefinition have been striking, for alcoholics have finally established their right to dignity and to treatment (23, 24).

Having worked to establish the dictum of "alcoholism as disease," members of A.A. have actively played the role of moral entrepreneur (25), proselytizing their beliefs with such vigor that their view of alcoholism, as I have already suggested, has come to be accepted as fact rather than as one of a number of competing hypotheses. One result of this, and of an almost universal acceptance of a view of alcoholism as a unitary phenomenon (26), has been a strong and unfortunate tendency toward the homogenization of a wide diversity of drinking problems. As a result, many professionals seem reluctant to accept the fact that the label "alcoholic" is being applied to different kinds of drinking problems that necessitate different kinds of intervention. This bias is most clearly manifest in many A.A. members' having adopted as a bête noire the issue of alternative strategies for dealing with drinking problems, particularly strategies raising the possibility of conditioning for controlled drinking.

While it is possible to question the adequacy of many controlled drinking experiments and the appropriateness of many of their conclusions (27), it is not at this point possible to reject the hypothesis that to the degree to which alcoholism (particularly early-stage, nonaddictive alcoholism) can be viewed as learned behavior, it may be susceptible to a variety of behavior modification techniques. Pattison et al. (1), who are admittedly in the forefront of what might be called a revisionistic view of alcohol dependency, have found "strong evidence from 17 major clinical ventures suggesting that controlled drinking can sometimes be used as a successful and legitimate goal of treatment."

The proponents of controlled drinking have to their credit been very careful to caution about the dangers of an indiscriminate use of their method. Davies (28), whose 1962 work sparked the controversy over controlled drinking as a treatment goal, remains an

advocate of lifelong abstinence as the only realistic goal for the vast majority of alcoholics; the Sobells (29), who seem to have borne the brunt of the reaction to controlled drinking proposals, have cautioned as well that their advocacy does not imply that controlled drinking is a viable objective for all or even most alcoholics. All of these researchers, however, raise the possibility of an alternative to the often unrealistic goal of total abstinence.

Much of the vilification with which these proposals have been met results from a conviction that advocates of controlled drinking are suggesting that time-honored (and A.A.-validated) assumptions about the irreversible nature of alcoholism may be at least partially incorrect, or are at least inappropriate for many persons who have alcohol-related problems. While much of the criticism of controlled-drinking treatment programs has been cast into "don't take chances with people's lives" terms (30),[4] it is predicated upon an acceptance of an A.A.-rooted ideology about alcoholism which, with its strong tendency to generalize from the situation of the gamma alcoholic (for whom controlled drinking is probably an inappropriate goal) to the situation of all problem drinkers, unequivocally insists (31, *p. 30*) that "the idea that somehow, someday, he will control and enjoy his drinking is the great obsession of every abnormal drinker," many of whom "pursue it into the gates of insanity or death." The result is rejection of innovative strategies aimed at nonaddictive alcoholics, for whom alternatives to total abstinence are probably more realistic, and deprecation of the possible discovery and implementation of alternative approaches.

Conclusion

It is important not only to reiterate what I am proposing but also to emphasize what I am not proposing. I am not suggesting that we abandon A.A. or that we in any way reduce its role in the treatment of addictive alcoholism or in the delivery of the kinds of aggressive aftercare that are vital to long-term recovery. I am proposing only that we become aware of the implications of generalizing the A.A. philosophy to all intervention, and that we evaluate on their own merits alternative and innovative strategies for dealing with the extremely complex range of problems too often lumped under the rubric of "alcoholism."

[4] National Council on Alcoholism. Position statement regarding abstinence. News release, 19 July 1974.

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