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A

BEYOND THE BRIDGE -

STEPS TOWARDS AN ECOLOGY OF SOBRIETY:

A STUDY OF LONG-TERM RECOVERING ALCOHOLICS

by

LENORE HILDEBRAND

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York.

2001

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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THE CITY UNIVERSITY OF NEW YORK

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ABSTRACT

BEYOND THE BRIDGE -
STEPS TOWARDS AN ECOLOGY OF SOBRIETY:
A STUDY OF LONG-TERM RECOVERING ALCOHOLICS

by

Lenore Hildebrand

Adviser: Professor Paul Kurzman

An exploratory study of the experiences of 30 long-term recovering alcoholics sober in Alcoholics Anonymous for 10 or more years. Subjects selected were representative of a diverse urban population. A researcher-developed interview guide was used to gain an in-depth understanding of the long-term recovery process--how these individuals got sober, how they stayed sober, and why they remained sober and still active attenders of A.A. Nine themes emerged--1) reasons for entering A.A.; 2) intensity of A.A. involvement; 3) milestones in the recovery process; 4) non-A.A. supports to recovery; 5) changing views of self and personal identity; 6) alterations in work and professional life; 7) changes in social life and environmental context; 8) development of spirituality; and 9) meaning and significance of long-term sobriety. The study applied

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narrative theory, a cultural competency perspective, and an ecological framework to an interpretation of the data. Subjects managed to develop, foster, and maintain their own self-created ecology or culture of sobriety which served as a counterpoint to a larger social context dominated by what some have called a "culture of drinking." The study was designed to bridge a gap between the research and practice communities, provide a linkage between A.A. and the professional treatment community, improve the integration of alcoholism treatment with social work practice, and contribute to a more positive understanding of the alcoholic in recovery.

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A project of this scope and dimension has had many helping hands. I wish to thank Peter O'Brien for his wise and gentle counsel in encouraging me to pursue this topic and Dr. Judith Caligor for her candor and interest in helping me to stay the course.

I want to acknowledge my appreciation to Dr. Michael Fabricant, now the Executive Officer of the Doctoral Program at the Hunter College School of Social Work. Dr. Fabricant's course in qualitative methods introduced me to new and stimulating ways to conduct social work research. I owe Dr. Elaine Marshack a special note of thanks for her long-standing mentorship and cheerful encouragement. I am most grateful to the members of the Committee who supervised this dissertation. Dr. Mildred Mailick (Emeritus), now retired, began as my Dissertation Adviser and Chairperson of the Dissertation Committee. She was always available to provide feedback and direction as I undertook this project. I am especially indebted to Dr. Paul Kurzman, who graciously consented to take her place as my Dissertation Adviser and Committee Chairperson. Dr. Kurzman's invaluable support and encouragement, along with his insights and commentary as I completed drafts of each chapter, helped me to persist through this long process and to bring it to successful completion. Dr. Florence Vigilante and Dr. Robert Salmon, the other members of my Committee, provided additional assistance in clarifying my thinking about the topic.

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reminder that "there was a light at the end of the tunnel and it was not a train coming towards me."

This project would never have been completed without the presence and assistance of Ms. Gloria Camarero who, as my reader, editor, and dear friend, never doubted for a moment that I could complete what I had started.

Finally, I am deeply grateful to the 38 men and women whose courage, honesty, generosity, and support made this project possible--the 8 individuals who participated in the initial pilot project and the 30 individuals who contributed their time and effort to the final project. Alcoholics Anonymous' guiding principle (as stated in its 12th Tradition), that "anonymity is the spiritual foundation of all our traditions," keeps me from identifying them by their real names. But they know who they are in the stories that come alive in the following pages. As they cross and move beyond the "bridge back to life," their metaphor for their A.A. experience, I am deeply humbled to have had the privilege of sharing in this journey with them. This project is dedicated to them and to the loving memory of my parents.

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"'There is a principle which is a bar against all information, which is proof against all arguments and which cannot fail to keep a man in everlasting ignorance--that principle is contempt prior to investigation.'"

Herbert Spencer
(Quoted in Alcoholics Anonymous, p. 570)

* * *

"I have not tried to write the history of that language, but rather the archaeology of that silence."

Michel Foucault
(Madness and Civilization: A History of Insanity in the Age of Reason, p. xi)

* * *

"'. . . more stories, less theory . . .'"

Robert Coles
(The Call of Stories, p. 27)

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CHAPTER 1

STATEMENT OF THE PROBLEM

INTRODUCTION

Chapter 1 provides an overview of the problem of alcohol abuse in the United States. It then reviews traditional approaches to the treatment of alcoholism and the limitations of outcome-oriented research in identifying the key factors in sobriety maintenance. Discussion centers on the need for more attention to studies of long-term recovery and the origins of the present study. The chapter closes with a consideration of the key questions to be explored in subsequent sections of this dissertation.

THE PROBLEM

Of all the major health problems in the United States today, alcohol abuse remains among the most persistent, baffling, and intractable for social workers and other health professionals to understand and to treat. According to the U.S. Department of Health and Human Services' (DHHS) most recent Ninth Special Report to the U.S. Congress on Alcohol and Health (1997), which is issued triennially, "alcohol-related morbidity and mortality remain significant problems in this country" (p. 27).

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Alcohol abuse affects individuals and families, in the home and at the workplace, in all corners of the country, its urban centers, suburban communities, and rural areas. An equal opportunity disease, it takes its toll on men and women alike, regardless of age, race, ethnicity, sexual orientation, economic circumstance, or social status. It has an impact on every service delivery system familiar to social workers--health, education, child welfare, criminal justice, to name a few--and causes incalculable damage to the nation's economy in lost productivity, accidents, crime, victimization, incarceration, homelessness, escalating health and medical costs, and premature deaths. The following data provide a brief overview of the scope of the problem:

- Nearly fourteen million Americans either abuse or are dependent on alcohol. (Ninth Special Report, 1997, p. xxvi)

- Alcoholic cirrhosis is the 11th leading cause of death in the U.S. (Ninth Special Report, 1997, p. 11)

- Binge drinking is a "widespread" problem among college students. (Ninth Special Report, 1997, p. xxvi)

- Almost half of all traffic crash fatalities are alcohol-related. (Ninth Special Report, 1997, p. 10)

- Alcohol use is strongly associated with illicit drug use. (DHHS, Summary of Findings from the 1998 National Household Survey on Drug Abuse, 1999, p. 19)

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> • Heavy and chronic drinking is implicated in almost every major disease entity--liver disease; stroke; pancreatitis; pneumonia; and cancer, especially of the upper digestive tract, breast, colon, and liver. (National Institute on Alcohol Abuse and Alcoholism [NIAAA], "Alcohol and Cancer," Alcohol Alert, July, 1993, p. 1)
>
> • Children and adolescents who grow up in alcoholic families are themselves at risk for developing problems with alcohol later in life. (Ninth Special Report, 1997, p. 34)
>
> • Adolescent drinking is associated with high-risk sexual behaviors that can lead to AIDS, sexually transmitted diseases, and pregnancies. (National Council on Alcoholism and Drug Dependence [NCADD], "An Interview with Surgeon General David Satcher," NCADD Amethyst, Spring, 1999, p. 1)

With alcohol abuse so endemic to the population, it is all the more noteworthy that individuals do try to stop drinking. Some do so through formal treatment; others through self-help involvement with or without formal treatment; and a smaller percentage seem to do so without any professional intervention or self-help participation. For example, according to the Uniform Facility Data Set (UFDS): Data for 1996 and 1980-1996 (1997) produced by the DHHS Office of Applied Studies, 940,131 clients were in specialty substance abuse treatment on October 1, 1996, with 261,977 (or 27.9%) treated for alcohol-only problems; the most common pattern of substance abuse was found to be clients abusing both alcohol and drugs with 404,932 (or

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43.1%) of clients abusing both substances (pp. 14-15). Meanwhile, Woodward et al. (1997) have noted the "large gap between the number who need and the number who receive treatment" (p. 15). In an analysis of this treatment gap, the authors estimated that "approximately 50 percent of those in need receive treatment, but this percent has declined during recent years" (p. 15). They cite two possible reasons for this gap--difficulty accessing treatment or avoidance of treatment--and observe that people with alcohol problems "probably experience similar difficulties [as compared with drug abusers] in obtaining access to treatment" (p. 16). Galanter, Keller, Dermatis, and Egelko (1999) note too that addiction disorders continue to be "significantly undertreated" (p. 3).

Traditional treatment settings may include inpatient care (hospital detox units), intermediate or residential facilities (halfway houses, therapeutic communities), rehabilitation/recovery programs (Hazelden, Betty Ford), and ambulatory public and private outpatient programs. Traditional treatment modalities may consist of brief and extended individual and group counseling, family and marital therapy, and pharmacological therapy. A major resource like

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Alcoholics Anonymous (A.A.), the well-respected self-help program that has become the model for the popular 12-step movement in the U.S., is estimated to have attracted over 1.1 million members (A.A. World Services, A.A. 1998 Membership Survey, 1999).

In the past two decades, outcome-oriented research has attempted to evaluate the efficacy of these traditional approaches. Do they work? As the report of the Institute of Medicine (1990) makes clear, "there is no single superior treatment approach for all persons with alcohol problems." A decade ago, the Institute's researchers saw encouraging signs in the availability of a "range of promising alternatives" and in the attempts by practitioners to more carefully match patient characteristics to treatment modalities. As for the efficacy of A.A., the report concluded that there was a need for more rigorous evaluation and elucidation of the "impact and mechanisms of change within A.A." (p. 537).

By 1992, a NIAAA Alcohol Alert report on treatment outcome research issued recommendations similar to those advanced by the Institute of Medicine but the Alert went further and mildly rebuked direct practitioners for ignoring

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the latest developments in outcome research:

> While treatment outcome research is not a new idea it is fairly new in the alcohol field. Just as it would be unthinkable to unleash a new drug therapy for cancer . . . without scientific evidence of safety and efficacy, treatments for alcoholism must be rigorously evaluated to ensure that patients get the best help possible. . . .
>
> Treatment outcome research will support new approaches; alcoholism treatment providers must take the time to keep up with and apply the results of research in their programs or practice. Simply put, there is nothing sacred about any of today's treatment methods. For any disease, we hope that tomorrow's treatment will be better than today's. The experience and wisdom of the many . . . dedicated alcoholism treatment personnel will continue to be key ingredients in alcoholism treatment. However, new treatment technologies . . . will improve patient outcome, and it is important that treatment providers stay abreast of new developments. (p. 3)

Interestingly, nearly the same conclusions were reached towards the end of the same decade in the Ninth Special Report (1997). Its authors envisioned "patient-treatment matching" as the "cornerstone of treatment selection decisions" (p. 363). The Report also emphasized the importance of "incorporating a range of services within treatment facilities to meet the diverse psychosocial needs" of patients. It cited patient "readiness for change" as a "strong predictor of treatment response" and as a "basis for intervention selection" (p. 363). It promoted such

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relatively new pharmacologic interventions as naltrexone to prevent relapse and called attention to "issues of comorbidity of alcoholism and other psychoactive substance abuse and the impact of comorbidity on treatment effectiveness" (p. 363). It also cited the need for better understanding of the role of social support in the recovery process and encouraged a greater focus on "quality of life" issues, particularly through the use of new assessment tools to "measure intrapersonal and interpersonal functioning and other person-environment areas relevant to alcoholism recovery" (p. 363). As for research on A.A., the Report urged greater research efforts to further "define the 'active ingredients' of sobriety maintenance associated with AA affiliation" (p. 354).

Perhaps because outcome results for conventional treatment modalities have been inconclusive while efforts to conduct research on A.A. have proved frustrating, attention has shifted in the last decade to a search for newer, more effective strategies and other ways of conceptualizing, not only alcoholism treatment, but also the recovery process. Thus, there has been increased emphasis on early recovery models, relapse prevention, stage or phasic paradigms, and

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other process-oriented approaches focusing on the "active ingredients of treatment efficacy," that is, such variables as "motivation, compliance, mandated treatment, and therapist skills and characteristics" (Institute of Medicine, 1992, p. 12; see also the Ninth Special Report, 1997, pp. 354-356). Some attention has even begun to be paid to non-traditional pathways of recovery--to those individuals who seem to recover "spontaneously," without any professional intervention or self-help involvement--in the hope of gaining insights into the process by which this population has managed to overcome its alcohol dependence.

Most of this outcome-oriented research, however, centers on the newly sober individual or the person returning from relapse. Studies of long-term recovery are fewer in number. Most, as we shall see, are quantitative and attempt to isolate key variables that are likely to characterize, or serve as predictors of, the individual's sobriety. Moreover, the samples used tend to be blended, that is, the length of sober time can vary substantially. People with protracted abstinence, in fact, often constitute only a small percentage of these samples.

In short, with the exception of mass market books

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(Cary, 1993; Picucci, 1998), several journal articles (De Soto, O'Donnell, & De Soto, 1989; Finney & Moos, 1991; Snow, Prochaska, & Rossi, 1994; Bewley, 1995), and a recent doctoral dissertation in clinical psychology (Sagot, 1998), few serious attempts have been made in social work or in any other mental health discipline to focus exclusively on alcoholics in long-term recovery (defined here as 10 or more years of continuous sobriety), particularly those who have utilized or continue to utilize a self-help group like Alcoholics Anonymous. These individuals represent an untapped resource that can provide a more in-depth understanding of the recovery process--how they got sober, how they stayed sober, why they remain sober (and affiliated with A.A.), and how they still manage to maintain their sobriety. Why don't they relapse? Why have they stayed sober for so long?

That there are so few serious studies of this population in the professional literature is all the more surprising given the fact that researchers have continually found a "positive association between A.A. attendance and abstinence" and between A.A. involvement and maintenance of abstinence (DHHS, Seventh Special Report, 1990, p. 265).

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Indeed, as was noted earlier, the Ninth Special Report (1997) acknowledges the significant role of A.A. and urges further study of the "'active ingredients' of sobriety maintenance associated with A.A. affiliation." Unfortunately, there is little recognition of this subgroup, deemed a rarity by some researchers who have argued that "long-term abstinence or totally problem-free drinking are both rare, whereas substantial improvement is a quite common outcome" (Riley, Sobell, Leo, Sobell, & Klajner, 1987, p. 106).

Why the interest in long-term recovery? As noted, much of the contemporary and popular treatment literature is concerned with either the newly abstinent or the alcoholic returning from a slip. Thus, the focus is either on initiating and stabilizing sobriety in the newcomer or preventing a relapse. Much still remains to be learned about sobriety. Why is it that some individuals with once serious alcohol problems do not relapse? What are the experiences of long-term sober alcoholics in A.A., one of the few places where this population can be readily identified and accessed? What do their rich and complex narratives tell us about the experience of sobriety in the

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later years? To focus on their life-affirming experiences is very much in keeping with a major emphasis of recent social work literature on the application of a strengths perspective to intervention (see, for example, Miller & Berg, 1995).

Unless these individuals relapse, and some do, they are more likely to be invisible. In a pilot study conducted by this researcher that eventually inspired this doctoral project, interviews with 8 individuals (3 men, 5 women), who had at least 10 or more years of continuous sobriety, tended to confirm this observation. In fact, a frequently heard comment was, "where are the others like me"? Needless to say, as long-term recovering people, they are not candidates for treatment programs, although some may choose to become counselors in these programs. One estimate is that 60% of all alcoholism treatment professionals in the U.S. are A.A. members (Bradley, 1988, p. 193). And if they began in A.A., they may be less apt to attend meetings as often as they did when they first got sober, though they still maintain a stable affiliation with the organization. For example, of the 8 people in the pilot study, all attended at least one meeting per week and all continued to sponsor newcomers.

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For many, abstinence from alcohol through A.A. membership helped them to normalize their lives and return to family, friends, and co-workers as sober models, thus giving truth to a program slogan that "A.A. is a bridge back to life." But it is precisely as sober models (in A.A. parlance, as "old timers" or "powers of example") that they, and others like them, have much to teach us about how they achieved and now maintain a sober lifestyle, and why they have not returned to drinking. They are, after all, survivors.

Moreover, we tend to forget that even as "old timers," they too have needs that are not often met in Open, Closed, or Beginner A.A. meetings. In recognition of this fact, several meetings in New York A.A. have sprung up to address their special needs and the 30 participants in this study were largely drawn from them. Few treatment programs, however, design outreach strategies with them in mind. This researcher has only been able to locate two--Hazelden's Renewal Center in Center City, Minnesota, and the Freedom Institute in New York--which take a "continuum of care" approach (not to be confused with "aftercare"). For example, Hazelden's Renewal Center, open year-round, provides self-directed therapeutic, educational, and

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fellowship opportunities to anyone in recovery, though not specifically for the long-term sober individual. What needs then, if any, do they have that remain unidentified and unaddressed by more traditional programs and services?

Among A.A. people, folk wisdom has it that "at 5 years, you get your brains back; at 10, you learn to use them; at 15, you discover you didn't need them in the first place." Clearly, for A.A. members, 10 years is a kind of milestone. This was obvious even in the pilot study where individuals (names have been changed) commented on the significance of their 10th anniversary:

> **Ann:** It was astounding . . . probably the most significant number. It's a round figure. There's a distinction to that number. It was acknowledged by a lot of people. I remember remarking to myself--'I made 10 years.'
>
> **Charles:** Five years isn't long. A lot of people are around in meetings. Most people I know are more stable at 10 years. It's a natural break. A more mature celebration. Suddenly, it gets very stable. I felt like I had matured. I felt more recovered, more stable, more sober. . . . It felt like a real commitment. I was in a club of people over 10 years.
>
> **Everett:** It was intense. I felt it was significant. Irrationally, I felt it was closing me off from people in the program, like crossing a threshold. As long as I was single digit, a newcomer could relate. At 10, I became one of the ancients. I could see it happening, like an old fogey. I redoubled my efforts to share. I didn't want to retreat into wisdom.

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Maureen: A lot of changes took place. I was redefining the program. I got complacent. The program had been comfortable. I wasn't stretched. I finished my undergraduate degree at 9 years. I went to fewer meetings. I was working two jobs. It was a period of redefining. The program, steps, and spiritual life became more important to me. They were 'hitting me between the eyes.' Some of the issues in the recovery process were there when I put down the drink. I dealt with them in the way I could handle them at the time. But they needed to be addressed again. I hadn't been in therapy for a long time. The patterns were emerging that I had dealt with in early sobriety. Stuff was coming up, especially in areas of people, friendships, and relationships.

Angela: It was a period of great turmoil. It was the end of a relationship which had lasted for seven and a half years. I had hardly noticed my 10th. I remember the day well. I celebrated it. I certainly knew I could handle anything. I was in a lot of pain. It didn't feel insurmountable. From my 10th to 11th, I did the 3 month retreat. It was painful and quite wonderful processing the anger and the whole end of the relationship. It had a lot to do with spiritual development which culminated in going on retreat.

Barbara: It comes up against my self-esteem. When I was one year, I had enough self-esteem to have one year; when I was 2 years, I had enough to have 2 years. But now my sobriety is outpacing my self-esteem. By 10 years, it is an enormous gift. It's like having a chateau in Paris. It's bigger than I am.

Examined more closely, each of these individuals had a complex story to tell of profound personal transformation, of a life still unfinished, but firmly anchored in the A.A. experience. From them and others like them, we can learn much about how and why they stay sober (and indeed, why they remain loyal to and affiliated with A.A.) and what problems

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they face living in a larger social context, dominated by what some social observers have called a "culture of drinking" (Fine, Akabas, & Bellinger, 1982; see also Harford & Gaines, 1981) which seems to support and encourage personal indulgence and other forms of self-destructive behavior.

The present study is, therefore, exploratory in nature. It uses qualitative methods to focus on a heretofore invisible population, the experiences of a newly selected heterogeneous group of 30 long-term recovering people, 15 men and 15 women, sober in A.A. for 10 or more years. The goal of the study is to explore the commitment of these diverse individuals to this uniquely personal change process in the context of the A.A. experience by examining how these individuals got sober, how they stayed sober, why they continue to stay sober, and how they manage to develop, foster, and maintain their sobriety in an atmosphere free of alcohol.

SUMMARY

Chapter 1 provided a brief overview of the scope of the alcohol problem in the U.S. Against this background, it considered the efforts made by individuals to stop drinking

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through traditional treatment approaches, A.A. attendance, and other non-traditional methods. It then reviewed the limitations in the efforts of outcome-oriented research to assess the efficacy of various treatment approaches and proposed that more attention be devoted to the experiences of individuals with long-term sobriety, that is, 10 or more years of continuous sober time. The chapter concluded with a discussion of the origins of the present study and an introduction to the key questions this study proposes to address.

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CHAPTER 2

REVIEW OF THE LITERATURE

INTRODUCTION

This chapter contains a review of the literature pertaining to alcoholism, A.A. and long-term recovery. It is divided into two sections. The first section considers the social work response to these aforementioned areas from both a historical and contemporary perspective, while the second section considers the social science response to the same three areas. Each section contains a discussion of the limitations of current research in identifying and describing the experiences of individuals with long-term recovery. This exploratory study, the first of its kind in social work of which we are aware, is designed to begin the process of discovery to assist the professional treatment community in its efforts to respond to the needs of long-term recovering alcoholics.

THE SOCIAL WORK RESPONSE

TO ALCOHOLISM, A.A., AND LONG-TERM RECOVERY

It is not without some irony that while social workers are at the cutting edge of service to alcoholics in the U.S.--many work directly with alcoholics and their families in public and private treatment facilities, hospitals,

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rehabs, and more recently in private practice--there are few resources in the social work literature to serve as guides to research and practice with long-term recovering populations. In fact, with the exception of a few studies, one has to look elsewhere in the professional social science literature for more information on this special cohort. Indeed, a review of the social work literature on alcoholism in general discloses the rather curious fact that, until the publication of the Curriculum Modules on Alcoholism and Other Drugs for Schools of Social Work (1995), a product of the Curriculum Enhancement Task Force comprised of several national social work organizations, alcoholism and work with alcoholics occupied a somewhat anomalous position as a field of practice within social work.

It was little more than two decades ago that Barbara King (1978), Chairperson of the Alcoholism Committee of the New York City Chapter of the National Association of Social Workers (NASW), called attention to the "*quite recent* [italics added] broadening of professional interest in alcoholism" (p. 3), an interest stimulated by the Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment and Rehabilitation Act of 1970 (U.S. Congress,

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Senate, S3835, sometimes known as the "Hughes" bill after Iowa Senator Harold Hughes) which established a comprehensive federal program for prevention and treatment of alcoholism. But King also noted that, while social workers were well positioned to identify and intervene in cases of substance abuse, by 1978 there were still gaps in the recruitment, preparation, and training of skilled professionals:

> Nevertheless, it is still true (with important exceptions) that by and large students are not coming out of the schools of social work with interest and enthusiasm about, nor skill in working with, alcoholics, unless by virtue of special field work placements. Neither are the majority of administrators and supervisors trained as yet to help with the special approaches and techniques which have been found to be useful and essential in working with alcoholics and their families. (p. 4)

King reminds her readers that long before the medical profession recognized alcoholism as a disease, a social worker had already done so in a classic work of the profession. In 1917, Mary Richmond had written in Social Diagnosis that "inebriety is a disease" (p. 429). But, as King noted, for too long the social work profession ignored this insight and continued to view alcoholism as a "symptom of an underlying psychological disorder or as an interactional problem alone," rather than as a "primary

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disease in its own right"--"It is as if we have pursued an arsonist while ignoring the continued raging of the fire" (p. 4). King's remarks, therefore, represented one such attempt to correct misconceptions in the diagnosis and treatment of alcoholism and to bring new knowledge about "basic definitions, diagnostic tools, and 'how-to' techniques of actual, day-to-day treatment" (p. 4) to the social work professional.

Moreover, it was not until 1979 that the social work profession recognized its responsibility to "acknowledge and support the direct treatment of alcoholism" (National Association of Social Workers [NASW] Policy Statement, 1979). In November of that year, the National Delegate Assembly of NASW approved a major policy statement on alcoholism and the profession, since revised and approved in 1987 and again in 1996 (Mayden & Nieves, 2000). But even a cursory reading of the 1996 document reveals that social workers still needed to be prodded into taking more responsibility in four critical areas--1) social policy; 2) professional issues; 3) prevention, intervention, and service delivery; and 4) research (pp. 22-24). The 1996 document demonstrated that the profession had now recognized

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that alcohol abuse (along with tobacco and other substances) was a "significant public health problem" (p. 22). This was a major advance over the 1987 Policy Statement with its special pleading that social workers "must understand that the abuse of alcohol and other substances is a pervasive mental health, health, and social welfare issue" (Curriculum Enhancement Task Force, 1995). Nevertheless, the need to change perceptions about alcoholism, while encouraging social workers to take a more active role in advocacy, policy development, prevention and treatment planning, even peer consultation with impaired colleagues, remained high on the profession's agenda--"Social workers need to view alcohol, tobacco, and other drug addictions as primary problems, rather than as symptoms of other problems" (p. 21). While the 1996 Policy Statement urged a "comprehensive public health approach" (p. 22) to the problem of alcohol and substance abuse, the profession acknowledged that it still had a major task of educating its own members about the issue--"To effectively treat clients' problems rather than symptoms, all social workers must develop basic knowledge and skills to identify, assess, treat, and refer clients with alcohol, tobacco, and other

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substance abuse problems" (p. 21).

Also, for the first time in 1979, the profession recognized that a major substance abuse problem existed in its own ranks. But as Bissell and Haberman (1984) noted, it was not until 1982 that action was taken on the national level within the NASW--in the form of the development of an Employee Assistance Program. In a brief survey of subsequent actions within the profession, the authors concluded that the pattern of response had been wary and haphazard, although since their study was published and since the revised Policy Statement was issued in 1996, there were some new and encouraging developments within the profession. For example, a small self-help network known as Social Workers Helping Social Workers was quietly organized to work with impaired social workers, the Peer Consultation Committee (a subcommittee of the Alcoholism Committee) of the New York City (NYC) Chapter of NASW published a pamphlet, "Helping Social Workers with Alcohol and Other Drug Problems: Options for Intervening with Colleagues" that was reissued by NASW and distributed nationally within the profession, and many NASW Chapters also conducted local surveys on alcoholism and drug abuse. In 1994, this

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researcher attended a workshop sponsored by the NASW's New York City Chapter Peer Consultation Committee on "Educating Social Workers About Alcoholism." Judging by the large attendance of social workers at that time, more remained to be done. With the publication of the NASW/CSWE Curriculum Modules in 1995, alcoholism (and substance abuse in general) was officially recognized as a field of practice in Master's level social work programs (note that the 1996 NASW Policy Statement calls for a strengthening of the core curriculum in substance abuse at the undergraduate and graduate levels; see p. 23). But NASW has yet to sponsor a national conference on substance abuse, though the Alcoholism Committee of the NYC Chapter of NASW has been conducting a full-day Alcoholism Institute each year for more than two decades.

Again, as recently as 1984, social work's response to the alcoholic client was still erratic. Indeed, according to Googins (1984; see also Cook, Fewell, & Riolo, 1983), the record of social work in helping to develop treatment programs was "dismal." If anything, professional helpers were not only ignorant about alcoholism but also were likely to avoid alcoholic clients, because they perceived them as

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"undesirable, untreatable, and unmotivated":

> From the available evidence, the record of the professional human service community in general and social work in particular in identifying and treating alcoholics is far from admirable. Reflecting the cultural bias in the larger society, the vast majority of human service agencies have ignored alcoholics, joined in the denial of the condition, and treated only that part of the alcoholic's problem that most closely fit the expertise and inclination of the staff. The individual, institutional, and professional barriers to effective treatment are complex and ingrained in a practice that inadvertently works to bar alcoholics from the mainstream of human services. (Googins, 1984, p.165)

While services to the alcoholic may have expanded in the decade since this was written, the fact remains that the alcoholism treatment field is currently in considerable disarray with respect to standards, credentialing, training, and education. Contrary to the call for greater responsibility in this area in the 1996 NASW Policy Statement, social workers have yet to exercise a significant leadership role in this domain. As a result, there is competition within the professional treatment community (that is, between Master's prepared social workers and credentialed alcoholism counselors) for jobs with the resultant negative impact on salary levels and professional status.

If social work has had an ambivalent attitude toward

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practice with alcoholics, there is even a more curious pattern of responses among social workers regarding such non-professional treatment resources like A.A. Margaret Bailey, acknowledged by Barbara King (1978) as one of the early advocates of social workers involving themselves in alcoholism treatment (King also argued that Bailey's book, Alcoholism and Family Casework [1968] was still one of the best books in the social work literature on alcoholism), had already written of this phenomenon in 1965:

> Social workers and other professional people appear to share somewhat mixed feelings towards Alcoholics Anonymous and the Al-Anon Family Groups as community resources to which clients may be referred. Virtually all social workers have at least minimum acquaintance with A.A., although some are not familiar with Al-Anon, similar in conception and general functioning to the older and better known A.A. fellowship. I have occasionally heard professional people express attitudes which attributed almost magical powers to A.A. and which perhaps reflect a sense of relief that responsibility for a difficult alcoholic could be transferred to the . . . A.A. fellowship, once a referral had been effected. On the other hand, there are those who question the wisdom of referring alcoholics and their families to such entirely non-professional groups. The prevailing attitude of social workers seems to be positive, but there is little . . . understanding of the therapeutic mechanisms involved in the two fellowships. (p. 159)

Bailey was not alone in noting this bias. In 1972, Vattano observed that the self-help movement was becoming a force to be reckoned with by the professional social work

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community. With conventional treatment approaches producing questionable results and increasing manpower training shortages, professionals were feeling "inadequate and impotent." Therefore, he urged a "new partnership" between social work professionals and lay groups and the design of new "conceptual models of helping" relevant to the treatment needs of clients (p. 15).

In 1985, despite the fact that self-help groups like A.A. had now established themselves as an important community resource, Toseland and Hacker noted the ambivalence that still existed among social work professionals toward self-help groups. The authors conducted a study of the ways in which social workers used self-help groups in their practice. Among their findings was the need for "educating, informing, and training social workers concerning the availability and potential uses of self-help groups as community resources." Moreover, they discovered that self-help group leaders did not have positive attitudes towards social work involvement and that they often discouraged members from seeking professional help. Also, they found that there was still a "significant minority of workers [especially among the Master's prepared]

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who know little or nothing about local self-help groups and do not use them in their practice" (p. 237). Kurtz (1985) was equally troubled by the tension that existed between the two communities:

> . . . the issue of cooperation between AA and professions is a sensitive topic now because more professional treatment exists than ever before. The upsurge of professional attention to alcoholism has resulted in scrutiny and frequent criticism of AA by persons who are not part of it. (p. 108)

Needless to say, A.A., in keeping with its 8th Tradition to "remain forever non-professional" and its 11th Tradition (see Appendix A) to attract rather than promote, does little to publicize its activities, though it will assist professional groups (as it did with the Peer Consultation Committee) in providing in-service training to its membership.

These public stances, as we will shall see, present a threefold challenge to the professional community in general and to the social work profession in particular. First, social work and social science researchers often are skeptical of A.A. because, as Vaillant (1983) notes, "AA is so unscientific":

> Researchers prefer to study variables that they can experimentally manipulate and observe without bias. But like the study of political parties

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> within one's own country, the study of AA tends to polarize its observers into believers and non-believers. Perhaps AA resembles the pixie dust in J.M. Barrie's Peter Pan that enabled Wendy to fly; for AA to work, one must be a believer. At present the actual effectiveness of AA has not been adequately assessed. (p. 197)

For example, when Kurtz (1985) began her study of the factors favoring cooperation between A.A. members and the professional treatment community, she was frustrated by the difficulties she encountered in getting A.A. members to cooperate with her research efforts:

> The limited sample size, the sample's confinement to only one state, and the poor response rate from AA members posed significant problems for the research. Results cannot be generalized outside the state or to private treatment centers. The likelihood of bias in the responses cannot be overlooked, especially by AA members, among whom the most negative recipients of forms may have refused to cooperate with the research. The difficulty of contacting AA members by mail because of AA's proscription against the use of its directory for this purpose made the snowball technique the only method available for contacting them and prevented followup with nonrespondents. Such problems are inherent in the study of AA and illustrate one reason why so few studies of AA exist. (p. 108)

Interestingly, her A.A. respondents (N = 31) averaged seven years in the program, a mean length that was higher than could be found in most studies of long-term sobriety.

Second, there are few scientifically conducted long-term follow-up studies of recovering alcoholics. A.A. produces no longitudinal data of its success rates, though

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it has produced its General Service Conference-approved membership survey literature. But still, as Vaillant (1983) acknowledges, a community self-help group like A.A. is in a "position to influence the alcoholic's behavior for a much longer period of time" (p. 200). He does not suggest, however, that A.A. is the "best" answer--"there are many paths to recovery in alcoholism" (p. 293). And, indeed, there are others, though none of them shows high rates of success and some, as we shall see, are controversial.

Third, the hesitation on the part of the social work community to embrace A.A. may also be rooted, as we have seen, in the traditional enmity of professional groups toward mutual self-help lay networks which appear to challenge the professional's claims to a monopoly on authority, judgment, and expertise. A.A.'s strategy to combat this inherent conflict of interest is to assert its neutrality as a non-professional organization (its 8th Tradition). The A.A. Preamble states that it "does not wish to engage in any controversy," while its 10th Tradition claims "no opinion on outside issues."

Finally, as Bissell and Haberman (1984) note, what is even more significant perhaps is that when impaired

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professionals, including social workers, were surveyed as to their awareness of A.A. as a helping organization, their responses showed them to be ignorant or misinformed about A.A.'s purposes:

> Very few of our subjects had first heard of A.A. as part of their professional training (11 percent of the medical professionals, only one social worker, and no attorneys). Many of those who had heard of it were poorly informed or even misinformed. Some had been led to believe that it represents a somewhat suspect variety of folk medicine, while others gathered that it was a group of people who now substituted for the dependence on alcohol an equally unhealthy dependence on A.A. Some were wary of involvement with what they feared was a fanatic religious group or a group whose members were of a much lower social class than their own. Few had visited an A.A. meeting firsthand, even to explore it as a resource for others, and based their opinions entirely on hearsay or on popular media. Only a few were aware of knowing any A.A. members. (p. 89)

In short, most professionals knew only that A.A. was supposed to help, but they "had only a vague idea of its methods. They were aware that its focus would be on drinking" (p. 91).

The message is clear. While A.A. may have won acceptance in the helping community, particularly among social workers, since Bissell and Haberman published their study in 1984, the fact remains that as recently as June, 1994, over 50 social workers attended a workshop sponsored

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by the NYC NASW Chapter's Peer Consultation Committee, which included a simulated A.A. meeting, to learn more about alcoholism and the A.A. philosophy. Thus, despite the number of entries since 1977 in the Social Work Abstracts on alcoholism and social work (there are 262 to be exact), there are far fewer references to social work and recovery (135 items) and even less written about long-term recovering alcoholics from a social work perspective (see Melvin, 1984; Lowery, 1999). Little wonder then that for a review of the literature on long-term sobriety, the reflective social work researcher-practitioner must turn largely to sources outside the field of social work. But even these references, as we shall see, contain considerable gaps in knowledge and, therefore, have limited value because they fail to address key issues concerning the long-term recovering alcoholic.

The following section contains a comprehensive review of the smaller social work literature as well as the larger social science research on long-term recovery.

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THE SOCIAL SCIENCE RESPONSE TO ALCOHOLISM, A.A., AND LONG-TERM RECOVERY

Over the past three decades, researchers have come to recognize that little is known about alcoholics in remission and even less, as Melvin (1984) put it, about the "fate of the alcoholic who attains sobriety" (p. 98). Over and over again, theorists have cited the paucity of research in this area (see Leukefeld and Tims, 1986; Sommer, 1997). Most studies of recovering alcoholics, in fact, draw their subjects from treatment settings.[1] But this has its problems. As Billings and Moos (1983) caution, a "significant gap in our understanding of alcoholism begins at the point at which the alcoholic's treatment ends . . . ." They remind us that:

> . . . the nature and determinants of the alcoholic patient's post-treatment functioning are comparatively unexplored. Basic and clinical research has examined the etiology, progression, and treatment of alcoholism more extensively than the interdependent processes of recovery and relapse that continue after the termination of treatment. (p. 205)

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1 While most people with alcohol problems do not seek treatment, the numbers are unclear. The ratio of untreated to treated individuals is variously estimated to range from 3:1 to 13:1 (Sobell, Sobell, Toneatto, & Leo, 1993, p. 217). The fact that most research on alcoholism is done with a clinical population raises issues of bias and is one reason for the increased attention to natural recovery cases.

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Given the fact that remission rates, especially continuous remission, are not high[2] (Emrick, 1974; Orford, Oppenheimer, & Edwards, 1976), it is perhaps understandable that some researchers have lowered expectations for identifying subjects to study. Billings and Moos (1983), for example, argue that for many alcoholics, recovery and relapse are "interdependent processes." Wiseman (1981) understood this and therefore chose to focus on the dynamics of this interstitial period, which she called "sober comportment," to ascertain what could be learned to reenforce and strengthen recovery. Polich, Armour, and Braiker (1981) studied the functioning of former patients at NIAAA facilities in an effort to identify different types of alcoholic remission and examine their stability over time. But in the end, even these authors were forced to concede that "all types of remission were subject to a high probability of relapse." Apparently, their subjects were unable to sustain any long-term continuous remission; therefore, the authors concluded that "Instead of

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2 Donovan (1988, p. 33) estimates that the majority of relapses occur within the first three months of posttreatment. Miller (1989, p. 70) notes that long-term followup data indicate that over 90% of those who leave treatment are at high risk for relapse.

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using long-term continuous remission as the measure of success, we suggest that a more reasonable standard would be the total length of time spent in remission periods" (p. 217).

This observation led them to an even more controversial conclusion--given that treated alcoholics are not likely to achieve a stable remission, "an expansion of treatment approaches, including goals other than the traditional demand for abstinence, might offer advantages for some alcoholics" (p. 220). Vaillant and Milofsky (1982) came to a similar conclusion. They regarded abstinence as an "oversimplified treatment goal" when it should, in their view, "remain a means, not an end"--"It is justified as a treatment goal only if moderate drinking is not a viable alternative and only if the real goal, social rehabilitation, is kept in view" (pp. 132-133). Riley et al. (1987) sound a similar note of pessimism. Following Marlatt (Marlatt and George, 1984), they endorse a "gradual rather than abrupt" recovery (p. 105), because in their view "Long-term abstinence or totally problem-free drinking are both rare, whereas substantial improvement is a quite common outcome" (p. 106).

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But as this present study intends to demonstrate, if the experience of alcoholics recovering in A.A. (where abstinence is the stated goal) is any guide, long-term continuous abstinence is not all that rare--it just remains to be discovered and documented. There are individuals--the 30 participating in this study, for example--who never found it necessary, as they say in A.A., to "go out and do more research."

Meanwhile, other theorists have noted the considerable gap in understanding that exists between the early sobriety period and the later stage of maintenance, though they are not always clear about where these periods begin and end. Allen, Lowman, Mattson, and Litten (1992) comment:

> A significant advance in conceptualizing treatment is recognition that principles underlying the initiation and stabilization of behavior change may differ from those underlying maintenance of change and that different types of intervention may be required to achieve these different objectives. The research findings on the prevalence of posttreatment relapse suggest that alcoholism treatment has enjoyed far greater success in initiating and stabilizing patients' sobriety than in facilitating its maintenance. (p. 51)

Even a brief review of the change process literature reveals that much more remains to be learned about the so-called maintenance phase. While Saunders and Allsop

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(1985) take the position that maintenance is better understood than all other phases, most researchers would disagree. Following Marlatt and Gordon (1985), in their work on relapse prevention, Miller (1989) observes that "*Maintenance* is the real challenge in all of the addictive behaviors. It is not difficult to stop drinking; it's hard to *stay* sober" (p. 70); or as they say in A.A., "it is easy to stop drinking, but difficult to stay stopped."

Over the last two decades, Prochaska and DiClemente (1983; 1984) have pioneered a series of studies on the constituents of the change process in smokers and in other people with addictive behaviors. They developed a model of self-change that involves progression through at least five stages--precontemplation, contemplation, preparation (this stage was added later in their research), action, and maintenance. The authors subsequently elaborated these stages into a more three-dimensional or "metatheoretical framework" that integrated stages with processes and levels of change.

Interestingly, Prochaska, DiClemente, and Norcross (1993) seem to agree with Polich et al. (1981) and Riley et al. (1987)--that most self-changers "will recycle several

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times through the stages before achieving long-term maintenance." Therefore, they caution practitioners that if they expect people to progress "linearly" through these stages, they are "likely to gather disappointing and discouraging results" (p. 13).

But of all the stages described by Prochaska and DiClemente (1983), maintenance, though conceived of as an "active stage of change rather than an absence of change" (p. 394), receives the least attention--"*Maintenance* is the stage in which people work to prevent relapse and consolidate the gains attained during action" (Prochaska, DiClemente, & Norcross, 1993, p. 5). Moreover, other questions remain unanswered in their research. Projecting maintenance as extending anywhere from six months "to an indeterminate period past the initial action" (p. 5), Prochaska et al. (1993) do not provide details about exactly how people work to prevent relapse and how they consolidate their gains. In addition, they generalize for all addictive behaviors without giving any consideration to the special problems encountered by specific recovering populations such as alcoholics. Finally, they lump together self-initiated with professionally assisted change (they do not examine

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change through mutual aid or peer group support), though in an earlier study, Prochaska and DiClemente (1983) cited the need for "comparative studies with other problem behaviors [besides smoking] to determine the extent to which change processes vary in emphasis as different problem behaviors are being changed" (p. 395).

More recently, the issue of protracted maintenance received renewed attention by Prochaska and his colleagues (Snow, Prochaska, & Rossi, 1994). This time the authors turned their attention to Alcoholics Anonymous in an effort to identify the maintenance factors in long-term sobriety. They assembled a sample of 191 A.A. attenders, the majority of whom were white males. Sobriety ranged from 1 month to 27 years with a mean of less than 6 years. While the authors found a positive relationship between the "use of behaviorally oriented change processes and increased involvement with AA," they were troubled by the need to more carefully determine how to measure affiliation and how to conceptualize spirituality as a "viable change process" (p. 369). They urged further study, among other things, into why A.A. is a primary factor in the maintenance of recovery.

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While there is no specific category in the alcoholism literature known as "sobriety or recovery studies," there are several sources of research that inform our present undertaking, though each has its limitations--1) follow-up studies of posttreatment alcoholics; 2) studies of spontaneous remission; 3) studies that attempt to conceptualize the recovery process; and 4) studies of A.A. as a self-help enterprise and the recovery experiences of its members. Most studies of the alcoholic in recovery concentrate on the early stage, that is, the first two years. Very few, as we shall see, include in their samples individuals with longer term sobriety. Far fewer include a balanced sampling of alcoholics by gender, race, or sexual orientation. Some of these studies are reviewed below (in chronological order) so as to describe better the emergence of long-term sobriety as a new and meaningful line of inquiry.

1. <u>Studies of Posttreatment Alcoholics</u> -

Hanfmann's (1951) case study of "Sam" was drawn from the files of the Harvard Psychiatric Clinic in 1946-1947. It was designed to fill a need for more studies of the personality and life history of the alcoholic, the dynamics

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of his alcoholism, and their relationship to his subsequent rehabilitation in A.A. However, the subject chosen had only 3 years of recovery. By the study's end, the author recognized the need for a "larger collection of case histories than we now possess to find out how common are the particular dynamics of recovery that seem to have been operative in the case of Sam" (p. 438). In Sam's case, Hanfmann concluded that his natural ability to socialize and his expansive personality made him a good candidate for A.A. because, in her view, A.A. seemed to benefit those who affiliated easily. But aside from anecdotal accounts of the life histories of alcoholics and their recoveries such as those found in A.A.'s Alcoholics Anonymous (1976; known as the "Big Book") few case histories of sober alcoholics appeared in the research literature in the intervening years.

Gerard, Saenger, and Wile (1962) produced a follow-up study (at intervals of two, five, and eight years after intake) of 55 male alcoholics known to the Connecticut Commission on Alcoholism who were abstinent but only for one year after the initial interview. Their study posed six questions:

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> . . . what happens to alcoholics who are not drinking? To what extent is abstinence associated with a general improvement in the adjustment of the alcoholic? What are these persons like in their current abstinent state; what led to their abstinence and to maintaining it? Are other symptoms which may or may not be less detrimental to society and the patient substituted for alcoholism when the 'normalizing' adaptive assistance of alcohol is withdrawn? In these terms, what does it signify to say that a person has become abstinent? How does this relate to conception of 'improvement'? (p. 100)

What the authors found was that the sample group of 55 (out of 299; gender and race/ethnicity not specified) seemed to have remained in better health and had better employment prospects than the nonabstinent subjects. Moreover, of those currently abstinent, 12% were "AA successes" (those who made a "spectacular shift in their lives through a successful identification with AA," p. 90). Abstinence, in short, seemed to be associated with a general improvement in the ex-patient's life. However, a more complex picture of this sample emerged in a fourfold typology (pp. 104-106) developed by the authors depicting the patient's interpersonal relationships and psychiatric status. There were the "overtly disturbed" (54%), the "inconspicuously inadequate" personalities (24%), the "AA successes" (12%), and the "independent successes" (10%). Of the "AA successes," the authors noted:

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> They have acquired a sense of purpose and value in life through their AA membership, which seemingly encourages the totality of their lives, their family relationships, and their occupational adjustment. (p. 106)

But, as we shall see when we examine the research on A.A. more closely, Gerard et al. (1962) are uneasy about their subjects' attachment to A.A.--"It is evident that they are as dependent on AA as they were before on alcohol and the pattern of relationships in which their alcoholism was integrated." And they speculate, "Without AA, where would they be" (p. 106)?

The authors regret, however, that they could not study this population in more depth and are left only to guess at the dynamics of the recovery process:

> Without understanding a person in depth, one cannot fully explain so major a shift in orientation and attitude which becoming abstinent is thought to entail for a person with a drinking problem. (p. 108)

Instead, they outline a research agenda for the future:

> We may conclude conservatively that much remains to be learned about the treatment of people with drinking problems, not only from the perspective of bringing them to abstinence, but also from the perspective of helping them to achieve a more stable and mature level of psychological adaptation. The reader is reminded that alcoholism is notoriously difficult to modify, and that the loss of a symptom may be as threatening to the person's total adaptation (or more so), as the maintenance of the symptom may be harmful in terms of its effect on health and social adjustment. (p. 111)

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In the cautious and conservative note struck in this peroration lies the seeds of this present study with the difference being that much also remains to be learned about the experiences of people who have committed to recovery. If alcoholism, as the authors argue, is "notoriously difficult to modify," recovery represents new territory to be charted in depth both by the alcoholic and the researcher.

Kurtines, Ball, and Wood (1978) conducted one of the earliest studies of the long-term sober alcoholic using a heterogeneous sample of males and females (a rare study of its kind), though race and ethnicity were not specified. They were interested in identifying the personality characteristics of the successfully recovered person. Their subjects were divided into three groups--1) 60 newly recovered alcoholics (30 male; 30 female) with sobriety periods of three weeks to four months; 2) 62 long-term recovered individuals (31 male; 31 female) active in A.A. with a minimum of four years of continuous sobriety and a mean length of 8.9 years; and 3) a control group of 61 non-alcoholics (30 male; 31 female), that is, people who either drank moderately, less frequently, or not at all.

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While previous studies searched in vain for an underlying distinctive alcoholic personality type, Kurtines et al. (1978) conclude that alcoholics are more complex and find that "differential patterns of psychological adjustment [exist] at each stage of recovery" (p. 971). Their study was undertaken because of a "conspicuous lack of data on the characteristics of individuals who have been able to maintain long-term sobriety" (p. 972). They further comment--"The paucity of research on long-term recovered alcoholics is particularly striking in light of the generally acknowledged difficulty in working with alcoholics as a treatment population" (p. 972).

In their view, two reasons account for this lacuna in research. First, and most obvious, is the fact that individuals with protracted abstinence are not involved with treatment programs (the traditional source of subjects to study) and are therefore not readily accessible to researchers. Second, and more significant, is the fact that alcoholism is still a stigmatizing condition and even a recovering person may wish to safeguard his or her anonymity. What the authors do not explore, however, is the extent to which the recovery process, particularly as

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fostered in A.A., becomes a form of "positive deviance" (see also Goode, 1991)--why, for example, do people in A.A. say, as several individuals in the present study did, that they are glad to be an alcoholic?

What Kurtines et al. (1978) did discover is that there were significant differences in patterns of adjustment and coping styles among all three sample groups. In particular, the long-term abstinent group displayed a "unique psychological adjustment profile"--while they were somewhat "socially maladjusted," they were "relatively nonneurotic" (p. 975). Long-term sobriety, in short, was associated with improved adjustment levels. These individuals were more self-accepting, had a stronger sense of well-being, and were in better health. The authors argue for greater appreciation of the need to adapt treatment interventions and modalities to a particular stage of recovery and recognize that each alcoholic has a different personality profile. Their emphasis on "stages of recovery" would eventually open up a new line of inquiry for future researchers.

Rubington's (1980) exploratory study of the first year of abstinence was based on interviews with 36 alcoholics (31

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male, 5 female; race/ethnicity unspecified). Twenty-three individuals lived in a half-way house, while 13 resided in other community contexts. The author does not make clear what kinds of treatment interventions worked for each group. Instead, his emphasis is on the contexts in which each group got sober and the extent to which context affected the quality of their recovery. He conceptualizes recovery as a three-part process consisting of "career," "symptoms," and "context." For the first time in the recovery literature, he introduces the notion of a "career of recovery," by which he means "changes in a recovering alcoholic's life which occur as a result of abstinence." These changes could occur in "social role, self-definition, status, and function." "Symptoms of recovery" mean the changes in an alcoholic's behavior in specific situations, while "context of recovery" refers to environments or situations encountered while abstinent (p. 577). It was the context that could either mitigate or exacerbate an alcoholic's symptoms and ultimately affect the quality of one's recovery life. Rubington's emphasis on recovery as a "career" not only called attention to a possible process underlying this new life, but also to recovery as a priority, a notion not too

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dissimilar from that promulgated in the A.A. Preamble--"The only requirement for membership is a desire to stay sober and help another alcoholic achieve sobriety." Rubington proposed additional research into the "frequency and kinds of problems that arise in divergent contexts of recovery" (p. 582). This was, moreover, one of the first times that anyone had called attention to the impact of environmental contexts on the stability of the recovery process. There was now a discernible shift in the literature away from an exclusive focus on treatment.

Vaillant and Milofsky's (1982) longitudinal study of 456 Core City white males is also a departure from previous research on alcoholism. In their cohort, 110 met the research criteria for alcohol abuse and 49 had achieved at least one year of abstinence. These individuals were followed up for multiple points in time from ages 14 to 47. Unlike other studies which utilized clinic populations, the authors argue that alcoholics in treatment are less representative of the alcoholic population in general. They are "more ill, . . . more psychologically impaired, and . . . reflect previous treatment failures." Moreover, they are at risk for attrition from treatment followup studies.

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Instead, the authors' strategy is to "let each alcoholic serve as his or her own control":

> . . . to understand the recovery process in alcoholism, the study should be so designed as to maximize the elucidation of natural healing processes as well as that of effective clinical intervention. Indeed, there is extensive literature . . . suggesting the recovery process in alcoholism may depend almost entirely on factors other than specific treatment interventions. (p. 127)

According to the authors, among the factors contributing to remission of the disease were the following: 1) finding a substitute dependence (e.g., candy, medication, prayer, even A.A.); 2) naturalistic behavior modification, compulsive or otherwise (e.g., Antabuse therapy, medical complaints, being court- or job-mandated); 3) discovery of a new source of hope and enhanced self-esteem (e.g., religious affiliation, A.A. involvement); and 4) acquiring new social relationships (p. 130).

Factors associated with A.A. affiliation were absence of maternal neglect and presence of a warm childhood. But Vaillant and Milofsky (1982) caution that early abstinence was not a predictor of stable abstinence. Moreover, on the basis of the experience of their subjects ("the proportion of Core City men that over time could be placed in the abstinent and return to social drinking categories . . .

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[was] impressive" [p. 131]), the authors argue that "abstinence per se must certainly represent an oversimplified treatment goal" (p. 132); that a return to "asymptomatic drinking is a common outcome for many alcoholic abusers, but these are rarely the very symptomatic alcoholic abusers who seek help in clinics; nor are they, once recovered, those who speak out on public issues in alcohol education" (p. 133); and that recovery is an ongoing process despite relapse.

As for A.A., the authors note that it embodies the four essential therapeutic factors in maintaining abstinence mentioned above in addition to facilitating or transforming the alcoholic's defensive structure. The alcoholic's embrace of A.A. and its positive spiritual message to surrender to a Higher Power is an instance of reaction formation; the alcoholic's denial of his or her problem is likely to give way to an eager acceptance of the label "alcoholic"; and the alcoholic's tendency to blame others for his or her drinking is now transformed into greater acceptance of personal responsibility for one's problems (p. 132). Thus, the authors encourage us to look beyond clinic populations ("clinicians do not usually meet

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recovered alcoholics in their clinics and emergency rooms" [p. 133]) for an understanding of "natural healing processes."

Meanwhile, clinic studies came under attack for other reasons. Pettinati, Sugerman, DiDonato, and Maurer (1982) question the utility of previous followup studies on the posttreatment of alcoholics, especially that conducted by Gerard et al. (1962) and Polich et al. (1981). These earlier studies are, in their view, "fraught with methodological problems"--1) patient self-reports may be untrustworthy; and 2) a one-year followup, as in the case of Gerard et al., or single intervening followup in a four-year period, as in Polich et al., may produce poorly reconstructed experiences (significant in a population not known for adequate recall) or what the authors call "window viewing" (p. 201), that is, the attribution of experiences to particular years without any basis for validating comparisons across populations.

To overcome these problems, Pettinati et al. (1982) propose a four-year followup study of 225 hospitalized patients (150 men; 75 women; 97% Caucasian) with an annual interview with the patient and at least one additional

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corroborative source (a rare research strategy) conducted by a social worker experienced in working with alcoholics. Also, the interviewer was to have added contacts with the interviewees and their collaterals over the years through A.A. meetings, letters, and phone calls.

Of the total sample, 22% maintained complete abstinence and showed good adjustment. The authors concluded that "complete abstinence without slips" was unrealistic, although they challenged other studies--"much of the literature . . . considers subjects who have had occasional slips as abstinent" (p. 206). If individuals were consistently able to maintain abstinence with good adjustment for two years, they were likely to do so for two more years (p. 208). By the end of the four years, those able to maintain sobriety and good adjustment had fewer psychological interventions during this time. The authors also found that regular A.A. attendance over four years (defined as 1-2 times per week for at least six months of each of the four years) was associated with the maintenance of a healthy psychological profile (p. 211). In short, regular A.A. attendance was associated with "maintaining long-term abstinence and good adjustment," although it was

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"not a necessary condition for a favorable outcome" (p. 212).

A similar longitudinal study of 45 posttreatment Native American alcoholics (37 men; 8 women; note that respondents were paid a stipend for their participation in the study) at ten year followup was conducted by Westermeyer and Peake (1983). In this study, only 7 (or 16%) remained abstinent for two or more years beyond treatment. Here the authors found that, despite the "dismal" outcomes, abstinence correlated with such extratreatment factors as steady employment, good living conditions, a strong social network, a stable marriage, and the least clinical pathology (especially depression). A significant variable was age, that is, older people with a child-bearing role fared better.

Melvin's (1984) study of the lifecycle of sobriety is one of the few that aims to "learn more about how the ex-alcoholic fares after attainment of sobriety" (p. 98). It is also a rare example of a study in the social work literature that focuses on the period beyond early abstinence. She reviews previous literature on sobriety and finds it dominated by a study of mood changes, depression,

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and management themes--"treating the alcoholic during sobriety is less frequently discussed than is therapy with the alcoholic who is still drinking" (p. 100). Melvin also outlines the various treatment models that have been proposed for helping the sober alcoholic. Finally, she examines the relapse literature for more information on the adaptive issues facing sober alcoholics.

Melvin's thesis is that there are no paradigms or prototypes to describe the "process of adapting to sobriety" (p. 102). Only anecdotes exist to explain the alcoholic's sober experience. While she tantalizes her reader by suggesting a distinction between "sobriety" and "recovery"--"it is apparent that sobriety is not all synonymous with recovery" (p. 102)--she never precisely defines these terms. Finally, she proposes a project to answer a key question--"How do recovering alcoholics deal with these stresses and re-adapt to an alcohol-free life" (p. 102)? Her sample consisted of interviews with 10 subjects (4 men, 6 women; race/ethnicity unspecified) with at least three years of abstinence. The mean length of sobriety was 6.7 years with a range of from three to ten years. All were active in A.A. Her major finding was that

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all perceived sobriety as an "evolving process of growth and [a] deepening emotional experience" (p. 104).

Melvin elucidates a series of three stages, which she likens to Erikson's stages of the life cycle, through which her subjects passed. In stage one--"starting over" (cf. Erikson's Basic Trust), the alcoholic, newly sober in A.A., learns to incorporate the messages from older A.A. members and to believe that these individuals are trustworthy. Out of this position of trust will come faith and hope, a foundation for "continued sobriety and the beginnings of personal and interpersonal growth" (p. 112). In stage two--"reality" (cf. Erikson's Autonomy), the alcoholic moves from incorporation to participation. He or she becomes active at A.A. meetings, develops ties with sponsors and other peer supports, and learns to let go of anger and other resentments. In stage three, a "whole new self now emerges to be involved in a world of people." While Melvin does not name this stage, nor does she analogize it as carefully to Erikson, she describes it as a period in which the "maintenance of sobriety [becomes] less of an issue." Now the recovering alcoholic is more goal-directed and eager to "imagine and construct new futures" (p. 113). Finally, she

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urges further research into how A.A. and psychotherapy "may collaboratively support such growth" and more study of the "re-adaptive problems posed by sobriety to the entire family" (p. 113).

Melvin's study, in short, suggests a powerful new direction in research on long-term abstinence that still remains to be pursued, though her cohort was too small and not fully representative of a protracted abstinent population. Moreover, while other researchers since Melvin have created phasic paradigms to explain recovery, few have pursued in any detail her fascinating analogy to Erikson's life cycle model.[3]

In the 1980's, more studies began to appear on what authors were beginning to call "long-term" recovering alcoholics. Mellor, Conroy, and Masteller (1986) note the paucity of research on postalcoholics. Their study was designed to build upon the work of Kurtines et al. (1978) comparing traits of long-term recovering A.A. members with those of nonalcoholic control groups. Mellor et al. tested four hypotheses, namely, that A.A. members would

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3 Van Wormer (1987) also uses the Eriksonian model in group work with alcoholics.

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show: 1) "significantly higher Responsibility scores"; 2) "significantly lower Self-deception scores"; 3) "significantly lower Impression Management scores"; and 4) would be significantly discriminated from controls through combined scores on hypotheses 1-3 (p. 413).

Their sample cohort consisted of 48 active A.A. members (23 men, 25 women; race/ethnicity not specified) with a mean of 6.8 years of continuous sobriety (the range was 1 to 26.4 years), again a heterogeneous cohort that, while allowing for in-group comparisons, was not fully representative of a long-term population. Interestingly, the A.A. members evinced an "intrapersonal structuring of values with more emphasis on responsibility" than the control group (23 men; 24 women--all randomly chosen from a large urban area), while they also manifested "less emphasis on a self-deceptive strategy for gaining approval, which is evidence of greater self-acceptance than controls" (p. 416). In short, the authors conclude that long-term recovery seems to involve a "restructuring" of personality traits that is distinctive and in need of additional comparison studies with nonalcoholics.

Longitudinal followup studies like those pioneered by

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Vaillant and Milofsky (1982) were a continuing feature of research on the posttreatment period. Many more appeared in the 1980s. Edwards, Brown, Oppenheimer, Sheehan, Taylor, and Duckitt (1988) conducted a ten-year followup study of 99 married male alcoholics (race/ethnicity unspecified) in an attempt to identify predictors of alcohol treatment outcomes. Several purposes guided their research: 1) to identify patients with an "inherently bad prognosis" so as to exclude them from treatment programs; and 2) to provide further guidance to clinicians for treatment-matching. But the authors also note the limitations in previous studies: 1) insufficient attention to process; 2) the need for a more extended time perspective of more than 1-2 years, which is generally the time frame of most outcome studies; and, perhaps most important of all, 3) the failure to acknowledge the multiplicity of variables that can influence outcome (pp. 917-919).

The work of Edwards et al. (1988) is an important reminder of the problems inherent in outcome research. While previous prediction studies of the posttreated alcoholic tended to be reductive in their search for single variables to account for success or failure, longitudinal

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studies of this population have overlooked the complexity of the recovery experience. As the authors note, outcomes are not unitary. Researchers need to "take account of the dynamics of the processes and pathways to recovery." Recovery is (as they remind us in an echo of what is often heard in A.A.) a process, not an event--"The search for predictors cannot be separated from the search for more meaningful descriptions of outcome" (p. 926).

Again, in 1988, Vaillant issued another report of his long-term followup of an addict population. In it, he argues for more longitudinal studies--"most studies of substance abuse have been too brief to clarify the recovery process." Echoing what Edwards et al. (1988) had already noted, he indicates that posthospital improvement is a more complex process than is often acknowledged--"improvement may be attributed either to treatment or to the natural history of any fluctuating disorder" (p. 1147).

Vaillant's focus this time was on a description of 10-20 years in the lives of 100 treated heroin addicts (all males) and 100 treated alcoholics (83 males, 17 females; race/ethnicity unspecified) to observe the clinical course of the disease and the "non-pharmacological variables

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affecting that course" (p. 1147). Even though his cohort had experienced high rates of relapse followed by periods of remission, his goal was to "clarify the regular sequence of events . . . under which drugs of abuse are sought" and to understand the "structure of an addict's life that facilitates recovery." He appreciated the complex "dynamic interrelations between behaviour and temporal variables." As he saw it, the problem was "if most urban addicts and alcoholics relapse after treatment--which they do--how often, in what conditions and for how long are they abstinent" (p. 1148)? Now abstinence as a delimited period, even if it was not continuous, became a dependent variable in the natural history of addiction that was worthy of study. What he noticed was that, over time, the number of abstinent subjects increased. A bold finding of the study was put in the form of a question--"addicts recover, albeit slowly, but . . . *why*?" Furthermore, he asked, "why should the cycle of detoxification and relapse finally be interrupted?" To understand this relapse phenomenon, he proposed three questions--"Why does addiction begin? Why does relapse occur? Why does relapse not occur"? (p. 1150).

Of these three questions, it seems that no one before

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Vaillant had asked the third one. In fact, despite the somewhat gloomy results of his study, he cautioned against what he called "therapeutic pessimism"--"On the one hand, relapse-not dependence-must be seen as the addict's most dangerous enemy. On the other hand, there is cause for optimism as well" (p. 1151). He found that what predicted remission was not detoxification, but rather the "premorbid capacity for sustained structured behaviour and the discovery of competing sources of gratification that distinguished the best from the worst outcomes." In short, the "more patterned the alcoholic's premorbid life had been, the most likely was he or she to recover from addiction" (p. 1152).

Vaillant (1988) also found that four other factors proved to be salient in an alcoholic's recovery:

> 1. Compulsory supervision or experiencing a consistent aversive experience related to drinking;
> 2. Finding a substitute dependency to compete with alcohol use;
> 3. Obtaining new social supports;
> 4. Inspirational group membership.
> (p. 1153)

He noted that A.A., in fact, played an important role in the recovery of the 100 alcoholics by providing, in the words of Stall and Biernacki (1986), a "'new nonstigmatized

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identity'" (quoted in Vaillant, p. 1154). Such "community abstinence" should not be underestimated for its power to interrupt the negative conditional reenforcements of the relapse-abstinence cycle:

> We must cease to conceptualize drug addiction as a more or less conscious use of an active drug in order to provide either emotional solace or exquisite self indulgence. If instead we conceive of drug addiction as a whole constellation of conditioned, unconscious behaviours, then the relative success of parole, methadone maintenance and Alcoholics Anonymous over conventional clinical intervention begins to make sense. (pp. 1155-1156)

De Soto, O'Donnell, and De Soto (1989) also found duration of abstinence to be a key variable in an evaluation of individual improvement. This study was designed to redress the limitations of the authors' 1985 study of sober alcoholics which was confounded by the fact that the earlier population had varying lengths of abstinence. The authors note that previous work on abstinence "made a serious mistake in treating a long-term recovery process as a stable or static state." Their 1989 study is a report of a four-year followup of subjects from the 1985 undertaking with the intent of clarifying earlier results by "measuring change in individual subjects." The authors hoped to investigate the relationship of relapse to the severity of

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symptoms, alcoholic history, and length of abstinence and to study recovery in relation to occupational history (p. 693). In this study of 312 subjects from A.A. (162 men, 150 women; race/ethnicity unspecified), 88% had been continuously abstinent. The authors found that length of abstinence significantly predicted relapse and that there was a relationship between salience of time and lessening of symptoms. In short, "abstinent alcoholics do get better over time" (p. 695) and there is a discernible recovery curve--"for the average or typical abstinent alcoholic, there is a describable course of recovery that extends over a time span of 10 or more years" (p. 696). Furthermore, the authors found no difference in recovery between men and women. They speculate, "An obvious question is, what is going on in this recovery process, and why does it take so long" (p. 696)? Again, they muse, "What is surprising and begs for understanding is recovery" (p. 697). While their questions are intriguing, they offer no answers.

Amodeo and Kurtz (1990) studied the cognitive processes at work in recovered and relapsed populations. But their 46 subjects were all males (predominantly Irish) and the mean length of sobriety was 5 1/2 years. The authors

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investigated precipitants to sobriety and found that the chief reasons were more internal than external--how the subject perceived his situation was more salient than any external life event. For example, a majority had hit a "personal bottom." The authors also found that even a respite from drinking could provide the impetus to commit to recovery. Many subjects also indicated that memory played a role in making a commitment to alter their drinking habits.

More interesting, however, are the factors they identified in the maintenance of abstinence. Many cited such cognitive processes as feeling supported by others, knowing they would lose their family, the desire to stop, a fear of death. Particular treatment modalities such as a VA alcohol rehab unit, A.A. availability, and individual counseling were also seen as keys to sustaining sobriety (pp. 996-1000). Finally, the authors call for further research into the "criteria for assessing both success and failure in alcoholism recovery" (p. 1007).

Finney and Moos (1991; 1992) produced a two-part study examining the long-term outcomes for 113 posttreated alcoholics (88 men, 25 women; 88% white) as compared with community controls at two year and ten year intervals. They

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asked several questions--1) What are the mortality rates of treated alcoholics over an extended followup period?; 2) What are the relapse and remission rates for posttreated alcoholics?; 3) How stable are these rates at the 2 year and 10 year followups?; 4) How well do posttreated alcoholics do on nondrinking dimensions--depression, anxiety, family functioning, work history, and coping skills (1991; p. 44)?

Of the original 113 patients, 83 (or 88%) were successfully followed. Of these 83 patients classified as remitted at two years and ten years, 77% remained sober. They were found to be "functioning as well as demographically matched, community controls, although they were still more anxious, had more doctor visits and used more medications, were more likely to smoke and were less active socially" (p. 46). It is not clear whether these individuals were A.A. attenders. However, the authors found that remission in drinking behavior was more associated with improved "intrapersonal or endogenous functioning" such as physical and psychological health and family functioning rather than with interpersonal or "exogenous functioning" such as social activities or occupational role (p. 53).

Two more recent studies attempt to examine the

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experiences of more long-term recovering individuals as they intersect with therapeutic methods. Bewley (1995) drew her sample of 8 recovering women from A.A. All were white and middle-aged. Their length of sobriety ranged from 3-12 years (mean = 8 years). The purpose of her study was to further their growth in a psychoeducational group through the exploration of her own theory of meta-recovery ("recovery from recovery"; see also Bewley, 1993). Meta-recovery is grounded in the principles of psychosynthesis, a school of transpersonal psychology:

> Psychosynthesis describes the personality as a collection of semi-autonomous subpersonalities, each with its own world view and agenda. It articulates a process of growth and healing through bringing these various parts of the personality into greater harmony through balancing and synthesizing their qualities. (p. 2)

The theory of meta-recovery posits a dialectic between two subpersonalities--the addict self and the recovering self. She argues that meta-recovery, though an extension of the A.A. experience, helps the individual to negotiate between these two selves a "third, more inclusive way of being in the world" (p. 3); hence the notion of a "recovery from recovery." Bewley, however, faced several obstacles in carrying out her research. She had difficulty retaining all

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8 subjects (2 eventually dropped out); she discovered that not all were ready for meta-recovery; and she admitted the potential for bias in that the theory was derived from her own recovery experience. Left with a norm group of 6, her theory of meta-recovery was considerably undermined.

Sommer (1997) interviewed A.A. members with "long-term" sobriety about their experiences in recovery and their perspectives on therapy. Although she recognizes the failure of research to "fully capture the nature of recovery beyond the early years" (p. 75) and cites problems in accessing longer-term recovering individuals, her sample is small (12), the report of their demographics is unclear (males and females were included but she does not specify their numbers or identify them by race/ethnicity), and their recovery time was limited to 4-7 years.

A final word on previous dissertations bearing on the present study. Although there are many dissertations in social work and the social sciences on alcoholism, this researcher was able to locate only four completed in the past 15 years that focused on what their authors called "long-term" recovery. Chapman's (1986) quantitative study examined personality characteristics of alcoholics in

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long-term recovery, but his population sample was disproportionately male (42 men; 13 women), mostly white, and the mean length of sobriety was 5.7 years. Interestingly, Chapman's definition of recovery did not include total abstinence--he permitted up to four days per year as a "maximum drinking criterion" (p. 6). Herban's (1986) descriptive exploration into the meaning and significance of sobriety as perceived by recovering alcoholics used 17 subjects. The majority were white and the average length of sobriety was 7.0 years (though the range was 1-26 years). Morgan's (1992) study was an investigation of the psychological aspects of long-term recovery with special attention to spirituality. Though his cohort of 15 had ten or more years of sobriety, they were hardly a representative sample since all were white males. Finally, Sagot (1998) conducted interviews with 5 recovering females in A.A. with at least 15 years of sobriety to ascertain their experience of addiction and recovery. While this dissertation in its content comes closer to the present study, its sample size is small and also not representative of the general population. None of these studies, however, was produced by doctoral candidates in

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social work. In fact, this researcher could not locate any studies of a "long-term" sober population (of the kind proposed for this project) produced by anyone in the field of social work.

2. Studies of Spontaneous Remission -

While most studies of alcoholics concentrate on the treatment factors that may influence an individual's recovery, researchers also have argued, on the basis of outcome studies, that treatment is no more effective than the natural history process. This is the view of Vaillant (1988) who, after conducting longitudinal research, concluded that addicts must undergo a sea change and "alter their whole pattern of living" for recovery to be effective (p. 1151). It is a view shared by Edwards et al. (1988)--"treatment is often only a rather slight and ephemeral influence on the evolution of the individual's life story" (p. 919)--and Saunders and Allsop (1985)--"The belief that treatment is a necessary and humane response is constantly challenged by research evaluation which fails to demonstrate the superiority of one approach over another, or the impact of treatment itself" (p. 206).

The lingering doubt about the efficacy of treatment has

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led researchers to explore other pathways of recovery such as "spontaneous remission" or "natural recovery." Tuchfeld's (1981) qualitative study of 51 untreated alcoholics is frequently cited as one of the most influential of its kind. One of the difficulties in conducting such research is locating a population. Tuchfeld's sample, assembled through media solicitation, proved to be more self-selected than representative. The average number of years since active drinking was 6.4, although not all were completely abstinent. Out of 51 (35 men, 16 women; 45 whites, 6 blacks), 40 were abstinent, while 11 drank occasionally. Among his most salient findings were--1) alcohol problems do resolve without treatment or professional intervention; 2) this "resolution is effective for some people"; and 3) spontaneous remission is a process that is open to investigation and has "theoretical implications" (p. 630).

Moreover, Tuchfeld discovered that making a commitment to stop drinking, while necessary, was not sufficient to resolve the problem. Other factors such as involvement in non-alcoholic leisure activities and the development of stable support networks were important in solidifying maintenance. In addition, external "commitment mechanisms"

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such as religion and "justifying rhetorics" served to reinforce the postresolution behavior. Most individuals required some kind of external motivation though this process had a trajectory of its own; namely, it entailed "psychological processes preceding the alteration of a drinking pattern and social processes as maintenance or support factors" (p. 639). In the treatment process, the goal is usually to get the patient at least psychologically to accept the label "alcoholic." In the nontreatment process, "social conditions [were found to] facilitate positive changes in alcohol-related behaviors and self-definitions without necessarily requiring the internalization of a stigmatic label" (p. 639). Tuchfeld urged further research into the extratreatment factors or external social conditions that help alcoholics to maintain their problem resolution. He endorsed Saunders, Phil, and Kershaw's (1978) suggestion that clinicians "monitor the personal environment of treatment failures" (Tuchfeld, 1981, p. 640). Given this suggestion, one wonders about the "personal environments" of the "successes" and how they may have been transformed in the process, a question that remains to be investigated in the present study.

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Waldorf's (1983) study of spontaneous remission in opiate addicts was an attempt to go beyond previous research which attributed resolution either to a "maturing out" process (see also Winick, 1962) or to some form of existential or "bottoming out" crisis. He conducted a qualitative study using snowball sampling techniques (but respondents were paid a stipend for their participation) to locate a more diverse cross-section of addicts. He compared a treated versus a nontreated population. More than two-thirds of his total group (N = 201) were male (70.3%); 43% were black or Hispanic. The mean length of time stopped was 7.1 years for the entire population. But he found that the majority of untreated ex-addicts did not believe in total abstinence. Where the untreated group substituted other drugs to relieve their cravings, the treated group used athletics and social activities, a finding that paralleled Tuchfeld's (1981) results. Waldorf described six pathways out of addiction-- 1) "developmental change"--that addiction results may be associated with changes in the adult life cycle (see also Melvin, 1984; Van Wormer 1987); 2) drifting out of addiction; 3) situational or environmental change; 4) experiencing a "general conversion"

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(religious or social); 5) retirement; or 6) becoming alcoholic or mentally ill (pp. 270-275).

Stall (1983), a medical anthropologist, conducted a qualitative study of 13 self-selected subjects (gender and race/ethnicity unspecified) to search for thematic patterns and social contexts relevant to their spontaneous remission from problem drinking. He analyzed life and drinking history data culled from extensive interviews with subjects sober for up to twenty years (no mean given). Although the sample was small and non-randomized and the outcomes hardly generalizable, the findings were interesting for their parallels to the experience of getting sober in A.A.--1) the group was highly diverse in education, income, and drinking patterns; 2) nearly all came from dysfunctional families; 3) all showed alcohol-related problems during their drinking years (e.g., problems with family, work, health, and finances); 4) many changed their attitudes toward drinking after experiencing a "significant accident" (cf. A.A.'s "hitting bottom"); 5) important changes in life style and leisure activities occurred after drinking remitted (e.g., many developed new non-drinking social networks in a kind of "public renegotiation of their indentities [sic]"); and 6)

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social supports were positively associated with successful "remission and maintenance of sobriety" (pp. 203-204).

Stall's (1983) conclusions are strikingly similar to those formulated by Prugh (1986) in his review of five studies of spontaneous remission, namely, that the latter "appear to be more like than unlike alcohol abusers and alcoholics who succeed in treatment." Two variables, in particular, caught Prugh's attention in both populations--1) the need for a dramatic change in perception or attitude towards one's drinking; and 2) the critical importance of a support network for the maintenance of change (p. 71).

Meanwhile, Klingemann's (1992) study of natural recovery was the first of its kind in Switzerland. Using a life-history approach and employing "grounded theory," this qualitative study compared autoremission (defined as a "'significant improvement in consumption behavior . . . without any or with minimal treatment or self-help groups'" [p. 1361] and lasting at least one year before the index interview) in an alcohol and heroin population (30 alcoholics; 30 heroin addicts; gender and race/ethnicity not identified; subjects paid a small stipend).

The goal of the study was to identify the coping

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strategies used by autoremitters and to examine the assumption that social support was important to the autoremission process. To ensure validity, the author collected information from collaterals. Among the study's outcomes was the observation that normalization was preceded by a series of stages--motivation, action, and maintenance.

Klingemann (1992) noted that the least elaborated stage was maintenance. Therefore, he undertook a typology of maintenance. More specifically, he identified three subphases of maintenance (pp. 1365-1377)--1) a period of testing of one's coping strategies in high-risk situations; 2) increased sense of well-being leading one to perceive rewards in this new behavior and seek ways of protecting these gains; and 3) the "internalization of new social roles" or the "successful completion of a search for meaning in one's life" through the negotiation of new identities or roles (p. 1367). Like Prugh (1986), this study also found that social support was crucial to maintenance. But unlike A.A. subjects who proudly displayed their positive identity as alcoholics and received positive reinforcement from their A.A. peers for doing so, Klingemann noted that remitters sought to forget or hide their stories. Moreover, because

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alcohol remitters were perceived more skeptically by their collaterals than heroin remitters, the chances of long-term recovery seemed to be undermined.

While the alcoholics, unlike the heroin users, were older, it is not entirely clear from his analysis why the alcoholics were more relapse-prone than the heroin users. The author associates resolution with a more profound change in identity or social role and with a stable family life. Heroin remitters also manage to distance themselves further from their drug-using worlds than alcoholics suggesting that deviance does serve some purpose after all. What he does observe in both groups as an underlying "leitmotiv," is the "search for a new meaning in life as the motor of natural recovery" (p. 1379). Interestingly, he finds autoremission figures higher where there is a less developed treatment system or more limited access to treatment:

> . . . less intervention and a recognition that autoremission is possible probably accord with a general social policy of decentralization of social services and a shift of responsibilities to the informal sector. Political liberalism, after all, also trusts the 'self-healing market forces.' (p. 1384)

Here he raises a rarely discussed issue about the politics of treatment, that is, the extent to which its availability either positively or negatively affects the incidence of

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relapse and recovery.

Finally, Sobell, Sobell, Toneatto, and Leo (1993) sought to overcome such methodological problems in past studies of natural remitters as small sample size, lack of data on drinking history, short resolution periods of no more than 6-12 months, inclusion of treated subjects, lack of validity, lack of clarity about abstinence criteria, and no control groups. Their study of natural recovery had three goals--1) to identify factors associated with "successful resolution of alcohol problems without treatment"; 2) to uncover the strategies that facilitated these recoveries; and 3) to "develop testable treatment interventions" that might serve as "enduring effective treatments"[4] (p. 218).

They interviewed 182 subjects plus their collaterals recruited through advertisements in the media and then

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4 In a subsequent study, Sobell, Cunningham, Sobell, and Toneatto (1993) further analyzed data from their previous study for "patterns of resolution across the life span" (p. 37). They found interesting differences in patterns of usage, resolution, attitudes toward treatment, and maintenance strategies between older and younger age cohorts. Moreover, recruiting by media advertisements proved to be a spur for some subjects to initiate a change in behavior producing the kind of shift from contemplation to action noted in a "stages of change" model of recovery (see Prochaska et al., 1993).

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divided them into four groups. Group 1 (the Resolved Abstinent; n = 71) had a minimum of three years of recovery; Group 2 (the Resolved Nonabstinent; n = 21) had returned to "nonhazardous" drinking after at least three years of abstinence; Group 3 (the Resolved Abstinent Treated; n = 28) resolved problems on their own after treatment which they did not find helpful and were abstinent for a minimum of one year; and Group 4 (the Nonresolved, Nontreated; n = 62) had drinking problems for a minimum of five years and served as the control group.

As with most previous studies, however, the majority of subjects in all groups were male, nearly all were white and the mean years of actual sobriety, especially for the Resolved Abstinent group, was 8.2 Among the major reasons for cessation were the cognitive evaluation by the subject of the costs and benefits of drinking and the occurrence of both traumatic health problems and trivial events that acted as catalysts or triggers. Chief among the reasons for maintenance was a positive family environment, especially spousal support as well as other social supports, and changes in self-control, health, and social, recreational, and leisure activities.

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The authors call for more "prospective research" to track the careers of alcohol abusers not only prior to, but "over the course of their recovery" (p. 222). They also cite the importance of decision theory to explain not just relapse but why alcohol abusers manage to resolve problems on their own and the need to "search for factors that produce change in the decisional balance process" (p. 222). In short, what is needed is a

> theory that purports to provide a comprehensive explanation of recovery from alcohol problems. To better understand the multifaceted processes associated with recoveries, especially the cognitive processes antecedent and consequent to the change, further refinements of this research area, including prospective studies are needed. (p. 223)

3. **Models and Metaphors of Recovery** -

While there are many models and metaphors to explain active alcoholism--the impaired model, the "dry" moral model, the "wet" moral model, the psychoanalytic model, the family interaction model, the older and newer medical models and more recently the biopsychosocial models (see, for example, Siegler, Osmond, & Newell, 1968; Kissin & Hanson, 1982; Donovan, 1988), there are just as many models and metaphors to describe recovery. The problem in exploring this literature, however, is the confusion that exists

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between paradigms associated with treatment and the aftercare stage (they often confound modalities, services, and settings with orientation) and paradigms that describe the experience or process by which the individual has attempted to achieve sobriety with or without treatment intervention. Viewed from the perspective of time away from drinking, these process-oriented paradigms, as we shall see, rarely capture the experiences or concerns of the long-term sober alcoholic.

Historically, the formulation of recovery models has arisen out of the empirical experience of clinicians working either in treatment settings or in private practice. Many emanate from the difficult and painful lessons learned from watching alcoholics relapse. Thus, these models have tended to be more practical than theoretical as they attempted to delineate the facets of the recovery experience and offer suggestions about how to avoid failure. In fact, according to Donovan (1988), "until recently the field of addiction has been in a preparadigm stage of scientific development" (p. 11). Over the past two decades, as we shall see, as practitioners and researchers have begun to build a wider knowledge base about alcoholism and recovery, these models

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have grown from somewhat unidimensional and simplistic forms to more complex integrative structures. But rarely do we find any conceptual frameworks that describe, encompass, or illuminate the totality of experience of the long-term sober alcoholic who is already well beyond the treatment or "continuum of care" phase.

While the process by which one becomes a full-blown alcoholic is estimated to be almost a decade-long (Keller, 1975, p. 144),[5] many theorists fail to appreciate the length of time it may take to develop a full-blown recovery (perhaps this is why in A.A. people wish one another with some irony a "slow recovery"). Prochaska and DiClemente (1983), for example, observe that the maintenance phase for all addicts begins in as little as six months. But Donovan (1988) cautions us not to believe in the "'uniformity myth' that all addictions are equivalent" (p. 11). Few clinicians who work with alcoholics would agree that maintenance begins as early as six months.

As noted, models to explain recovery have ranged from

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5 Keller cites Jellinek's (1952) estimate of 5-12 years as the average length of time to develop full-blown alcoholism.

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the simple (e.g., they might focus on a single variable such as the social or cognitive dimensions of recovery) to the more complex. Usually, they are associated with treatment, especially with the assessment and planning phases; some even extend beyond treatment to account for the extratreatment factors that can influence the recovery process (e.g., chronic or acute life stressors, family environment, work environment, and social support networks).[6] Other models are more developmental or process-oriented. Some try to conceptualize the recovery experience as progressive (Bean, 1983/1984; Zackon, 1986; Van Wormer, 1987; Gorski, 1991; Picucci, 1998); others see it as cyclical (Brown, 1985). All envision the alcoholic as having to negotiate a series of tasks before going on to the next phase or stage. More recently, as we have seen, models have been devised to explain the natural or spontaneous recovery experience (Tuchfeld, 1981; Donovan, 1988; Klingemann, 1992).

Three major recovery orientations have dominated the

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6 See Donovan (1988, pp. 33-38) for a further discussion of the extratreatment factors associated with the maintenance phase.

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treatment literature and have served as the rationale underlying the operations of various treatment programs--the disease or medical model, the social learning or psychological model, and the social-community or sociocultural model. But these models rarely exist in pure form. Many programs, in fact, combine these approaches or take from each the strategies that prove most workable.

The medical or physiological model emphasizes alcoholism as a progressive disease requiring diagnosis, treatment, and supervision by medical personnel. The unit of treatment is the individual; the provider is the physician whose focus is on the etiology of the disease and the alleviation of physiological symptoms. Treatment is usually some form of pharmacological therapy--for example, Antabuse, naltrexone, or other psychoactive agents--to lessen symptoms of anxiety or depression often associated with withdrawal.

But while most alcoholism treatment programs incorporate this approach, researchers have noted its limitations. O'Briant, Lennard, Allen, and Ransom (1973), for example, argue that it represents only a short-term solution that has "little effect in changing the long range

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pattern of the patient's alcohol use":

> He is most often discharged without learning about the nature of his illness and with no plans for follow-up treatment. Many of those receiving treatment re-enter the community only to return weeks or months later with the same or more severe medical problems created by the use of alcohol. This state of affairs exacts a heavy toll in the morale of medical and nursing personnel who work with alcoholic patients, often knowing fully well that the result of their labors will be short lived. Nonetheless, in terms of the model of illness and treatment within which they operate, they are powerless to change this vicious cycle. (p. 5)

In fact, pharmacological therapy can do more harm in that alcoholics often leave these programs with two problems. They are now sedated on psychoactive drugs and this only compounds their dependence on alcohol. It is for this reason that many inpatient programs refer the newly sober but vulnerable alcoholic to outpatient care where, with ongoing medical monitoring, he or she will receive intensive structured counseling.

The psychological model, now more often combined with the medical perspective, sees alcohol problems as originating in dysfunctional aspects of the individual's personality or character structure. It uses behavioral or psychodynamically-oriented therapy to address the underlying individual pathology. Anti-anxiety medications may also be used as adjunctive therapies, but primarily treatment

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consists of dyadic interactions with a professional. Again, the focus is on the individual as the unit of treatment. But as with the medical model, researchers have faulted this model for its narrow focus. Briant et al. (1973) comment:

> This method of treatment is frequently as unsuccessful as a purely medical approach; so much so that many therapists feel that alcoholics are essentially unsuitable for psychotherapy. Those therapists who do attempt to treat alcoholics tend to accept only the youngest, most motivated, best educated, and most socially intact candidates; and even under these circumstances, treatment is often ineffective. (p. 5)

Even alcoholics have complained about the inadequacies in their own treatment.[7]

A third major perspective--the sociocultural model--views alcoholism as more than just a problem originating within the individual. This orientation explains alcoholism as being a product of the complex transactions between individuals and their social and cultural contexts. It recommends a course of treatment that may include a restructuring of the individual's social networks as well as changes in the person's physical living

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7 See Brown (1985, pp. 4-5) for a brief summary of the uses and abuses of psychotherapy with alcoholics.

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arrangements. Programs like one described by O'Briant et al. (1973) in San Joaquin County, California, in which the alcoholic is literally and symbolically "reterritorialized" (p. 30) represent costly and more elaborate versions of this model; but changes in context can begin with the individual's attendance at a 12-step program where new sober social relationships can be formed.

In recent years, because researchers have recognized that "no one profession, no one discipline, no single-minded approach" (Keller, 1975, p. 145) has worked, there has been an emphasis on developing newer, more integrative approaches that have combined all three orientations. Thus, Kissin and Hanson's (1982) biopsychosocial model is an inclusive framework that provides treatment personnel with a more complex set of assumptions and strategies from which to develop individual treatment plans. Bean's (1983/1984) integrative paradigm, a reconceptualization of three more common but controversial models--the medical, the moral, and the symptomatic--was designed to overcome the limitations of each one:

> These models have been tenaciously championed, suggesting that each is partly right. Each is intuitively satisfying and empirically corroborated *some* of the time. Clinicians and patients often use

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> them alternately. This paper suggests that each model alone is too simple to be clinically useful, and that what is needed is a more complex collage or cascading series of models to approach the complexity of the clinical phenomena. If developing alcoholism is a multi-factorial process, then with each model shaping the clinical picture at different points, recovery is likewise a process in which different forces predominate at different times. To intervene effectively one must know which frame of reference one inhabits. When the model is adequately complex and rich clinicians will be able to oppose, point for point, the forces acting on the person sustaining the alcoholism and recovery will begin. (p. 93)

But while these models have been more associated with traditional alcohol treatment programs, another category of model proffered by Brown (1985) has been created in the past 15 years that focuses more on recovery as a "dynamic" process and the phases or tasks an alcoholic has to negotiate to develop his or her sobriety. Implicit in her perspective is the recognition that abstinence is not a static state and that the alcoholic is not thereby the passive recipient of treatment. Instead, recovery is now conceived of as a process of "movement and change" and the alcoholic as an active participant and initiator of that change (p. 8).

There are many variations of this process-oriented perspective to account for recovery. Brown (1985, p. 9) credits Bean, Jellinek, and Bacon with pioneering work on

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this aspect of recovery which in turn laid the foundation for her own developmental model. She also sees Alcoholics Anonymous as the prototypic exponent of this recovery paradigm. For example, Brown notes that A.A. custom favors the celebration of "birthdays" as important milestones in the course of recovery. New members are called "pigeons" or "babies," while older members are admired as "sponsors" and guides. Many interviewees in the current study alluded to a similar "process" metaphor so often heard in A.A.--"If alcoholism is progressive, so too is recovery." A.A. members generally describe themselves as "recovering," rarely as "recovered," alcoholics.

Brown (1985) elaborates a complex theory of recovery which is by turns "linear, circular, and vertical, expanding and contracting":

> The interaction and integration of components reflect the continuing importance of behavioral, cognitive, and dynamic modes of treatment and accent the developmental nature of recovery. In ongoing recovery, individuals focus on alcohol, establishing a routine that maintains that focus (three AA meetings per week and daily reading, for example). As the identity solidifies and the AA story develops over time, the movement may be characterized as linear or forward along a central line. Backward movement, or regression along the alcohol focus, represents problems with the focus or identity. Individuals who question whether or not they are alcoholic, who express fears of drinking, or who experience a strong environmental pull incongruent

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> with the identity are regressing toward the drinking side of the continuum. (p. 211)

She then discerns another pattern:

> At the same time, individuals move out into other activities--family, work, social [life]. This pattern produces an interaction between two components, the alcohol and the spiral; individuals move around the spiral, circling or returning to the alcohol focus. . . .
>
> Introduction of the third component, expanding awareness and interpretation of self and others, adds the third line of movement. The boundaries of the new identity expand and contract in concert with the interaction of the first two components. The line of movement is conceived as vertical on the continuum. (pp. 211-212)

Since Brown, other researchers have offered alternative process-based explanations of what happens when alcoholics stop drinking. As noted earlier, Prochaska and DiClemente (1984), though not specifically writing about alcoholism, provided a "transtheoretical" explanation of the change process involved in giving up addictions. Gorski (1991) has written extensively on the "stages of recovery"--he identifies six stages--and the tasks associated with them:

> 1) transition--recognition of addiction
> 2) stabilization--recuperation
> 3) early recovery--changing addictive thoughts, feelings, and behaviors
> 4) middle recovery--lifestyle balance
> 5) late recovery--family of origin issues
> 6) maintenance--growth and development. (pp. 10-14)

His aim was twofold: 1) to provide a clinical tool for the

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counselor to aid the alcoholic in the identification and management of relapse warning signs; and 2) to improve the matching of individuals to treatment.

Bean (1983/1984) also delineated a series of recovery tasks that flowed from each of three common models of alcoholism (the medical, the moral, and the symptom models), the combination of which would provide a "more satisfying theoretical basis for the clinical work" (p. 104). Her model brackets the recovery experience:

> The time frame of recovery varies from patient to patient. Most physiologic healing occurs by six months to two years alcohol free, depending on length of exposure, and relapses. Rate of learning how and why to stay sober varies with intensity of educational and treatment effort and patient motivation, but probably is not complete for one to two years. Grief work, psychological reintegration and remodeling, and maturation may take several years more. If at any point in treatment the patient relapses, one must drop the sophisticated focus of late recovery, and return to fundamental attention to keeping the patient alive, and safe. (pp. 97-98)

Zackon (1986) has formulated a Second Recovery Track model that became the basis of a series of recovery workbooks developed by Arnold Washton (1990) for cocaine addicts. Zackon devised a two-track scheme of recovery. The primary track is the "acquisition of psychological insight and healthy values together with the generation of a

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positive self-concept" (p. 18). Zackon sees it as the "route of inner change." It is linked to spiritual development and is reinforced by a strong peer support network such as that found in A.A. or other 12-step programs. Other modalities, such as psychotherapy, may also help the alcoholic to do the work of "inner change." On the contrary, secondary recovery is tantamount to a full-scale "lifestyle rehabilitation." According to Zackon, its key tasks include--1) "de-addiction," the reduction of the "power of conditioned craving"; 2) "learning new pleasures," participation in new leisure activities; 3) "social integration," socialization into new purposeful support networks; and 4) "creating new goals," the search for personal fulfillment[8] (p. 18; 70).

Zackon sees A.A. and other self-help programs as "primary track vehicles" and seems to give little credit to the role of the peer network in fostering later recovery. In what is clearly a bias for professional treatment over peer group help, he argues that treatment programs need to assume more responsibility for secondary recovery training

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8 See also Shields and Wing (1992) for more discussion of the importance of goal setting to the recovery process.

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so as to "play even larger roles in the health promotion field." Such a focus will result in the expansion of opportunities for professional growth and development--"Let our professional programs pioneer pathways of secondary recovery in the addictions fields and, thereby, create for themselves new opportunities in other health fields" (p. 70).

What is missing from Zackon's analysis, however, is any clarification and linkage of secondary recovery with length of time. When does primary track recovery end and secondary recovery begin? He does not say. Nor is any credit given to the role of A.A. in fostering and helping to maintain what he would consider secondary recovery. Clearly, long-term A.A. attenders would not maintain their affiliation with the program if they did not continue to derive some benefits.

Finally, Van Wormer (1987) describes a phasic approach but in alcoholism treatment group work. Building upon Brown's (1985) developmental model, she devises "appropriate time-oriented treatment interventions" that extend from early stage (1-6 months), middle stage (6 months-1 year), and "ongoing" (1 to several years). Using Erikson's life

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cycle model, she identifies each stage with a major life crisis, the successful resolution of which allows for passage to the next level. Thus in early stage recovery, the major issue is denial vs. identity; in middle stage, it is anger vs. acceptance; while in the "ongoing" period, it is isolation vs. intimacy. To each stage she appends a series of tasks which the alcoholic must complete. The ultimate goal, needless to say, is to foster autonomy and develop and strengthen coping skills (pp. 81-82).

But with all this emphasis on models and phases of recovery, the fact remains that we still know little about the fate of the long-term sober alcoholic. Since, for obvious reasons, these individuals are not associated with treatment programs, the only other likely place to find them is through the auspices of A.A., that "primary track" recovery vehicle which ironically still manages to attract and retain their loyalty. This phenomenon so caught the attention of the authors of the Institute of Medicine's Report (1990) on alcoholism treatment modalities that they called for more research on this population. More specifically, they asked the following key questions, among others:

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> What are the characteristics of individuals who maintain a stable affiliation with mutual help groups and experience favorable outcomes? . . .
>
> What are the key mechanisms of effective change for those who maintain successful affiliation with mutual help groups?
>
> What differentiates long-term affiliates from those who do not attend or who drop out after brief attendance?
>
> What common stages or processes of change may underlie . . . remission associated with participation in mutual help groups? (p. 521)

Since A.A. clearly has played such a meaningful role in their recovery, it is to a survey of the research on A.A. and the experiences of its members that we now turn as a final source to inform our discussion.

4. **The A.A. Model** -

For the past 65 years, A.A. has been in the vanguard of the self-help movement in the U.S., while its ideas and methods have continued to exercise a pervasive influence on the alcoholism treatment establishment both in the U.S. and abroad (Mäkelä, 1993; Mäkelä et al., 1996). Founded in 1935 by two active alcoholics--Bill Wilson (known in A.A. as "Bill W."), a stockbroker, and Dr. Robert Smith (known in A.A. as "Dr. Bob"), a physician--A.A. has since become the prototypical model of the self-help group, having spun off a variety of other "twelve-step" programs designed to address

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contemporary psychosocial problems--Al-Anon, Cocaine Anonymous, Gambler's Anonymous, and Debtor's Anonymous are a few that come to mind.[9]

Much has been written about the core characteristics of all of these self-help groups and how they differ from professionally-run service programs. Robinson (1986), following Killilea (1976), has identified seven key features of self-help organizations. Anyone familiar with A.A. will recognize the program in this description:

> 1. *Common experience of members:* the care giver has the same disability as the care receiver;
> 2. *Mutual help and support:* the individual is a member of a group that meets regularly . . . to provide mutual aid;
> 3. *The helper principle:* in a situation in which people help others with a common problem it may be the helper who benefits most from the exchange;
> 4. *Differential association:* the reinforcement of self-concepts of normality, which hastens the individual's separation from commitment to their previous deviant identities;
> 5. *Collective will power and belief:* the tendency of each person to look to others in the group for validation of their feelings and attitudes;
> 6. *The importance of information:* the promotion of greater factual understanding of the shared problem as opposed to intrapsychic understanding; . . .

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9 Note that other self-help recovery models have arisen as alternatives to A.A., the most well-known of which is the "Rational Recovery" movement (see, for example, McCarthy, 1991; Gelman, 1991; Ellis, 1992).

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> 7. *Constructive action towards shared goals:* mutual aid groups are action orientated, their philosophy being that members learn by doing and are changed by doing. (pp. 293-294)

Stuart (1977) emphasizes the uniqueness of the self-help approach as compared to the professional service delivery system. Self-help groups define the problem as "inappropriate behavior," while professionals tend to diagnose the problem as an "intrapersonal illness." They rely on "faith building," while professionally-run groups rarely encourage this focus. They have no formal objectives, while professional services are goal-oriented. They promote acceptance, normalization, and personal responsibility, while professionals attribute success to treatment and intervention. They have their own special discourse which differs from professional language. They rely on "social marketing" and informal peer networks to attract new members, while professional services are fee-based (pp. 286-292).

A.A. members often distinguish the "program" from the "fellowship," though the two are intimately related. The A.A. program, embodied in its 12 Steps and 12 Traditions, emphasizes abstinence (cf. the A.A. Preamble--"the only requirement for membership is a desire to stop drinking"),

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spirituality (cf. Step 11--"Sought through prayer and meditation to improve our conscious contact with God as we understood Him"), and personal change, both internal and interpersonal (Step 5--"Admitted to God, to ourselves, and to another human being the exact nature of our wrongs"). As A.A. members are fond of saying, there are no rules, only suggestions. These include such practical admonitions as "Don't drink," "Go to meetings," "Get a sponsor," "Get phone numbers," and "Work the steps." At the same time, the A.A. "fellowship," an intricate network of social ties and source of mutual support available to anyone who attends, serves as a powerful tool in the socialization of new members into A.A. norms, values, and ways of operating.

While A.A. has grown exponentially over the past six decades (membership as of 1998 is estimated to be over 1.1 million, with 97,000 registered groups worldwide; see A.A. World Services, 1999), researchers have continually noted the difficulties inherent in evaluating its effectiveness as a treatment modality (Leach, Norris, Dancey, & Bissell, 1969; Leach, 1973; Leach & Norris, 1977; Baekeland, 1977; Glaser & Ogborne, 1982; Vaillant, 1983; Thoreson & Budd, 1987; Institute of Medicine, 1990; NIAAA, July 1992; Mäkelä

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et al., 1996; **Ninth Special Report**, 1997). They have cited, for example, the problem of ascertaining who is a member, especially given A.A.'s tradition of anonymity and lack of recordkeeping, and how many are successful remitters, given A.A.'s casual and uncritical attitude toward those who relapse.

Even when researchers can design quasi-experimental studies, assessments of A.A.'s efficacy have ranged widely from the negative (see Tournier, 1979; Sobell & Sobell, 1979) to the positive (see Madsen, 1979; Rosenberg, 1979; Schulman, 1979). In 1973, when Leach reviewed the literature on A.A.'s success, he found that there were "few satisfactory evaluations of its effectiveness" (p. 279). However, he conceded that it was hard to ignore the results of three independent investigations of A.A. populations and A.A.'s own General Services Board survey, all of which showed extremely positive outcomes. This led him to conclude that A.A. "really does work" (p. 279). In 1982, in the face of A.A.'s growing influence among the public and within the treatment field, Glaser and Ogborne again raised the question of A.A.'s efficacy:

> . . . although we 'know' at some level that A.A. does work, we find that painstaking reviews of all the

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> available literature lead to the inescapable conclusion that the efficacy of A.A. has not been proven; that A.A. has not been demonstrated to be effective beyond what might be expected by chance, and in a manner sufficiently direct and powerful to convince the most skeptical. (pp. 123-124)

Instead, they urged more appropriate research designs and called for more searching studies of A.A.

In 1988, Bradley reassessed the A.A. evaluation literature to date and again noted the discrepancy between outcome results and professional attitudes towards A.A. as an adjunct to treatment:

> Although all the studies examined reported positive relationships between drinking behavior outcome and one or more aspects of active AA participation, there was considerable disagreement among the studies on which aspects of the AA program were positively related to outcome and which had no relationship. In particular, data from AA's own triennial surveys have reported frequency of meeting attendance as unrelated to length of sobriety, whereas other studies--most of which were samples that recently had completed treatment--reported a positive correlation between outcome and meeting frequency. (p. 197)

Moreover, she observed that there was a discrepancy between A.A.'s understanding of alcoholism and recovery and the scientific community's need to "question, test, and quantify":

> Unlike the scientific community whose habit it is to question, test, and quantify, AA relies on a phenomenological understanding of alcoholism and the recovery process. AA also applies different measures from the measures of evaluation research to the various

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> aspects of alcoholism and recovery. Thus 'outcome' cannot be assessed at 6 months or 4 years; personality characteristics, or 'character defects,' undergo constant amendment; and a 'dropout' from the fellowship is simply someone who is not ready yet. (p. 198)

It is interesting that Bradley's recommendation is for researchers to approach A.A. from the vantage point of the cultural anthropologist--by implication the qualitative researcher--rather than the scientist interested in cold statistics and experimental designs:

> If evaluation scientists 'keep coming back' to AA, perhaps with more of the attitude of cultural anthropologists, they may discover that the world's most enduring alcoholism treatment program offers a number of 'solid truths' to enrich the conceptualization of a therapeutic model. Less through dissecting the AA program than through accepting its integrity--and more closely observing its processes--can alcoholism treatment research profit from a valuation of AA. (p. 198)

Of relevance to the content of the present study, however, are the statistics contained in the research about A.A. membership and long-term abstinence. After all, if we want to readily identify a long-term abstinent population for study, where else but in A.A. would we be able to locate these individuals. Even if the research does show that they attend meetings less frequently (according to the 1998 A.A. Membership Survey, members attend an average of two meetings per week), the fact is that many still actively participate

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in A.A. and are a good, though underutilized, resource for access to others like themselves. It is, moreover, only in A.A. that the negative stigma associated with the label "alcoholic" is converted to a positive badge of achievement. It is, in short, only in A.A. that alcoholics accrue status and stature on the basis of their length of sobriety and not on the basis of who they are, where they come from, or how much money they earn.

The review of research conducted by Leach (1973) provides some preliminary indication of extended stable remission outcomes. He examines four previous studies of A.A. members and utilizes data from three of them to compare duration of abstinence. While he issues two cautionary notes--1) long-term sober individuals may actually be underrepresented in such studies because these individuals attend less regularly; and 2) there are some problems in the way each study classified data--he argues that the studies are instructive for their similar findings.

The first study was conducted by Bailey and Leach (1965) for the National Council on Alcoholism in 1962. This was an attempt by external, that is, non-A.A. evaluators to describe 1,058 members attending A.A. meetings in New York

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City. The authors found that 23.4% (or 248) had achieved at least five or more years of sobriety, with 9.1% (or 96) having ten or more years in the program. The second study, again by independent, non-A.A. researchers, was conducted by Edwards, Hensman, Hawker, and Williamson in 1966. They reported on 306 A.A. members attending London A.A. The authors found that 21% (or 64) had achieved six or more years of sobriety, with 5.8% (or 18) having been without a drink for eight or more years. Finally, the A.A. General Service Board studied 11,355 members attending U.S. and Canadian meetings in 1968 and published its findings in its Directory (A.A. World Services, 1970). It found that 25.4% (or 2,884) had achieved over five years of abstinence with 12.1% (or 1,374) having eleven or more years in the program. In summary, Leach noted that the mean duration of abstinence for London members was 48.1 months, while in New York City, it totalled a little more than four years. He concluded, "The statement that A.A. members by the thousands do stay sober for years seems reasonable" (p. 267).

Leach also reported figures for relapse rates in each population studied. In the General Services Board study of its North American members, 41% reported no slips since

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their first A.A. meeting. In the London study, the figure was 43%, while in the New York City study, it totalled 32%. Because the figures for continuous abstinence were so impressive, Leach concluded that A.A.'s emphasis on "sustained, complete abstinence as a starting point for recovery," seemed "eminently sound." Clearly, he was answering critics who were frustrated by the frequency of relapses observed among alcoholics:

> Fewer relapses may represent improvement for a given alcohol addict (or a diabetic or a tubercular), but can hardly be an ideal goal for groups of alcohol addicts any more than sociable skin popping represents an acceptable goal in treatment of heroin mainliners. (p. 271)

While Leach is mindful that slips do occur, he is less troubled by their frequency than are others. He offers two explanations to support his viewpoint. First, "unbroken sobriety" in A.A., he argues, often follows a period of relapse and the addict and professional helper should not be discouraged by this and prematurely reject A.A. (p. 271). This trial period often precedes "enduring abstinence," a fact noted by Bill Wilson himself (1949; 1967, especially, pp. 11, 68, 49, 154, 184, 251, 291) or as the folk wisdom of A.A. would have it, relapses can be explained by saying that some people need to do more research before "they get the

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program." Second, Leach argues that opinions about A.A.'s effectiveness are often biased by observations of relapsers rather than of those who are continuously sober. Thus, because professional helpers are less likely to encounter the completely abstinent in their practices, they have to be more aware of their own biases:

> Any opinion of A.A. based more on its drinking members than its sober ones would probably be biased, since it would tend to ignore the finding that probably two-fifths of its active membership have never had slips, and about three-fifths of the members at any given meeting have at least 1 year of continuous sobriety behind them. Clinical studies of A.A. slippers of course have value, but more accurate opinions of the fellowship might be achieved by study of A.A. members at their meetings, where sobriety is much more common than inebriety. (p. 271)

Leach and Norris (1977) summarize data from the 1968 A.A. General Services Board study of 11,355 respondents and compare outcomes to a subsequent survey conducted by the Board in 1971 of 6,000 North American members. In a fact worth noting, of the 17,355 respondents in both studies, 42.8% (or 7,434) indicated "instant and enduring abstinence," while the proportion of those reporting this phenomenon rose 5.3% from 1968 to 1971 (p. 483). The authors further analyze data from the 1968 study and find that people with fewer or no relapses seemed to have higher

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self-motivation. Many appeared to be utilizing other therapeutic resources. Again, the authors underscore A.A.'s "therapeutic use of slips" and its support for and toleration of the relapsing alcoholic:

> For the therapist and the alcoholic, however, the present authors believe the findings on slips are useful chiefly to the extent that they prevent discouragement should a relapse occur. Clearly, the odds are in favor of abstinence being maintained by the alcoholic who perseveres (and is so encouraged) at being an A.A. member. (p. 490)

They further cite a study conducted by Bill C. (1965), himself an A.A. member, which showed the "mathematic probabilities of gaining sobriety in AA" (p. 490). Bill C. conducted an unusual followup study of 393 members of a large A.A. group in the Midwest by keeping careful records of their attendance at meetings and their sobriety time (no such records are ever required to maintain A.A. membership, but their absence is considered by many to be a serious methodological problem hampering systematic research of A.A.):

> Bill C. reported 31.0 percent of his sample had stayed sober for at least one year and were sober at the time of the follow-up, and 12.0 percent had stayed sober at least one year, but slipped. He found that 'about 70 percent of those who stay sober for 1 year continue on to 2 years, and about 90 percent of those who stay sober for 2 years continue on to 3 years.' From his data, Bill C. plotted [a] curve . . . showing the

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> possibility of continuation of sobriety at least one year for those who attend at least ten A.A. meetings is approximately 0.43. Thereafter the curve rises fairly steeply until two years is attained, then begins to flatten. (p. 490)

Again, Leach and Norris reproduce the statistics on duration of abstinence, this time comparing the 1968 and 1971 studies. For those with eleven or more years of enduring abstinence, the figures were 12.1% (or 1,374) in 1968 and 13.1% (or 786) in 1971. Recognizing similar limitations in both studies--that fewer long-term abstinent people participated in these surveys because they tended to go to fewer meetings--the authors nevertheless again conclude that "until better quality studies are published, the assertion that A.A. members by the thousands do remain abstinent for years seems reasonable and modest" (p. 499).

The most recent survey of A.A. membership was conducted in 1998 by the A.A. General Service Office. Survey figures were distributed to 639 randomly selected A.A. groups from the U.S. and Canada (W. Stafford, A.A. World Services, personal communication, August 22, 2000) and 6,800 A.A. members responded. Of this number, 47% were sober over five years, 26% were sober between one and five years, and 27% were sober for less than one year. The average length of sobriety was more than seven years. The composition of

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responding members was as follows--88% white, 5% black, 4% Hispanic, 2% Native-American, and 1% Asian and other (A.A. World Services, 1999).

One of the most significant questions researchers have asked about A.A. is "who affiliates with it and why"? Trice (1957) studied 141 male nonpsychotic alcoholic patients in a Wisconsin Hospital who were nonaffiliates of A.A. and compared their responses to 111 A.A. affiliates, though the author admits to problems in locating a representative sample of A.A. affiliates (affiliation is defined as having attended A.A. at least twice a month in the past year, though only 5% in fact met this criteria; Trice does not provide figures on length of sobriety). He discovered that it was possible to isolate factors that discriminated one group from another. These factors were associated with an affiliative process that occurred in three phases--1) Phase 1 - antecedents to initial A.A. contact; 2) Phase 2 - initial contact with A.A.; and 3) Phase 3 - post-introductory A.A. contact (pp. 39-54).

In Phase 1, prior to initial A.A. contact, potential A.A. affiliates defined themselves as empathic, highly verbal, and able to share feelings. By contrast,

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nonaffiliates did not see themselves as able to share their feelings with others. Affiliates had no prior role models for sobriety, that is, people who claimed to have gotten sober on their own will power; therefore, they could embrace A.A.'s call for surrender more easily. Nonaffiliates had more "will power models" whose individualistic claims to personal "will power" became barriers to surrender. More affiliates seemed to have lost their drinking companions and had a more favorable exposure to A.A., while nonaffiliates had unfavorable impressions of A.A.

In Phase 2, affiliates had clear expectations of what A.A. would be like. Moreover, they had found sponsors, had experienced wider contacts with group members, and were less sensitive to social class symbols.[10]

In Phase 3, which was completed after a few weeks of contact with A.A. meetings, affiliates made a better adjustment to A.A. fellowship activities (that is, informal socializing before and after meetings), enjoyed the support

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10 See also Lofland and Lejeune (1960) for a discussion of the influence of class symbols on A.A. socialization.

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of family and friends who were not threatened by their frequent meeting attendance, accepted their status as alcoholics, and were not opposed to the program's emphasis on spirituality.

In 1970, Trice and Roman pursued the question of characteristics of successful A.A. affiliates in a longitudinal study of 378 white males who were treated for alcoholism in a state hospital and then discharged. According to the authors,

> the successful AA affiliate is characterized by affiliative and group dependency needs, a proneness to guilt, considerable experience with social processes which have labeled him as deviant, and relative physical stability at the time of entrance into treatment. Ego strength, social stability at the time of entrance into treatment, and a middle class background are not significant characterizations of successful affiliates. (p. 58)

In short, specific personality traits, rather than external sociological factors proved to be better predictors of successful A.A. affiliation. Thus, the authors challenge previously held beliefs that to be successful in A.A. one had to be middle class and socially stable.

Beckman (1980) uses attribution theory--"how persons think about cause-effect data and how they attribute meaning and order to their worlds" (p. 716)--to explain how

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individual alcoholics, new to A.A., come to accept the program's core beliefs. With few data "available on the characteristics of 'successful' recovering alcoholics in A.A.," Beckman contends that A.A.'s success results from its power to facilitate changes in the alcoholic's belief system so that the individual can eventually accept abstinence as a goal. She argues that the alcoholic's lower self-esteem, social isolation, and disillusionment "seem to accompany the successful AA conversion, or reattribution of causal belief" (p. 718). In her view, A.A. works because it relieves the alcoholic of any personal responsibility for his condition. Thus, A.A. offers the alcoholic a "reprieve from guilt." The individual is not responsible for having the disease of alcoholism, but "he is responsible for recovery from it" (p. 721). And, as she reminds us, successful A.A. members always say they are "recovering," not "recovered" alcoholics in keeping with their belief that the disease of alcoholism can never be cured, only arrested.

Boscarino (1980) examined nine variables that might significantly predict stable or unstable affiliation with A.A.--age, socioeconomic status (SES), sex, treatment, problems, ideology, A.A.-time, participation, and slips.

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He found that younger men of lower SES, with more severe alcoholism histories, affiliated for shorter periods in A.A. and were at risk for more slips. He urges more longitudinal research that follows A.A. members to confirm this tendency.

One concern that emerges from the affiliation research is whether A.A. is appropriate for every alcoholic. Tournier (1979) was an early proponent of the view that not only was A.A. not appropriate for everyone, but that its dominance in the alcoholism treatment field had "fettered innovation, precluded early intervention, and tied us to a treatment strategy which . . . [was] limited in its applicability to the universe of alcoholics" (p. 231).

Hoffmann, Harrison, and Belille (1983) also raise this question, though they are unable "to identify those for whom AA would be most appropriate and those for whom it would be least helpful, or potentially harmful" (p. 316). On the contrary, Seiden (1960) has argued that alcoholics who affiliated with A.A. may not be typical of alcoholics in general. Ogborne and Glaser (1981) consider this question in more depth. They review the research to ascertain what personality characteristics typify the A.A. affiliate and conclude that the "affiliates appear to be distinctive in

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personality, perceptual style, cognitive style, social functioning, values, attitudes, beliefs, drinking history, and drinking problems, and demographic characteristics" (p. 670). But they also note that the evidence from previous studies of the kinds of characteristics listed below still remains "inconclusive" and should be regarded merely as a "set of working hypotheses":

> Researchers have found that affiliates of A.A. are more likely to be men, over 40 years of age, White, middle- or upper-class and socially stable. A.A. affiliation has been associated with binge drinking, physical dependence on alcohol, loss-of-control drinking, and the loss or threatened loss of a valued life-style because of drinking. It has also been associated with an authoritarian personality, strong affiliative needs, proneness to guilt, an external locus of control, field dependence, cognitive simplicity, formistic thinking, a low conceptual level, high autokinesis scores, a religious orientation, existential anxiety and a tendency to conform. (p. 670)

One reason for this inconclusiveness is that studies of A.A. affiliation are sometimes confounded by the failure to specify length of sobriety as a powerful variable influencing changes in personality, cognitive and perceptual style, values, attitudes, and beliefs. Seiden (1960), for example, concluded his comparative trait analysis of A.A. members versus non-A.A. alcoholics without ever specifying how much exposure the former group had to A.A. Yet he

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argued against the use of A.A. members in research because, as his study showed, they were not representative of alcoholics in general.

While some would argue that recovery is a return to a premorbid self, others claim that the A.A. experience facilitates a transformation of the self. No study, however, could hope to settle this difficult question if it drew its sample only from newly recovering A.A. members or failed to specify the length of time spent in A.A. as a variable. This is the shortcoming of Giannetti's (1981) study of 130 male clients from various rehabilitation centers. The minimum requirement for participation in his study was that subjects had to be detoxified and in treatment for at least seven days. Given the conclusions he draws--that A.A. affiliates displayed greater life purpose, more internal locus of control, and a higher degree of positive expectations of successful treatment outcomes than nonaffiliates (p. 366), it is hard to attribute such positive outcomes to A.A. on the basis of a population that had such minimal exposure to the A.A. program.

Hoffmann, Harrison, and Belille's (1983) study of 900 adults six months after discharge from inpatient treatment

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showed a significant relationship between length of sobriety and frequency of attendance. In fact, the individual who regularly attended A.A. meetings was "twice as likely to be abstinent" as the one who did not attend. However, the authors are uncertain about "which aspects of AA are most important in the recovery process"--is it regular A.A. attendance or is it other supportive aftercare alternatives? They call for more research, though they are confident that "AA support groups remain an important component of long-term recovery" (p. 316).

Finally, Hurlburt, Gade, and Fuqua (1984) tried to resolve the question of whether there were personality differences between A.A. members and nonmembers. They studied 91 alcoholics (36 white males, 14 white females; 22 Native American males, 19 Native American females) with at least six months of sobriety. As with Giannetti, the results were also inconclusive. While A.A. provided more social acceptance, a greater positive identity, group membership that fostered normalcy, and increased self-confidence, it was unclear whether A.A. membership produced these changes or whether A.A. attracted people who were psychologically healthier in the first place (p. 171).

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What can we learn from studies like the ones described in the preceding pages when results prove to be so contradictory? As noted, nearly all are quantitative. Many struggle to overcome the methodological problems that so often confound alcoholism research--poor sampling, inadequate baseline data, untrustworthy self-reports, imprecise recordkeeping, poor standardization of instruments, lack of uniform criteria for recovery, inadequate followup, an emphasis on univariate statistics, faulty cross-comparisons, and results that cannot be generalized.

Less commonly appreciated perhaps are two other considerations not often mentioned in the literature. First, and perhaps most serious of all, is the failure to link research to practice. In a rare examination of this problem, Woody, McClellan, Alterman, and O'Brien (1991) discuss the "discontinuities between the focus and findings of research studies on the one hand, and actual treatment practice on the other" (p. 221). While they call for new forms of collaboration between the research and practice communities, they recognize the slow pace of change within the field. For example, they suggest changes in the

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research agenda to approximate the practical concerns of clinicians, enhanced communication between the two communities to reduce stereotypes and challenge negative attitudes, and better integration of research and clinical staffs to "encourage mutual respect and cooperation" (p. 227).

Second, and rarely mentioned in the literature, is the compassion fatigue and frustration that can set in when dealing with such an intractable psychosocial problem as alcoholism and, most especially, with such a high risk, relapse-prone population as alcoholics. Success rates for recovery, much less extended recovery, are not high[11] and there is, as we have seen, continuing skepticism about the claims for success associated with even A.A. involvement. Alcoholics who relapse do not make the track records of treatment programs look good, especially in this era of managed care, and burn-out and turnover rates are high among among professional staff who quickly discover that despite

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11 Estimates of recovery rates for A.A., for example, have varied from as low as 5% (see Tournier, 1979, p. 233) to the statistics cited by Leach et al. (1969) and Leach (1973). The problem, however, is the lack of uniform criteria for recovery as well as a set of baseline data that can be used for cross-comparison purposes.

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their best efforts their patients may have failed once again. Nor has the growth of the self-help movement completely improved the treatment climate. Despite the interpenetration of self-help groups like A.A. with the treatment community, there remains much suspicion and hostility between the two (see Tournier, 1979; Kurtz, 1985; Clark, 1987),[12] to say nothing of the lack of information and knowledge that still abounds. To address this latter problem, for example, the Peer Consultation Committee of the New York City Chapter of the NASW sponsored an information workshop about A.A. for social workers in June 1994. The fact remains, as this literature review reveals, that more and different kinds of research are needed about recovering alcoholics in A.A. (see, for example, Mäkelä et al., 1996, for a list of 14 research recommendations). As the Report of the Institute of Medicine (1990) indicated, it is indeed "unfortunate that AA has not been the subject of more empirical research." In particular, the Report notes, what

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12 The relationship between A.A. and the professional treatment community also preoccupied A.A.'s founders. See, for example, the A.A. Conference-approved pamphlet, A Member's Eye's View of Alcoholics Anonymous (1970), that deals with this subject.

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is most "worthy of study" is the "enduring success of this organization in attracting alcoholics to recovery" (p. 521). Even Tournier (1979), one of A.A.'s most persistent critics, commented that "in an area where documentable recoveries are rare, A.A. alone has appeared to succeed" (p. 231). Since A.A. depends on attraction, not promotion (its 11th Tradition), what better population to study than that invisible cohort of long-term affiliates who by their ongoing commitment to sobriety help to account for that organization's "enduring success."

SUMMARY

This chapter contained a review of the social work and social science literature regarding alcoholism, Alcoholics Anonymous, and long-term recovery. The social work response was examined from both a historical and contemporary perspective. The social science response contained a more extended discussion of the subject from four vantage points--studies of posttreatment alcoholics, studies of spontaneous remission, models and metaphors of recovery, and the A.A. model.

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CHAPTER 3

THEORETICAL FRAMEWORK

INTRODUCTION

This chapter contains a discussion of the theoretical underpinnings of the present study. It begins with a consideration of the choice of qualitative research as an appropriate vehicle with which to explore long-term sobriety. Theory development continues with a brief explanation of how the study was conceptualized, namely, as a phenomenological inquiry. Two contributions to the making of a theory are then reviewed. They are taken from narrative theory and the literature on cultural competency and serve as a conceptual bridge to the final section of the chapter--the development of a more clearly articulated theoretical framework, an ecological model of sobriety, that was generated by this discovery-oriented process.

CHOOSING A RESEARCH STRATEGY

As noted in Chapter 2, researchers in the field of alcoholism have long complained about the methodological problems they encountered in studying either active alcoholism, alcohol treatment outcomes, or the phenomenon of recovery. Many of their concerns bear directly upon the strengths and weaknesses of conducting quantitative versus

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qualitative research.

Patton (1990) reviews the various advantages and disadvantages of either approach. He notes that while quantitative methods accommodate larger statistical samples more easily and facilitate a "comparison and statistical aggregation of data," they also force people's experiences and reactions into a "limited number of predetermined response categories to which numbers are assigned" (p. 14). Moreover, while such studies may yield results that can be generalized, they focus more on the measuring instruments frequently to the exclusion of who or what is being measured. This is what Agar (1986) terms the "'received view'" of social research, one that emphasizes the "scientific testing role" (pp. 11-12). Here the researcher moves in linear fashion from "hypothesis through data collection to analysis" (p. 16).

According to Patton, qualitative research allows for a more in-depth study of a subject. While sample size may be smaller, qualitative methods yield more detail, insights, and understanding. However, much depends on the "skill, competence, and rigor" (Patton, p. 14) of the researcher to tease out information in a non-manipulative way. Strauss

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(1990) refers to this ability as "theoretical sensitivity":

> Theoretical sensitivity refers to a personal quality of the researcher. It indicates an awareness of the subtleties of meaning of data. One can come to the research situation with varying degrees of sensitivity depending upon previous reading and experience with or relevant to an area. It can also be developed further during the research process. Theoretical sensitivity refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't. All this is done in conceptual rather than concrete terms. It is theoretical sensitivity that allows one to develop a theory that is grounded, conceptually dense, and well integrated--and to do this more quickly than if this sensitivity were lacking. (pp. 41-42)

In a qualitative investigation, the researcher assumes what Agar (1986) calls a "learning role," visiting in a world he or she does not understand by "encountering it firsthand and making some sense out of it" (p. 12). Of greater interest is understanding what just occurred--the "here and now"--rather than knowing what comes next. As Agar says, "You cannot possibly know what to do next unless you know what just happened" (p. 16). Thus, qualitative research emphasizes the emergent and unformulated experience. The researcher "begins with an area of study and what is relevant to that area is allowed to emerge" (Strauss, p. 23).

As we have also seen, typically much research on

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alcoholism has been quantitative, but not without authors criticizing the inherent limitations of their own choice of method. Qualitative research, on the contrary, has much to recommend it as a methodologically appropriate strategy for research on long-term recovering alcoholics. In fact, Strauss (1990) endorses it for research that "attempts to uncover the nature of persons' experiences with a phenomenon, like . . . addiction" (p. 19). Blumer (1969) also finds it a valuable methodological tool in the study of drug use among adolescents (p. 47).

Given that researchers complain about the "conspicuous lack of data on the characteristics of individuals who have been able to maintain long-term sobriety" (Kurtines et al., 1978, p. 972) in a population defined more by its invisibility, there is much yet to be learned through a discovery-oriented paradigm.

CONCEPTUALIZING THE PROBLEM

As Patton (1990) reminds us, "In new fields of study where little work has been done, few definitive hypotheses exist, and little is known about the nature of the phenomenon, qualitative inquiry is a reasonable beginning point for research" (p. 131). Epstein (1985) agrees,

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stating that "The use of qualitative research methods in theory development has been called grounded theory and is more suited to the study of relatively uncharted social terrain" (p. 266). As we have seen, while it is not unusual to include this population in studies of recovering individuals, it is rare indeed to focus exclusively on this cohort and to find key informants who represent the diversity of the recovering community.

Given the exploratory nature of this study, it is anticipated that any theory that will explain these "naturally occurring phenomena" (Patton, 1990, p. 119) will be grounded in and emerge from a study of the real world of our key informants. As Patton would say, "how you study the world determines what you learn about the world" (p. 62).

In essence, this study is phenomenological. According to Patton, a phenomenological inquiry asks the question--"What is the structure and essence of experience of this phenomenon for these people" (p. 69)? Thus, following Patton, this study asks, what is the structure and essence of the recovery experience for the long-term sober alcoholic, though what remains to be determined is the extent to which this experience is a uniquely common or

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uncommon phenomenon among the study's participants; hence, the exploratory nature of the study.

CONTRIBUTIONS TO THE MAKING OF A THEORY

While it was initially impossible to approach this study with any predetermined theoretical framework, it was not too premature to sketch the outlines of a possible model that could frame and elucidate the phenomena under observation. To do so, this researcher was guided by the use of two theoretical formulations, not incompatible with each other, that suggested a pathway to a more fully articulated theoretical framework.

First, given the importance of storytelling to the A.A. experience, Rappaport's (1993) use of narrative studies as an analytic and methodological tool to examine self-help organizations like A.A. proved provocative. He argues:

> In its simplest form, the narrative approach means understanding life to be experienced as a constructed story. The stories that people tell and are told are powerful forms of communication to both others and one's self. Stories order experience, give coherence and meaning to events and provide a sense of history and of the future. (p. 240)

He then makes a distinction between personal stories and narratives. Personal stories invite a more individual level of analysis, while narratives represent what he calls a

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"community level of analysis":

> Consistent with the mutual help ethos, the narrative approach highlights the nature and functions of the community, the power of its narrative, and how it changes (and is changed by) the members' personal life stories. (p. 240)

Thus, instead of regarding A.A. as an alternative treatment for a DSM-IV diagnosis, A.A. becomes a kind of "normative narrative community" that helps to transform a member's identity or sense of self "according to a narrative provided by the organization" (p. 242). Rappaport argues that such a community represents a challenge to the "professional centrism" that often dominates treatment of medical and psychiatric disorders. The community fosters the kind of empowerment that social workers are taught to promote in work with their clients.

Davis and Jansen (1998) recommend a similar reframing of A.A. as a counterpoint to the tendency of professional service providers to view A.A. as an alternative treatment model. They argue that placing A.A. in a narrative framework implies a conceptual shift from a "rational (service delivery) model to a metaphorical (spiritual) understanding" (p. 173). Such a reformulation frees the observer to examine language and metaphors more closely,

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that is, the symbolic communications conveyed in the stories and the meanings that recovering people assign to their experiences.

Second, Leigh's (1998) work on cultural competency (a much discussed theme in recent social work writing) provides another conceptual building block in our attempt to construct a theoretical framework. Like Rappaport (1993) and Davis and Jansen (1998), he too argues for a narrative approach, but for a different reason. Leigh's formulation is drawn from his work with individuals from ethnic minority backgrounds, a clientele much like alcoholics who face stigmatization and denigration by a majority culture for their differentness:

> In the professional helping endeavor, the client's storytelling needs to be encouraged as a beginning to filling the cultural gap between client and helper. Telling a story--a narrative--according to Young-Bruehl [1996, p. 466; the well-known biographer of Freud and a psychoanalyst in her own right], provides 'the need to master (if not overcome) the trauma, to make the world inhabitable again after it has been experienced as so malignant and so deadly.' (p. 4)

Advocating an ethnographic approach to interviewing, Leigh cautions the social worker that "to rely on empathy alone is not enough" (p. 15). Instead, he advises putting aside theory in favor of developing the kind of communication

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skills that would elicit such a narrative:

> It is in the narrative that the helper will find the client's hopes, aspirations, values, and views of the world. It is through the narrative that the client is understood, is helped, and feels better rather than through the theories about how people in distress improve, are helped, and are made to feel better. (p. 4)

Storytelling, he continues, is a powerful therapeutic tool that leads the individual to "reflection and the discovery of meaning":

> By having an opportunity to tell the story, the minority person begins a process of healing through self-discovery, self-definition, and movement away from the role of victim and subject. The stigma of being unable to sort out one's life experiences, identify their causes, and solve problems is mitigated in the process of narration. (pp. 13-14)

TOWARD AN ECOLOGY OF SOBRIETY

Using these two formulations as methodological tools provided a clearer linkage to a more fully developed theoretical framework, namely the use of an ecological approach to depict and explain the world of the long-term recovering alcoholic. A review of the literature on recovery indicates that little attention has been given to the application of an ecological framework to this population. As we shall see, this is ironic in that the ecological framework and qualitative research design share

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many of the same attributes.

The use of an ecological framework is not new to social work. It belongs to a well-established perspective in the field--the social reform tradition--that locates the individual in a social context and identifies the target problem as existing not inside the person but between the person and his or her environment. In fact, social reform has long vied with the more conservative emphasis on individual psychodynamics for hegemony within the profession. Since the 1960s, there has been renewed emphasis on more sociocultural approaches to social science problems, part of the movement away from an exclusive concentration on psychodynamics that dominated social casework for decades. With the interest in social reform sparked anew by the dramatic political events of the 1960s, social workers turned their attention once again to the intersection between the social environment and human behavior. Stein (1963) was an early advocate of the integration of these two polarities in social work practice:

> Albert K. Cohen has suggested that psychologists and sociologists ask different questions about the same things--the one, why X is as he is, the other, what are the social conditions and the social locations within which this behavior tends to occur. The social worker must ask both these questions, utilizing

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insights from both fields. (p. 86)

Stein continues:

> Let us keep in mind, moreover, that we know relatively little of the interactions of social and personality systems; or of the personality correlates of different levels in the social structure. And, finally, while we have some understanding of how social and environmental factors can aid us diagnostically, we have far too little recorded experience with the ways in which such expanded understanding actually affects social work process and objectives in specific practical terms. (pp. 87-88)

After Stein, there were more calls for a social work practice linking the individual to the environment. Oxley (1971) proposed a life-model approach that brought both worker and client into a more action-oriented collaboration with therapeutic benefits:

> Assisting clients in constructive action often requires resources within the community. The social worker's own action orientation to bring about positive change in the environment is essential to the successful clinical practice of this concept. (pp. 632-633)

Strean (1972) saw the utility of the life model in sharpening the caseworker's diagnostic skills. Finally, Germain (1973) discussed the various theoretical sources that informed the ecological model (e.g. field theory, systems thinking, developmental psychology) and provided a rationale for this shift in perspective:

> The life model defines problems not as reflections

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> of pathological states but as consequences of interactions among elements of the ecosystem including other people, . . . places, organizations, ideas, information, and values. They are conceptualized as problems in living, not as personality disturbances. The approach is concerned with modifying transactions that are damaging to identity and self-esteem, ego development, human relatedness, social functioning, and realization of potential. It is also concerned with modifying transactions hurtful to the environment, whether these occur in dyadic relationships, families, groups . . . . Thus, the life model requires modes of professional action that will engage the healing potential and the growth potential in the individual's adaptive capacities and in the social supports of his real world. It seeks to bring about social situations and group contexts that will promote growth and maturation, on the assumption that increased competence leads to improved coping capacity in future life space events. (p. 327)

The life model, with its emphasis on transactions between the person and situation, tried to avoid "dichotomizing person and situation." Thus, it veered away from more traditional practice approaches which had placed clients in a passive role, used disease metaphors to explain their difficulties, and focused treatment efforts on getting clients either to change themselves or adjust to their situation (Germain, 1973, p. 326).

In a series of separate workshop papers, Goldstein (1975) and Maluccio (1975) elaborated further on the clinical applications of the ecological model. Goldstein summed up the important elements in this approach:

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> 1. a different view of the nature of causality--a multicausal perspective;
> 2. an appreciation for the conflict-free sphere of the ego and of the capacity for growth all through the life cycle;
> 3. an awareness of the mutuality between an individual's phase-specific needs and environmental supports;
> 4. an appreciation of natural life events in promoting change and growth;
> 5. an assessment based on an understanding of all the transacting forces in a client's life space;
> 6. interventions geared to promote growth and remove obstacles to growth in the clients through expansion of their autonomous ego functioning as well as creating and mobilizing positive resources in the environment. (p. 25)

Meanwhile, Maluccio (1975) noted the unique value of the ecological model to the social work profession:

> The most appealing feature of the life model is that it can help us to develop something which is badly needed in our field, namely, an integrative framework that is uniquely social work: a frame of reference that fully encompasses social work values, purposes, and knowledge and that is truly responsive to the needs of human beings and the realities of life. (p. 3)

He also reviewed some of its key features:

> 1. The model emphasizes human strengths and adaptive processes more than human defects or inadequacies.
> 2. It offers important insights and guidelines for translating into practice the concept of the person-environment configuration that has long been talked about in social work.
> 3. It includes renewed emphasis on work in and with the environment, on imaginative use of the environment on behalf of people, and on provision of nutritive environmental resources and supports.
> 4. It stresses the use of life experiences and natural processes and activities in efforts to help people to cope with 'problems in living.'

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> 5. It is concerned with the purposes of social work intervention more than with techniques per se. (p. 9)

As we have seen, the model itself was not new; what was new, however, was the more imaginative uses to which it was put by theorists and practitioners in various disciplines. For example, Bronfenbrenner (1979) developed a multi-level schema of micro-, meso-, exo-, and macro-systems which incorporated individual developmental experiences into a larger systems framework. He then applied it to problems encountered in an educational setting. Wetzel and Redmond (1980) used it to study depression hypothesizing that to be depression-free, one must have environmental supports. They predicted that a lack of support from both family and work correlated with depression. In their view, the "person-environment incongruence model provides a practical conceptual tool for possible preventive and interventive strategies" (p. 373). Balgopal and Vassil (1983) then developed an ecological perspective for social group work.

Just as other disciplines adopted the ecological framework, it was not long before the alcoholism field borrowed it as a conceptual tool. In an attempt to go beyond the more traditional disease model formulations, Ward and Faillace (1970) used systems thinking to describe the

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pathological nature of the alcoholic's interactions with others. By contrast, they suggest that A.A. provides the kind of positive interactional system that can "counteract the alcoholic's social isolation, lack of motivation, denial of illness, and guilt regarding his own and his helper's failures." They add:

> For those who benefit most from it, participation in A.A. is an intense life experience bearing upon many, if not all, aspects of the alcoholic's world. The more he becomes involved in it, the more it serves as a contrasting substitute for previous pathological interactional systems, most notably his family, and he may finally be more a member of the A.A. system than of any other. Its effectiveness may be related to the fact that it is a shrewdly programmed and comprehensive system in which equilibrium within the system is maintained when its members are abstinent and helping other alcoholics. (pp. 689-690)

From the 1970s on, alcoholism researchers called attention to the influence of environmental or extratreatment variables (e.g., family, work, social support networks) in treatment and posttreatment, even the natural recovery, of the alcoholic (see, for example, Bromet & Moos, 1977). As we have seen in O'Briant et al. (1973), some researchers proposed elaborate and costly social treatment strategies that entailed the creation of socially engineered recovery communities. These ventures provided a safe haven from the mean streets where the pressure to abuse substances

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was a constant menace.

By the late 1970s, social workers practicing in the alcoholism field began to apply ecological concepts to treatment but in a more limited way. In dissertations and articles, they examined such single variables as social delivery systems (Regan, 1978; Buetens & Kern, 1991), social milieu (Schulte & Blume, 1979; Turner, 1979; Stead, Rozynko, & Berman, 1990), family systems (Rathbone-McCuan & Triegaardt, 1979; Starr, 1989; Sandoz, 1991), self-help programs (King, Bissell, & O'Brien, 1979; Winegar, Stephens, & Varney, 1987; Master, 1989), personal or social support networks (Yellowthunder, 1981; Macdonald-Grant, 1982); Segars, 1989; Cornille & Hicks, 1993), and the workplace (Fine, Akabas, & Bellinger, 1982; Dunkin, 1983).

But to date there has been no systematic effort to apply a unifying and coherent ecological framework to an examination of the multi-faceted experiences of long-term recovering alcoholics. Moreover, what these earlier studies fail to capture is the unique total environment which long-term sober alcoholics have virtually invented for themselves in order to maintain their sobriety and ultimately thrive. The creation of this new ecological

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analog or "culture of sobriety" begins with the individual's positive acceptance of his or her deviant role as an alcoholic, albeit a recovering one. However, this ecology or "culture of sobriety" is not limited to the intricate "social world" of A.A., the kind of social construction studied by Smith (1993) for its power to foster group participation and meet affiliative need. Rather, it begins with A.A. and extends outward into new pathways of social construction beyond the bounds of A.A.

Why choose an ecological model? For an exploratory study in which the attributes, experiences, behaviors, and actions of a long-term recovering population in A.A. remain to be elucidated, the ecological perspective is a powerful tool with which to "map" unknown territory. In fact, as we shall see, its basic concepts seem to be compatible with the recovery philosophy espoused in A.A.

In a discussion of the ecological framework, especially as it applies to social group work, Balgopal and Vassil (1983) note that the word "ecology" derives from the Greek and means "living in the home or homestead." According to the authors, this definition "incorporates the formative idea of natural habitat and related notions of

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interdependence and continuity." They further observe that a fundamental shift in metaphor is required to understand this framework:

> . . . from the language of the machine metaphor--viz., social engineering, friction, resistance, equilibrium, force field--to the vocabulary of the organic metaphor--viz., adaptations, development, cycling, transaction, and open, dynamic system . . . . Process and context take precedence over structural arrangements. Underpinning the ecological perspective is the assumption that a minimal degree of integration is necessary between the person and various environments in order to maintain and enhance the problem-solving capacities and growth of constituent members in their own habitat. The fundamental task for professional practice in groups is to build a culture that contains within it adequate provisions for its own change. This permits the reconciliation of various frames of reference that are represented in the ongoing interrelationships among person, group, and environmental processes. (p. 20)

This notion of a dynamic habitat or "culture that contains within it adequate provisions for its own change" could almost be a metaphor for the A.A. experience. Moreover, the attendant emphasis on "development, cycling, [and] transaction" accords well with the perception of A.A. by its members as a "home" (some A.A. members greet newcomers with the words, "Welcome home"; newcomers are advised to find a "home" group) or "school" environment (Step 12 mentions the "A.A. campus" and older members sometimes salute one another with the phrase, "see you

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around the campus"), with other members serving as surrogate family, with sponsors acting "in loco parentis" as role models, and with recovery depicted as a process--progressive, dynamic, ever-changing (or in the folk wisdom of the program--"it gets better; it gets worse; it gets different").

Another concept central to the ecological framework is the "ecosystem," that is, that "living organisms and their nonliving environment are inseparably interrelated and interact upon each other" (Balgopal & Vassil, 1983, p. 25). Individuals, in short, do not live in isolation; for better or worse, they are inseparably linked to others whether in small groups, families, communities, or nation-states. A.A., as a self-help mutual aid organization, continually recognizes this principle of interdependency and reciprocity. If alcoholism is a disease of isolation and if the alcoholic, in the words of Step 4, suffers from an "inability to form a true partnership with another human being" (A.A. World Services, 1983), then A.A., as an extended social laboratory (in A.A. parlance, the "fellowship") provides many opportunities for members to practice negotiating new relationships, building new

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situations in one's life, and living out one's commitment to sobriety in actions that help others with a similar problem ("you have to give it away to keep it"). These actions may include sponsorship, developing a sober support system, engaging in such service activities as answering phones at A.A. Intergroup, leading meetings, making 12-step calls, and doing hospitality at meetings. All are sober activities designed to get the notoriously self-absorbed alcoholic, consumed with shame, remorse, and guilt, to look outward beyond the bounds of self to a larger social and environmental context.

To this end, members are further encouraged not to focus on why they drank--they drank, they are told, because they were alcoholic, and not for any other reason. This exclusive attention on the fact of drinking (i.e., drinking as a separate disease entity) and not on its causes (i.e., drinking as a symptom of some underlying pathology) helps minimize the alcoholic's tendency to rationalize his or her actions. It also liberates the alcoholic from self-recrimination and morbid self-pity.

Moreover, systems that are open constantly receive input from other systems. This feedback mechanism not only

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enables systems to remain in balance, but also to grow and develop. A.A. members also participate in a kind of feedback loop with sponsors and other confidants from whom they can receive feedback; they are even encouraged to form a relationship with a Higher Power, which for some can be the A.A. group itself. In addition, they do personal inventories (Steps 4-5 and 8-9) with sponsors who help them to modify negative personal behaviors.

Ecological systems theory further shifts attention from an analysis of cause and effect to the more holistic notion of the *gestalt* or person-environment configuration. As Compton and Galaway (1989) note:

> The person is observed as a part of his/her total life situation; person and situation are a whole in which each part is interrelated to all other parts in a complex way through a complex process in which each element is both cause and effect. These dynamic interactions, transactions, and organizational patterns that are critical to the functioning of both the individual and the situation are only observable when we study the whole system. Thus the whole is always more than the sum of its parts. (p. 123)

Put another way, individuals are perceived in the "context of their relationship with different levels of the environment such as family, friends, work associates, neighborhood and the like" (Balgopal and Vassil, 1983, p. 29). A comparable idea is fostered in A.A. when

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newcomers are reminded that A.A. is not an end in itself, but a "bridge back to life." The metaphor is of an open system (another key concept in ecological thinking) in dynamic transaction with a larger environmental context. Thus, the individual is encouraged to develop new and healthy interactions in a world beyond A.A.

From this discussion, it is clear that the ecological framework is a powerful tool to capture the transactions of the recovering alcoholic at all levels. An additional contribution by Sarbin (1970) helps to clarify and explicate these various levels which constitute the recovering individual's social world or "culture of sobriety."

Sarbin's notion of "differentiated ecologies" is a useful formulation that has received little attention for its potential applications to a study of the recovery experience. He posits a set of four ecologies or domains--a "self-maintenance ecology," a "social ecology," a "normative ecology," and a "transcendental ecology"--in which individuals must situate themselves in order to survive and thrive "as a biosocial organism, as a valued person, as a conceptual entity, and as a member of society" (p. 90). The ability to locate oneself correctly in each domain has

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significant consequences for how well one functions in society, for the formation of one's social identity, for the degree to which one accepts personal responsibility, and for the way in which one works out a place in the universe. All of these dimensions have relevance to the experience of recovering from alcohol as their resolution at each level has much to do with the successful passage of the alcoholic into a more meaningful life (that is, if A.A. is a "bridge back to life," then to what extent does the recovering alcoholic cross that bridge and to what kind of life?). This remains to be discovered in the present exploratory study.

In summary, what is the significance of an ecological model for the present study? Compton and Galaway's (1989) discussion of the contributions of the model to social work practice (pp. 137-139) prompts the development of the following rationale for the present undertaking:

1. It provides an organizing, inclusive framework for the collection of a vast amount of data on a little known aspect of the recovery phenomenon.

2. The concepts which inform the model can be applied equally to a heterogeneous population of long-term

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recovering alcoholics.

3. While the model focuses on transactions between the individual and the environment, it also allows for a more specific focus on the developmental processes occurring within individuals as they actively engage the environment.

4. Its emphasis on goal-oriented mechanisms and dynamic open systems provides a standard of wellness and emotional health that parallels the suggestions for attaining the goals of the A.A. program.

5. Its emphasis on overcoming resistance and achieving a balance between adaptation and change speaks well to the dilemmas facing recovering alcoholics and the choices they face as solutions (in the words of the A.A.'s famous Serenity Prayer, "change what you can; accept what you cannot").

6. It provides a useful framework within which to identify gaps in knowledge and potential areas of service by social workers to a little known population.

SUMMARY

Chapter 3 presented a discussion of the theoretical foundations of the present study. The choice of a qualitative research paradigm as an appropriate vehicle for

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exploring long-term sobriety was considered. Theory development proceeded with a conceptualization of the study in phenomenological terms. Contributions from narrative theory and the literature on cultural competency provided a conceptual link to the final portion of the chapter--a more detailed discussion of the theoretical framework that emerged from this discovery-oriented research process, namely, an ecological model of sobriety.

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CHAPTER 4

OVERVIEW OF THE STUDY

INTRODUCTION

Chapter 4 contains a brief description of the study which includes where it took place, when it was conducted, along with a discussion of the obstacles encountered in implementing the plan as originally conceived. The section then outlines the five major goals of the study and the anticipated outcomes. It concludes with an attempt at clarifying such terms as "abstinence," "recovery," and "sobriety" while providing a list and definition of some key terms used in the study.

DESCRIPTION OF THE STUDY

This is an exploratory study of a heterogeneous group of 30 individuals who are sober in A.A. for ten years or more. The study uses qualitative methods of personal interviews and observations.

The study was conducted in New York City, which has one of the largest and most active A.A. communities in the world. According to the 1999 A.A. meeting book, there are over 1,000 A.A. meetings to be found in New York City alone. Interviews with the 30 study participants, nearly

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all of whom were New York City residents (one lived in New Jersey and another on Long Island) and attenders of New York meetings, took place over a three year period, from 1996-1999.

The original plan called for interviews with 30 collaterals, such as family and friends, selected by the primary subjects who could provide further insight into the A.A. members' unique experiences. These individuals would confirm what could be learned through the original interviews. The plan also anticipated that the researcher would not only attend A.A. meetings with each of the identified subjects to observe their interactions with other members but also would attend those special-interest A.A. meetings that generally attract long-term recovering individuals. Attendance at the latter was for the purpose of providing additional insight into the issues and concerns of this long-term recovering population.

From the outset of the study, however, it was clear that this original plan was far too ambitious in scope--interviews with collaterals were too cumbersome to schedule and attendance at A.A. meetings to observe study participants' behaviors proved too time-consuming to

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undertake. Therefore, an attempt was made to refocus the project to the study participants alone. This was easily accomplished without an adverse impact on the study's original five goals.

The study is an elaboration of a smaller, more preliminary undertaking conducted in 1995. At that time, this researcher identified eight individuals known to her who had ten or more years of sobriety and interviews were conducted with each lasting two or more hours. This purposeful sample was notable for its diversity in representing, in part, the contemporary urban New York A.A. recovering community--5 females, 3 males; 6 Caucasians, 2 African-Americans; 4 heterosexuals, 4 homosexuals. As key informants, these responsive individuals provided a tentative, but tantalizing glimpse into the heretofore little known world of the long-term recovering alcoholic. Their previously unrecorded and undocumented accounts made clear that there was still much to be learned about them and their experiences; hence, the exploratory nature of the present study.

GOALS OF THE STUDY

The study has five goals:

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1. To describe these individuals and understand the significance they attach to being self-identified as recovering alcoholics.

2. To ascertain how they got sober and how they manage to maintain their sobriety.

3. To explore how their personal lives have been transformed by their participation in A.A.

4. To examine the extent to which their participation in A.A. has enabled them to modify and reconfigure their environments, thus creating a new environmental analog, so as to sustain their sobriety.

5. To enumerate the constraints, if any, that may exist in the environment which threaten their sobriety and how they cope with them.

ANTICIPATED OUTCOMES OF THE STUDY

In addition to the aforementioned five goals, the study was expected to have the following anticipated outcomes:

1. It will enhance our understanding of a little known aspect of the recovery phenomenon--protracted and secure sobriety. The knowledge gained from personal interviews and observations will serve to fill in the gaps that currently exist in the rather meager literature about long-term

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recovery. This literature, as we have seen, is more concerned with quantifying A.A. success rates than with focusing on the clinical utility of self-help recovery programs (Clark, 1987, p. 233) and on the unique experiences of A.A. members.

2. It will provide a much needed bridge between the research and practice communities. A study of this kind will yield immediate and practical insights that can be incorporated into the design of new treatment strategies, while making possible the more efficient use of older, more tested ones. This is particularly crucial given the current pressures from managed care on the delivery of services.

3. It may also provide a necessary linkage between self-help entities like A.A. and the professional treatment community--which have had an uneasy history of collaboration (see Powell, 1993; Rappaport, 1993; Riordan & Walsh, 1994)--despite the official position of A.A. welcoming cooperation with the professions (see, for example, A.A. World Services pamphlets, 1970 and 1974; Bill W., 1981). Such a study might identify additional factors in the recovery process that could influence cooperation between the two sectors and make a "critical contribution to

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treatment outcomes" (Kurtz, 1985, p. 111). More positive collaborative efforts may also serve to lessen the hostility of members of the recovering community towards those professional helpers who may have misdiagnosed their alcohol problem.

4. It will contribute to the ongoing accumulation of a body of knowledge about alcoholism, with special attention to recovery within the field of social work, and may also improve the integration of alcoholism treatment with social work practice. As we have seen, the social work profession traditionally has demonstrated an ambivalence toward working with alcoholics and a hesitancy in playing a more active role in advocacy, policy development, program planning, diagnosis, treatment, and research and evaluation within the alcoholism field. For many years, alcoholism occupied an orphan status within the social work profession. The development of alcohol and other drug content for BSW/MSW programs only occurred in the mid-1990s with the completion of the work of the Curriculum Enhancement Project, a joint effort of the National Association of Social Workers, the Council on Social Work Education, the National Association of Deans and Directors, and the National Association of

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Baccalaureate Program Directors. The Project, under the sponsorship of the U.S. Department of Health and Human Services' Center for Substance Abuse Prevention, published its five Curriculum Modules for Schools of Social Work in 1995. Despite this major curriculum contribution, there still are noticeable gaps in the recruitment, education, and training of social work professionals specializing in alcoholism treatment. Moreover, no national social work conference has ever been devoted to alcoholism, and social workers still maintain the kind of uneasy working alliance with other alcoholism treatment professionals that was noted more than thirty years ago by King, Bissell, and O'Brien (1979). Finally, as we have also seen, social work as a profession has been slow to acknowledge the problem of impaired workers in its own ranks, although this has begun to change modestly with the creation of a Peer Consultation Committee within the national NASW office and many of the chapters. Nevertheless, there is still a need for more peer education to sensitize colleagues and supervisors to this phenomenon.

5. It will offer a paradigm--that there is an environmental analog to the recovery process--that will be

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familiar to social workers as it corresponds to the profession's historic commitment to the person-environment interface and to the amelioration of harmful social conditions.

6. It will challenge the negative stereotype and pessimistic view of the alcoholic as hopelessly self-destructive by focusing on positive role models within A.A.

7. It will also sensitize the social work professional to the diversity of the recovery community and encourage the development of a practice orientation that is flexible and accommodating to the special needs of various subgroups, especially women and sexual and ethnic minorities, populations often ignored in research studies. Focusing on such exemplars (in A.A. terms, "powers of example") will further aid in the empowerment of individuals from these disenfranchised groups and encourage the development of culturally sensitive treatment interventions.

8. It will improve continuity of care mechanisms by encouraging ongoing alliances with A.A. and providing professional caregivers with more opportunities to formulate new and innovative problem-solving programs and

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interventions.

DEFINITION OF TERMS

One of the most difficult tasks facing the researcher in conducting a study of this kind is the lack of conceptual clarity that exists about the terms used to describe what happens to an alcoholic when he or she stops drinking. Such words as "abstinence," "recovery," and "sobriety," are used almost interchangeably in the professional literature with little thought given to their precise meaning and how they relate to the experience being described. Moreover, when researchers study A.A., they often fail to realize the metaphoric richness of the language used in A.A. to describe the recovery process.

Leukefeld and Tims (1986), in a summary of research contributions on relapse and recovery, note the "limited amount of information available on recovery" and cite the need for a better definition of the term "recovery" (p. 188). They recall how some define it as "total abstinence," while others accept some "limited substance use." However, in A.A., they observe, an "alcoholic never actually recovers, and is always at risk for relapse" (p. 185). Indeed, many people in A.A. identify themselves

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as "recovering," not "recovered" alcoholics to denote the fact that recovery is an ongoing process and not a completely finished state or event, since alcoholism is a chronic disease without a cure. Wesson, Havassy and Smith (1986) comment that A.A.'s use of the term "recovery" means more than just abstinence. In their view, it implies that the individual has accepted "addiction as a lifelong, incurable disease; that the person is participating in 12-step recovery groups; and that the person is learning to live a comfortable and responsible life without the use of psychoactive drugs" (p. 15).

Other theorists employ the term "abstinence," but still they are unable to achieve clarity. Maddux and Desmond (1986) discern two meanings in the word. It can refer to the "abstinence syndrome" which "follows cessation of use when physical dependence on a substance exists." It also refers to the "continuing state of abstaining from substance use" (p. 50). They try to find an agreeable substitution in the word "recovery," but soon learn there is much disagreement over its meaning. It can variously mean "'cure,' 'maturing out,' remission, 'de-addiction,' cessation, stable abstinence, and 'quitting.'" They look to

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A.A.'s use of the term "recovery"--A.A. members use it to mean a process rather than a state. "If recovery is viewed as a process, then it becomes possible to identify and describe, more or less arbitrarily, levels in the process" (p. 60). For example, one could have achieved a "continuous voluntary abstinence from [a] primary substance with only occasional use of other substances" like tobacco. As the authors note, one could be at this level for one year or more, or possibly less:

> The levels could be extended for two years, three years, or longer. The use of levels of recovery avoids the difficulty of attempting to determine whether the person has regained a 'normal or usual state.' The person who has had a substance use disorder may never completely return to his 'usual' state which preceded the disorder. Some remnants of the disorder, such as the loss of liver cells or the memories of substance effects, probably endure for a lifetime. (p. 61)

Vaillant (1983) also wrestles with the multiple meanings implied in the term "abstinence." He observes that because its definition is "relative," the "parameters of abstinence must be carefully defined." To this end, he delineates three categories of abstinence: 1) the "ever abstinent," 2) the "currently abstinent," and 3) the "securely abstinent" (pp. 183-185). But only the "securely abstinent" are those for whom a return to asymptomatic

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drinking is never an option.

Some theorists go further and introduce another term into the discussion--"sobriety." Thus, Shields and Wing (1992) distinguish sobriety from abstinence. Abstinence is the "cessation of alcohol consumption," while sobriety "implies a change in lifestyle from the unhealthy behaviors of drinking to the healthy behaviors of recovery" (p. 159). Cooke, Fewell, and Riolo (1983) make a careful distinction among all three terms--abstinence is the term "used to describe someone who has ceased the ingestion of the drug alcohol," recovery is a "process that continues long after the drinking has stopped," while sobriety is used to "describe someone who is involved in an active and ongoing effort to repair the damage done during the drinking years" (p. xiv).

During the interviews, participants were asked to provide their own definitions of these terms. Some clearly delineated "abstinence" from "sobriety"; others conflated the terms "sobriety" and "recovery," making them indistinguishable from one another.

Nearly all who responded were in agreement as to the meaning of "abstinence"--it was not using any drugs or

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alcohol, but some offered more nuanced explanations of the term:

> • It's white knuckling it, but the person doesn't really want to [stop drinking]. I know they're gonna drink. I did. I had tremendous will power and it couldn't stop me from drinking.
>
> • It's stopping. You know there's a problem, but you don't know what to do.
>
> • Somebody is not drinking for this while.
>
> • Something is missing in people who are abstinent.

Others used a different language to describe their so-called "abstinent" family members. They offered vivid, sometimes painful, recollections implying that, though "abstinent," something was indeed "missing" in their troubled loved ones:

> • [one woman speaking of her "abstinent" grandfather] I didn't hate my grandfather. He was . . . always kind to me . . . . He really had a tough time of it . . . he smoked cigars one after another . . . the room was always blue from the [smoke] . . . . It was such alcoholic behavior. It was hysterical. And he could make . . . very unkind remarks, I guess, to my grandmother and to my mother . . . .
>
> • [one woman speaking of her "non-drinking" alcoholic father] I'd say he's non-drinking. I don't think he's a dry drunk. I think he's non-drinking. . . . he got into a place where it was as if he never had a past and that's where, I think, we don't . . . we try not to do that in A.A. He didn't acknowledge his past, of which I was of course a part. He never apologized to us in his family for the trouble he brought to us. I still have a resentment about that.

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> • [one woman speaking of her father who committed suicide] . . . my father stopped drinking at some point. I don't know what that was about. . . . I don't think he was an alcoholic. But I don't know that. And he just got angry.
>
> • [one man speaking of his wife who he described as a "dry drunk"] A dry drunk is just a person who still has all the character defects and is not making any progress with them. They're not . . . they're not moving towards . . . a sense of community, accepting their responsibilities in a way that's productive. They're . . . continuing to live their lives and it's not improving. It may be getting worse even.

The term "sobriety" evoked more complex responses derived from years of experience in recovery. Some viewed it as a "process"; others saw it as an "outcome." Many attributed their sobriety to their experience of being in A.A., though a few thought that one could be sober without any A.A. intervention:

> • I make a distinction of that [sobriety] in degrees. . . . If someone . . . hadn't had a drink in 10 years, I would say well, you're sober. I agree. That's a sobriety. But I also reserve to myself a much bigger definition of sobriety in terms of A.A. . . . It implies . . . a continuous sobriety in A.A. . . . a continuous process of . . . of gaining self-knowledge, gaining awareness of . . . of the nature of life, gaining awareness of the intricacies of dealing with other people and . . . and, you know, various deepening levels of trust, of the world, of yourself, and of other people. It has a . . . it's layered and layered and layered on a much more comprehensive level, than simply not drinking. [process]
>
> • Being sober is looking at all the attitudes, why you used--it's poor man's therapy--it's understanding yourself; knowing you have to stop and have to change

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and do something about it; it's going on and moving on in your life, to improve your life. [process]

• Sobriety means more than just not drinking . . . it means what happens when you do so practicing the Steps, working the program, giving service. If you don't drink long enough, you have to change. It's not enough not to drink. Once you don't drink, then you're in the stream of life whether you want to be or not and you have to do something or you will drink again--I think I would. [outcome]

• A sober person is fully responsible for themselves and their own behavior and has a spiritual balance in life . . . is there for themselves and for others. [outcome]

• [A sober person] . . . is someone who works the Steps, maybe doesn't know they're Steps, but is honest with God, with themselves and another human being, knows they can't drink, accepts that it's a disease, helps other people, works through prayer and meditation--you can be sober without A.A., do it through religion, but it's harder and the odds decrease badly. [outcome]

The term "recovery" inspired the following definitions which, as noted, were sometimes confounded with "sobriety":

• Abstinence is not touching a substance. Sobriety is the same thing, not touching, well in this, alcohol or drugs. And recovery is learning how not to do it gracefully.

• Recovery is making progress, having direction. I believe you can be sober without A.A. but you can't recover without A.A. Recovery is progressive and you have to be involved with something that's leading you along, changing . . . so whether it's doing the Steps, looking at yourself, changing, gaining insight . . . .

• I'm sober in recovery. I'm actively trying to change some of my behavior and personality, things that

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are self-destructive.

Of all the definitions described above, those provided by Cooke, Fewell, and Riolo (1983) appear to be the most experience-near and to encapsulate the various meanings conveyed by study participants. Their definitions, therefore, will be adopted in subsequent chapters.

Finally, mention needs to be made of a series of other terms used repeatedly in the following pages. Many are drawn from the New York A.A. experience and may require additional clarification because the language used in A.A. can vary with the geographical location of meetings. The following is a list of key terms and their definitions as used and understood by New York A.A. members:

Drunk-a-log - that part of one's personal history containing anecdotes of one's drinking, especially the stories recounting those incidents with the most devastating consequences to one's self and/or to others; these incidents are recounted as a way for A.A. members to keep their memories "green" (A.A. teaches that alcoholism is a disease of "forgetting") so as not to forget what first brought them into the program

Hitting bottom - generally acknowledged by A.A. members as the critical moment in one's personal history leading to an admission that one has a problem with alcohol and needs help

Home group - a meeting attended regularly and regarded as one's primary group in A.A. where the member makes a strong effort to establish ties with others in the group and actively participate in the group's

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discussions and business meetings

Qualification - a term used generally in Northeastern regional A.A. to signify an invitation offered to those who have a reasonable period of sobriety (at least 3 months) to lead a meeting by recounting one's alcohol-related personal history

Sponsor - an individual with a year or more of continuous sobriety who serves as mentor and guide in the recovery process to one usually with less time

the "Big Book" - a synonym for the book, Alcoholics Anonymous (1976), the basic text of A.A. describing its program of recovery and the personal stories of selected A.A. members

the fellowship - A.A. members use this term to describe the informal social interactions that take place both inside and outside of A.A. meetings; it is often used as a synonym for A.A. itself

the program - A.A. members use this term to describe the 12 Steps, the 12 Traditions, and the general wisdom (known colloquially as the "tools" of the program and other suggestions) that members have accumulated on the basis of personal experience and share with one another in order to stay sober

the "slogans" - the practical wisdom of A.A. members embodied in a series of aphorisms which are usually displayed prominently in a typical A.A. meeting room (e.g. "keep it simple," "don't drink and go to meetings," "it's one day at a time," etc.)

the "tools" - practical suggestions offered in A.A. meetings to help the individual maintain sobriety (e.g., getting a Sponsor, taking phone numbers, reading the A.A. literature, using the "slogans," etc.)

the 12 Steps - the core of the A.A. program articulated in the book **Twelve Steps and Twelve Traditions** (Alcoholics Anonymous World Services, 1983); regarded by A.A. members as a "suggested" blueprint for recovery and

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personal transformation (after a reasonable period of sobriety, the A.A. member is encouraged to "work" the Steps, usually with a sponsor)

the 12 Traditions - the 12 principles governing A.A. as an organization defining its general purpose, philosophy, and functions

"12 Step" call - the response of an experienced A.A. member to a request for help by a prospective newcomer

SUMMARY

Chapter 4 has provided an overview of the study. The study was explained in general terms which included a description of where and when it was conducted and the problems encountered in its initial implementation. The five major goals of the study were enumerated along with eight anticipated outcomes. Finally, an attempt was made to clarify the use of such terms as "abstinence," "recovery," and "sobriety" and to provide a short list of key terms frequently used in the study.

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CHAPTER 5

METHODOLOGY

INTRODUCTION

Chapter 5 begins with a discussion of the design of the study. Special attention is given to the extent to which the present study fulfills the requirements of a good research design as enumerated by Yegidis and Weinbach (1991). Next the study is evaluated for the extent to which it embodies the "ten interconnected themes" proposed by Patton (1990). The section continues with a discussion of the sampling strategy, sample size, and a description of the interview instrument and its development. It concludes by addressing the validity and reliability issues and ethical considerations raised by the study.

STUDY DESIGN

As noted in Chapter 3, the choice of an exploratory research design is appropriate for the current study given the paucity of information about people in advanced recovery. Following Yegidis and Weinbach (1991), the objective was as much to "lay the groundwork for other knowledge building" (p. 76) as it was to contribute to knowledge building by in-depth descriptions of their lives in context. The study utilized a grounded theory approach

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in that theory would be:

> inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. (Strauss, 1990, p. 23)

It was anticipated that the use of an ecological framework, while not a new construct, would further enhance the researcher's ability to bring depth and breadth to the subject and yield new insights. At the same time, the ecological framework would be subjected to close analysis for its adequacy in accounting for what was observed and learned in the interviews.

The choice of an exploratory research design fulfilled the requirements of a good research design as enumerated by Yegidis and Weinbach (1991, pp. 81-82) in the following ways:

1. <u>It logically flowed from a review of the literature</u>. Most studies of recovering populations, as we have seen, are quantitative in nature and do little to overcome the methodological inconsistencies often cited in research of this kind. For example, unclear terminology, diffuse sampling criteria, and ineffective linkages between the conceptual framework and the data undermine earlier

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efforts. Moreover, univariate results yield only a one dimensional, partialized picture that does not do justice to the richness and variety of the recovery experience.

2. It was appropriate given the little that we know about this population. As we have seen, few research studies have focused exclusively on this population and more especially on such underrepresented groups as women, people of color, or sexual minorities. Thus, it was neither a well-described nor a well-understood phenomenon.

3. It was internally consistent. The selection of an explorative study design would help to resolve the kinds of methodological difficulties mentioned above. Its aim was to develop a future research agenda as well as to assess characteristics of a little known phenomenon. It sought to sensitize both researchers and clinicians to largely unknown variables and to remain open to emergent hypotheses. Its sampling decisions, as we shall see, were based on an informal consideration of the "range of cases" and not on any attempts at "representativeness of size." It made no attempt to control variables, but rather to discover them. Finally, it remained flexible in design so as to allow insights to emerge through a study of characteristics and

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not a validation of pre-existing hypotheses (Yegidis and Weinbach, 1991, p. 83).

4. **It was doable**. Its goals were realistic, sound, and capable of being achieved. Given the relative ease in conducting a preliminary study, few difficulties were encountered in implementing the current project.

Following Patton (1990), the current study embodied the ten "interconnected themes" (pp. 39-56) found in a qualitative inquiry. More specifically, these themes take on new meaning when applied to this study and further substantiate the choice of qualitative methods as an appropriate research strategy:

1. Naturalistic Inquiry -

This study attempts to understand the recovery phenomenon as it manifests itself in a cohort of individuals sober for ten or more years. These are the kind of "acute observers" and "well-informed" participants that Blumer (1969) states are necessary for an exploratory study (p. 41). Using a "discovery-oriented" approach, as described by Patton (1990, p. 40), the researcher observed and interviewed 30 individuals in a real-world setting of their choosing.

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2. **Inductive Analysis** -

The interviews consisted of open-ended questions and probes chosen from a relatively unstructured interview guide (see Appendix B). The objective was to allow significant "categories, dimensions, and interrelationships" (Patton, 1990, p. 44) to emerge from accounts of the recovery experience as depicted independently by the alcoholic. Thus, salient findings would be grounded in direct personal experience and from this paradigm theories would be derived.

3. **Holistic Perspective** -

The purpose of this exploratory study of such an "invisible" population was to bring into focus the full dimension of their experience. We know more about "cultures of drinking" (see, for example, Harford & Gaines, 1981; Fine et al., 1982) than we do about "cultures of sobriety." These individuals are representatives and carriers of a life experience that is antithetical to dominant cultural norms. This study, therefore, allowed them to give voice to a largely inchoate, unrecorded, and undocumented experience. It further allowed them to articulate the underlying structures, processes, dimensions, mechanisms, and relationships that comprise a sober life. The study, in

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short, illuminates what Blumer (1969) calls the "career of the act":

> This means seeing the situation as it is seen by the actor, observing what the actor takes into account, observing how he interprets what is taken into account, noting the alternative kinds of acts that are mapped out in advance, and seeking to follow the interpretation that led to the selection and execution of one of these prefigured acts. Such an identification and analysis of the career of the act is essential to an empirical understanding of social action . . . . (p. 56)

4. Qualitative Data -

One of the hallmarks of the A.A. experience is its emphasis on HOW--an acronym for "honesty, openness, and willingness." According to the A.A. interpretation of the alcoholism process (and following Tiebout [1944; 1953; 1954], one of the early professional friends of A.A.), the alcoholic must experience "deflation at depth"--hit a bottom--before he or she can get sober. A qualitative study, with its emphasis on "inquiry in depth" (Patton, 1990, p. 40) to capture people's personal perspectives, mirrors the program's injunction to the alcoholic to be honest--"Half measures availed us nothing" (A.A. World Services, 1976, p. 59)--and to lead an examined life.

5. Personal Contact and Insight -

The researcher had direct personal contact with the

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people in the study through the medium of interviews and observation. The early interviews took at least 2-3 hours, but as the discovery process unfolded, later ones lasted as much as 4 hours, more than enough time to allow the researcher to gain insight into the study participant's interior and exterior worlds. Moreover, because the researcher was known to nearly all of these individuals through professional and personal associations, this enabled her to overcome the unease or social distance that frequently characterizes research interviews. In fact, many participants noted this association and commented that they would have been less open had the researcher been a stranger. Needless to say, this close association inevitably raises questions of bias and contamination of research results. Qualitative research, however, is inherently subjective, as Patton reminds us. So the fact that the researcher was known to the study participants may actually have been a plus, lending nuance and complexity to the primary accounts and richness of meaning to the analysis.

6. **Dynamic Systems** -

If, as Patton (1990) argues, "naturalistic inquiry

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assumes an ever-changing world"--it "expects change, anticipates the likelihood of the unanticipated, and is prepared to go with the flow of change" (p. 53), then it is entirely compatible with the A.A. emphasis on action and change. A.A.'s action orientation, depicted in such slogans as "it's a program of action," "act as if," and "you can act your way into right thinking; you cannot think your way into right acting" as well as in its famous Serenity Prayer ("change what you can and accept what you cannot"), points to the dynamic, developmental process underlying the A.A. experience. Nor does that process go unexamined. A.A. members are repeatedly encouraged to "work the Steps" and continue to take personal inventory, a kind of introspective psychological housecleaning, through Steps 4 and 5, 8 and 9, and 10 (see Appendix A). Moreover, the use of sponsors, itself a kind of collateral, provides the recovering person with his or her own personal mentor/evaluator who helps the alcoholic conduct A.A.'s version of a periodic formative assessment of his or her progress. In fact, it was not unusual for study participants to comment that the interview process seemed to them like they were doing a retrospective 4th or 5th Step. Many welcomed the interviews as a chance

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to review their histories and inventory their progress over the years.

7. Unique Case Orientation -

If the statistics on recovery seem dispiriting, what better exemplar of recovery than the long-term sober person in A.A. Regarded in A.A. jargon as "powers of example," their protracted sobriety overshadows and subverts any biases that one may enter A.A. with about race, ethnicity, gender, class, or sexual orientation. With a disease that can never be cured, only arrested, their case studies delineate the subtle and not so subtle issues and idiosyncracies of advanced recovery which few programs are designed to address. These matters are more likely to fall within the domain of the practitioner who, as we have seen, is not always adequately trained or disposed to deal with the problems of the alcoholic.

8. Context Sensitivity -

Related to the notion of a holistic perspective is the emphasis on context sensitivity--"each case, event, or setting under study is treated as a unique entity, with its own particular meaning and its own constellation of relationships emerging from and related to the context

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within which it exists" (Patton, 1990, p. 50). Thus, the present study begins with a micro-level examination of individual experience and moves to a wider macro-level exploration of the larger domain or context inhabited by each subject. Designating this larger context a "culture of sobriety" emphasizes the potential structures and interdependencies that remain to be discovered through this research.

9. **Empathic Neutrality** -

As noted in Chapter 1, this researcher had ample experience and success in persuading eight A.A. members to participate in a smaller pilot project in the year preceding the inception of the present study. It is not always easy to penetrate A.A. subculture, as the alcoholic's fear of being stigmatized is still well-founded. In addition, A.A.'s 11th Tradition (see Appendix A) also admonishes members to avoid not only self-seeking personal publicity, an ego inflating characteristic of alcoholics, but also promoting their association with A.A. at the public media level. Thus, the fact that eight individuals agreed to personal interviews (even Bill W., 1967, p. 120, indicated that it was not inappropriate to talk about membership in

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the "right places") and offered to recommend others to do the same is evidence that this researcher demonstrated a balance of empathy, understanding, trustworthiness, and objectivity that inspired confidence in the current study.

10. **Design Flexibility** -

The qualitative design for this study was sufficiently flexible to allow for changes to be made and new pathways to be explored so as to provide more depth and breadth to the subject under consideration. Thus, as was mentioned in Chapter 3, the original plan to consult collaterals was discarded without any damage to the essential core of the study.

SAMPLE STRATEGY

As noted in Chapter 1, the present study was an outgrowth of a pilot project conducted in 1995. This earlier small-scale project utilized a stratified purposeful sampling strategy that led to the selection of eight cases. While individuals were chosen for their accessibility, the sample was notable for its diversity in representing the contemporary urban New York A.A. recovering community--5 females, 3 males; 6 Caucasians, 2 African-Americans; 4 heterosexuals, 4 homosexuals. They ranged in age from

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mid-30s to early 60s. They were known to this researcher, readily available and willing, if not eager, to contribute their time (the interviews lasted two or more hours). Each had ten or more years of continuous sobriety and was still affiliated with Alcoholics Anonymous.

Needless to say, while this group was small, what emerged from this rudimentary effort made it worthwhile. As key informants, these responsive individuals represented a first sampling of the rich data lode awaiting the researcher. Data analysis revealed that this "range of cases" (Yegidis and Weinbach, 1991, p. 83), though hastily chosen, was sufficiently varied in terms of race, ethnicity, gender, and sexual orientation as to warrant further, more careful study since these groups were so underrepresented in previous research efforts.[1] Making the present study as representative of the general population as possible not only reflected the unique demographics of a large urban area like New York City but was in keeping with the current social work emphasis on the need to develop greater

---

1 See, for example, Denzin (1987) who characterizes A.A. as a "white Anglo-Saxon social movement" (quoted in Mäkelä et al., 1996, p. 134).

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cultural competence among practitioners in the substance abuse field (see, for example, Philleo & Brisbane, 1995). Moreover, documenting the experiences of a culturally diverse group of long-term recovering individuals would also contribute to an emergent body of literature that, as one DHHS monograph notes (Cultural Issues in Substance Abuse Treatment, 1999), "still awaits systematic research studies" to record the "effectiveness of specific culturally derived treatment interventions" (p. 62).

Building upon this pilot project, the original intention of the present study was to utilize a combined strategy of stratified purposeful sampling, snowball or chain sampling, and confirming and disconfirming cases, that is, collaterals (ex: sponsors, peers, or family members) selected by the 30 key informants. These adjunct figures would not only add "richness, depth, and credibility" (Patton, 1990, p. 178) to the findings but would provide rigor and integrity to the study as a whole. However, the addition of collaterals proved too cumbersome and the original research design was modified to focus more directly on the responses of the 30 key informants.

Several criteria governed the selection of these 30

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subjects:

1. They were required to have at least ten years of continuous sobriety.

2. They must have attended A.A. on a regular basis over the course of their sobriety and still maintain some degree of affiliation with the program through current attendance at meetings, specified as at least once a week or once every other week.

3. They had to be representative of the U.S. population as a whole and include among them members of the following underrepresented groups--women, people of color, a sexual minority, and older adults (50 years and over).

It was hoped that the original eight interviewees would become the basis of a chain sample that would lead the researcher to others like them who would consent to be interviewed. As it happened, while several persons of the original eight served as links to second subjects, three emerged as positive confirmed connections in the present study through phone contact made by an original interviewee. In all other cases, the researcher made the phone contact and secured the interview directly. Chain sampling, though not abandoned by the researcher, proved of limited value for

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the following reasons:

1. Time constraints and scheduling conflicts made it difficult for others to become subjects despite their expression of interest.

2. Individuals identified as possible connections in the chain did not respond to repeated phone contacts.

3. It was difficult to determine whether some of the original eight interviewees actually made inquiries on behalf of the researcher, as promised.

Because of these difficulties, a combination of purposeful sampling strategies was adopted for the present study. For example, an intensity sampling strategy, that is, "information-rich cases that manifest the phenomenon intensely, but not extremely" (Patton, p. 182), yielded several long-term members of A.A., known to the researcher, who agreed to participate. They, in turn, became the links, in chain sampling fashion, to other individuals, one of whom was a "sponsee." This method provided a picture of a smaller in-group of triangulated individuals who not only knew one another but had functioned as an active social network over the years. In a few instances, word of mouth proved a sufficient incentive to recruit others from this

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informal grouping, indicating the presence of a kind of guerrilla network where the original informant would vouch for the trustworthiness of the interviewer, the significance of the research task, and the meaningfulness of the interview experience. A stratified purposeful sampling strategy produced subjects who represented "particular subgroups of interest," that is, sexual and racial minorities, women, older adults. Some among them were selected with the help of external facilitators. For example, the researcher's Dissertation Adviser served as a conduit to a human rsources professional who identified two Hispanic males in his organization known to him as long-term recovering individuals who agreed to participate. A non-A.A. colleague of the researcher arranged for her brother to be a study subject. Finally, opportunistic sampling led one subject to identify her husband, also in A.A., as a possible candidate. This unexpected result yielded a new and unintended subgroup for study, that of the A.A. couple.

In contacting potential interviewees, care was taken to preserve confidentiality by first briefing the facilitators on the criteria of the study and then instructing them to

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reveal the first name of the potential contact if, and only if, this individual agreed to a preliminary discussion about their possible participation. Facilitators were also reminded to state in their solicitations that potential subjects were free to decline to participate, and that a subsequent follow-up phone call from the researcher was in no way tantamount to an agreement to enter the study.

SAMPLE SIZE

In all, 30 individuals participated in the present study. As noted in Chapter 2, many researchers have commented upon the small number of individuals entering A.A. who actually remain continuously sober. While there are no specific figures for this population (as we have seen, A.A. does not maintain records or conduct extensive surveys of its membership, a problem that frustrates researchers), it is variously estimated to be at least 35% of the total. Anyone who attends A.A. regularly within a given geographic area comes to recognize these individuals, to use the A.A. jargon, as the "old timers" and as "powers of example." With the exception of one person who revealed in the course of the interview that she had stopped attending meetings but was still sober (she had 23 years of sobriety) and had

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maintained active contact with her A.A. network (the researcher decided to retain her in the sample because it was interesting to hear how she had internalized the A.A. message), all others met the stated criteria and were found to be "representative of the population from which they were selected" (Yegidis and Weinbach, 1991, p. 147). No individuals from the original pilot study were included in the present study's sample. This was done not only to build and preserve a new and credible data base, but to overcome any distortions created by the time lapse between the pilot study and the present one.

Patton (1990) notes that in a qualitative inquiry, "there are no rules for sample size":

> . . . the size of the sample depends on what you want to find out, why you want to find it out, how the findings will be used, and what resources (including time) you have for the study. (p. 184)

What matters, in his estimation, is that the cases be "information rich"--"In-depth information from a small number of people can be very valuable, especially if the cases are information-rich" (p. 184); that they represent a "reasonable coverage of the phenomenon" (p. 186); and that they maximize "to the full the advantages of in-depth, purposeful sampling" (p. 186), while taking care to guard

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against overgeneralization to the population as a whole. It was determined, therefore, that interviews with a minimum of thirty key informants met all of Patton's criteria.

THE INTERVIEW GUIDE AND ITS DEVELOPMENT

This exploratory study made extensive use of the research interview as the primary method of data collection. As Patton (1990) notes, such interviews "allow us to enter into the other person's perspective" which we assume is "meaningful, knowable, and able to be made explicit" (p. 278).

For an interview strategy, the study adopted the general interview guide approach (see Appendix B) used in the original pilot study. The guide contained a general outline of questions to be explored at length in each interview. Its use provided focus to each interaction while ensuring a more systematic and comprehensive gathering of data available later for cross comparison. At the same time, such a relatively unstructured instrument was flexible enough to accommodate probes and new conversational pathways that yielded more "information rich" data.

Following Patton (1990, pp. 290-295), types of questions included "experience/behavior" queries aimed at

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having the study participants describe their experiences both before and after joining A.A. This also included discussing their personal development, their relationships with friends and family, their professional life, the spiritual dimension of their lives, and their use of adjunct resources (ex: other 12-step programs, therapy). "Opinion/value" questions were directed at understanding what they thought about the program and how it had helped them to maintain their sobriety. "Feeling" questions asked them about their emotional responses to their experience, while "knowledge" questions asked them to reflect on what they had learned about their alcoholism. In the absence of a formal inventory, study participants were asked to fill out a brief "background" survey (administered at the beginning of the interview) to help assemble a demographic profile of the group (Appendix C).

But while the choice of interview strategy was important, Patton (1990) also reminds us that the "quality of the information obtained during an interview is largely dependent on the interviewer" (p. 279). The researcher's years of experience in counseling recovering alcoholics provided her with a unique understanding of how to engage

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these individuals and develop sufficient trust so as to initiate discussion and elicit open and honest responses from them. Indeed, the high quality information derived from the preliminary study gave rise to the expectation that the current project would produce equally substantive outcomes. Thus, while the researcher made extensive use of the general interview guide which provided a framework for the interactions, she was also guided by two other considerations--1) a recognition of and respect for the competence of recovering alcoholics to speak on their own behalf; and 2) a well-honed sensitivity to the need of the respondents to "express their own understandings in their own terms" (p. 290). At the same time, the researcher was mindful of the potentially subversive nature of the research act as described by Schön (1983) in his work on the "reflection-in-action" paradigm:

> In a practitioner's reflective conversation with a situation that he treats as unique and uncertain, he functions as an agent/experient. Through his transaction with the situation, he shapes it and makes himself a part of it. Hence, the sense he makes of the situation must include his own contribution to it. Yet he recognizes that the situation, having a life of its own distinct from his intentions, may foil his projects and reveal new meanings. (p. 163)

The interviews with these 30 individuals took place

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over a period of three years. Interestingly, as the discovery process unfolded, the interview time lengthened. So while the initial interviews took approximately two and one half hours to complete, the later interviews ran to 3-4 hours. The interviews were conducted in various private settings--homes or offices--at the convenience of the interviewees. In accordance with City University of New York guidelines, care was taken to protect the privacy of the participants and the confidentiality of the material. Each participant was asked, and agreed, to sign an Informed Consent Agreement (see Appendix D).

The original plan was to take notes during the interview. However, while this method had the subject's permission, the researcher quickly discovered by the end of the first interview that note-taking was both intrusive and insensitive given the intensity of feeling aroused in individuals as they began to share personal experiences. Thereafter, again with the subject's permission (no one ever objected), a tape recorder was substituted. Taping interviews was unobtrusive and allowed for greater interaction and engagement between researcher and subject. Subsequently, verbatim transcripts were made of each

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interview which, again following Patton, were then coded for "common patterns or themes shared by key informants," cross-compared for "distinctive variations" that emerged among the respondents, and analyzed (Patton, 1990, p. 172).

VALIDITY AND RELIABILITY

In a discussion of quality and credibility in qualitative analysis, Patton (1990) calls attention to three "distinct but related inquiry elements"--1) the techniques used to ensure integrity, validity, and accuracy of the study; 2) the researcher's credibility; and 3) the researcher's commitment to and appreciation of the qualitative research paradigm (p. 461).

A much discussed concern of alcoholism researchers has been the extent to which the self-reports of alcoholics are valid and reliable (see, for example, Institute of Medicine, 1992, p. 11; also Fuller, 1988). Understandably, this concern centers on the active or newly sober alcoholic or the individual who has relapsed, since denial and other defenses are crucial mechanisms propelling the illness. Researchers, however, seem less disposed to question the reliability and validity of self-reports when they emanate from long-term recovering individuals, especially those in

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A.A. One can only speculate why this is so.

Perhaps it is because of A.A.'s insistence on three principles to ensure the integrity of the recovery experience--rigorous honesty, openness, and willingness (known popularly by the acronym "HOW"). These principles were certainly on display in the interviews.

When subjects were recruited for both the pilot and the present study, few refused to participate (refusals were usually the result of scheduling conflicts that could not be resolved). Those who did agree to participate appeared eager to share their experiences of what happened before and after joining the program. Their responses seemed, at least to this interviewer who knew many of them, genuine, candid, deeply felt (some even to the point of tears as they recalled difficult periods of their lives), and uncontaminated by any self-serving motives. Once assured that confidentiality and anonymity would be respected, that no personal names would be used to identify subjects, that they could choose not to answer any question deemed too personal or intrusive, no one asked to have any details of their stories withheld or deleted from a final account. Only two people asked to be identified by first names other

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than their own real ones (all names have been changed in the present study).

As much as these techniques can affect the quality and validity of the present study, so can the credibility of the researcher. That 30 subjects, one third of whom were identified through chain sampling, agreed to participate and divulge their histories is an indication of the confidence they had in the researcher and their belief in the merits of the study. This is significant because many said that if they had not known the interviewer they would not have participated; nor would they have been so candid in their responses. This raises an interesting question about the validity of research in this field, especially as it concerns self-reports.

As noted, while researchers worry about the validity and reliability of informants' self-reports, especially when the latter are from active or newly sober alcoholics, little attention is paid to how the sober informant feels about being asked to divulge personal histories to an unknown and unfamiliar professional researcher. This is where qualitative research can make a major contribution to the field.

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Qualitative research is more art than science, more subjective than objective, since information about how key informants feel, think, and behave as well as how they organize and interpret their world is filtered through the eyes and ears of the researcher. If the researcher is not a participant in the informant's world, it seems useful if she is at least known to, and trusted by, the intended subject. In the present study, therefore, this researcher, known and trusted by her informants while beholden to them for their cooperation and good will, has tried to let them speak for themselves, since they have been largely invisible to the outside world. As long-term A.A. attendees, many commented that it was not unusual for them to be silent even in the insular world of an A.A. meeting room. They expressed gratitude for the chance to participate and share their stories for a study of this kind in the hope that it would help the professional community better understand alcoholism and the alcoholic.

A final word on the commitment of the researcher to the qualitative research paradigm. This study has been conducted at a time of considerable revisionist thinking regarding the efficacy of A.A. and the 12-step recovery

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model. For an organization whose central tenet, as stated in A.A.'s 11th Tradition, is attraction, not promotion, the A.A. experience has come to be viewed with some derision in popular culture as trendy and even glamorous. The sheer number of celebrities who have publicized their recoveries in the last decade has chagrined A.A. veterans who remain faithful to that part of the 11th Tradition which cautions members to "always maintain personal anonymity at the level of press, radio, and films." From articles in the media to best selling "tell all" autobiographies, a quiet but steadily growing enterprise has evolved into a major social movement. It is not surprising, therefore, that in the past decade the A.A. phenomenon has been the target of popular satire (see, for example, the "Saturday Night Live" Stuart Smiley skits) and media and academic criticism (Riessman, 1990; Blau, 1991; Rieff, 1991; Zimmerman, 1991; Kaminer, 1992). It remains to be seen how these counterattacks will affect the growth of A.A. (see, for example, Mäkelä et al., 1996, p. 251, for another perspective on whether A.A. membership has reached a saturation point). But it is interesting to note that one of the reasons why many of the subjects agreed to participate in the study was

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to demonstrate the seriousness of their commitment to A.A. despite its current trendiness. As one study informant, with 16 years of sobriety, commented:

> I think that A.A. is perfect. . . . I get upset sometimes because A.A. is sort of, it hasn't changed, but the people have since I came in. I get upset at times that I don't hear the kind of things I used to hear at meetings. And I miss that . . . and I hear a lot of stuff sometimes that doesn't belong in an A.A. meeting and then I just have to kinda think to myself, I have this theory. It's like go-go boots. You know, it's like a fad. Since I've been sober, I've watched other fads come and go. For a while, 'Course in Miracles' was a big topic at meetings and then that went away. And then for a while it was John Bradshaw, and the 'child within,' and then that went away. And I even remember crystals. Everybody was getting crystals and sticking them in everywhere. I mean I think back to all those things that have come in. It's interesting that people that are into those things kinda leave. They don't stay, but the program stays. And the program as it is written is fine. So I don't get distressed by it anymore. It's just like go-go boots. They're gonna come and go.

With many in the professional alcoholism research establishment still expressing skepticism about A.A.'s effectiveness and frustration with the organization's inability to conduct credible studies, the choice of a qualitative paradigm by this researcher, long committed to clinical practice in the field and familiar with the recoveries of so many individuals, represents an attempt to refocus attention on a little known aspect of recovery. In

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what can only be described as an attempt to forge a kind of "recovery studies,"[2] the present study is one effort in the direction of opening up new lines of inquiry and generating new pathways to replace older, more established theoretical perspectives such as psychotherapy and psychoanalysis which, heretofore, have had little success in helping to ameliorate the alcoholic's suffering.

ETHICAL CONSIDERATIONS

Patton (1990) alludes to the "power of interviewing" in connection with qualitative inquiry:

> Because qualitative methods are highly personal and interpersonal, because naturalistic inquiry takes the researcher into the real world where people live and work, and because in-depth interviewing opens up what is inside people--qualitative inquiry may be more intrusive and involve greater reactivity than surveys, tests, and other quantitative approaches. (p. 356)

Anyone remotely familiar with A.A.'s Twelve Traditions can only view with awe the ethical code in which A.A. members put their trust. Over and over again in meetings, new members are socialized into this code--"anonymity is the

---

2 Leukefeld and Tims (1986) seem to be the first to use this term (p. 187). They call for "studies of individuals in recovery [which] might provide a clearer picture and description of recovery processes" (p. 188).

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spiritual foundation of all our traditions" (12th Tradition). It is the adherence to these traditions that makes possible the feeling of safety in Open, Closed, Step, Big Book, and Beginner's meetings so that everyone who wishes can share personal experiences, the unfolding of which is so crucial to the recovery process. As older A.A. members remind newcomers, "we are as sick as our secrets." Thus, it is not surprising that interviews with A.A. members are likely to be intensely revelatory experiences. The researcher must take care, therefore, that every consideration is given to ensure that interviews are conducted with the utmost ethical rigor as well as respect for A.A. norms and values.

Patton (1990) cites seven key ethical issues in the conduct of a qualitative inquiry (pp. 356-357). The following is a list of these issues and how they were addressed in the design and implementation of the present study:

1. **Promises and reciprocity** -

Why did people agree to participate in the study? Many reasons were cited to explain their decision. Some did it for personal reasons. One woman agreed to participate

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because she hoped to pursue her own doctorate some day; another said she "envied" the researcher but admitted it gave her incentive to complete her college degree. A third woman saw a deeper, more mystical meaning in her participation--"I don't believe in coincidences. You appeared in my life for a reason. I obviously need to look at something. And the powers that be were going to give me the opportunity . . . to look at something." One man did it because he liked to talk about his life and his sobriety--"to be asked questions about it and have to come up with answers . . . is . . . just more discovery for myself." Another man did it despite his "second doubts" (he had wanted to go to the beach), because "once I make a commitment I've got to do it"; a second figured, "you wouldn't ask unless you wanted me"; a third consented only because he was asked and it "cost me nothing" ("you don't have a good reason not to"). Some did it out of intellectual curiosity.

A second set of reasons related to the researcher herself. Some were eager to help her complete her doctoral studies; others did it out of friendship or because someone else had once helped them with similar projects and this was

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a way of reciprocating. Some did it because they trusted the researcher and, as one said, the "authenticity of what you're trying to do."

Another set of reasons had to do with the intervention of a third party, either a key informant or a non-A.A. contact person whom they admired. One woman said she had been told by another study participant that it was an "interesting" experience and besides "no one ever asked me about my sobriety" or wanted to listen to her.

Some saw the interviews as an extension of their A.A. experience. One man felt as if he was being asked to "qualify"; another saw it as a kind of A.A. "service" ("I always say yes, if I'm asked to speak"). A third man said it was his way of being "involved with A.A."

Finally, some saw in it a larger purpose beyond themselves--either to help other alcoholics or to contribute to an understanding of alcoholism that they felt was lacking in the professional community:

> • I like that somebody is trying to go underneath or inside of what makes A.A. work and what makes A.A. valuable. I want as much of that to be out there in the world as possible.
>
> • I would like to be a participant in any way that would contribute to understanding the kind of person that can succeed in A.A. and how A.A. also contributes

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> to the well-being of that person. . . . I thought to myself . . . this is a call for you to crystallize or focus a lot of years. . . . you don't often do that and I don't . . . .

One woman commented with some passion on her participation as having a larger social and moral purpose:

> I don't think that people know these people. I think partly because of the anonymity of A.A. and the way we don't talk about our sobriety outside. . . . A.A. people are well-adjusted. I don't think we know much about those people. I think we know too much about the people who hit the newspapers having relapsed and those who go out over and over and over again. I think we need to know about this . . . the titans in industry who have made it through A.A. and brought an ethic and a humanity to business through A.A. . . . . Professional people, go to A.A. and check it out. Listen, listen, go find out what it's about. It should be part of a professional's training to try to understand what goes on in those rooms. I would tell them people can change . . . .

2. <u>Risk assessment</u> -

In what ways did the study put any of its participants at risk? The present project was not likely to put potential interviewees at any risk, psychologically, legally, politically, or otherwise. The purposes of the study, the methods for carrying it out, and the utilization of the product, were all made clear at the outset so as to reduce or eliminate uncertainty and suspicion.

3. <u>Confidentiality</u> -

What assurances were study participants given about

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confidentiality? From the outset, potential participants were assured of the confidential nature of the process. In keeping with the norms of A.A., as was mentioned earlier, all those acting as contacts were asked not to divulge to the researcher the names of potential participants unless the latter agreed to be telephoned. Once individuals agreed to participate, they were asked to read and sign an official consent agreement (see Appendix D) outlining the study's purpose and procedures. Further assurances were given that no personal names would be used to identify subjects in the narrative (all names have been changed) and that all tapes, transcriptions, and notes would be kept in a safe storage space. Individual responses have been coded so as to screen out any personal cues that would identify subjects to other readers. All interviews were conducted in a private setting to maximize privacy and ensure confidentiality.

4. Informed consent -

What kind of informed consent was designed to protect research subjects? Study participants were asked to sign an informed consent agreement pursuant to university policy. The agreement was carefully reviewed with each subject and the researcher took care to answer any questions before

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obtaining the participant's informed consent.

5. **Data Access and Ownership** -

Who would have access to and ownership of the data?

The informed consent agreement clearly spelled out who has access to the data, what is its purpose, and who owns the data.

6. **Interviewee Mental Health** -

What effect will the interview have on the mental health of the study participants? Based on the pilot study, there was no cause for concern that conducting interviews would in any way adversely affect the mental health of the study participants. While certain aspects of the interview in the present study generated much feeling, special care was taken by the researcher to show sensitivity and concern for those who needed more time to collect themselves. In fact, several participants commented on the researcher's empathic stance.

7. **Advice** -

Who was available to the researcher as consultants on ethical issues? The researcher had available to her the resources of the Program's official ethics coordinator as well as the Chairperson and members of the Dissertation

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Committee, should there have been a need to discuss any ethical concerns relative to the study. In one instance, the researcher consulted with the Chairperson of the Dissertation Committee when it was learned during the course of an interview that one study participant had admitted to drinking beer in the summer, though the latter minimized the significance of this behavior. The researcher and the Committee Chairperson discussed whether or not to drop this individual from the study. A decision was taken to retain him and use his narrative to try to learn more about the behavior.

SUMMARY

This chapter has contained a thorough discussion of the methodology of the study. It included an explication of the design of the study with special attention to the requirements of a good research design and the "ten interconnected themes" embodied in the study. This was followed by a review of the sampling decisions, the choice of sample size, and a description of the questionnaire and how it was developed. The section concluded with an examination of the key validity and reliability issues and the ethical considerations related to the study.

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CHAPTER 6

DESCRIPTION OF THE SAMPLE

INTRODUCTION

The sample assembled for this study was intended to be as representative as possible of the current demographics in urban America. A profile of the sample is presented in this section by categories--gender, age, length of sobriety in A.A., race/ethnicity, sexual orientation, relationship status, family history of alcoholism, occupation, drugs of choice--followed by a brief discussion, where relevant, of the issues and problems encountered in recruiting participants and implementing the study.

A. Gender -

The sample consisted of 30 individuals--15 men, 15 women--sober in A.A. for ten or more years. The researcher encountered no difficulty recruiting equal numbers of both sexes despite the fact that, while the percentage of women attending A.A. has generally risen in the past thirty years, estimates of the gender of current A.A. members, as given in the 1998 A.A. Membership Survey, suggest that males outnumber females by about 3:1 (Alcoholics Anonymous World Services, 1999).

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It was particularly important to include women in the sample in equal proportion with men because the focus of most research on alcohol use and abuse, to say nothing of patterns of recovery, generally has been on men. Such a male bias gives a false picture of the extent of the problem among women. As the U.S. Dept. of Health and Human Services study, Substance Use Among Women in the United States (1997), notes:

> Although substance use and abuse are reported more often by men, and research to date has focused mainly on the behaviors and needs of male substance users and abusers, substance use is a significant problem for women. (p. 1)

Moreover, while research has shown a decline in women's drinking in the past 20 years, women's risk of problem drinking has been found to increase with the prevalence of certain "personal and environmental factors" such as the influence of their partner's drinking, the incidence of depression, sexual behavior, sexual orientation, sexual victimization, and violence (Ninth Special Report, 1997, p. 22). Women who drink remain at risk for "unprotected intercourse, sexually transmitted diseases and HIV infection, unintended pregnancy, poor birth outcomes, child abuse and neglect, criminal activities, mental health

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disorders, and other adverse health and social consequences" (Substance Use Among Women in the United States, p. 1). Such risk factors are complicated by the stigma that accompanies alcohol use in women. Those who violate traditional norms are more likely to hide their drinking by remaining "invisible" to others.

Just as the bias of research on alcohol use and abuse has been towards men, there has been an equal male bias in reporting experiences of recovery. Thus, the inclusion of women's experiences of recovery in addition to those of men not only helps to correct distortions about women but allows for further discovery of gender differences in patterns of long-term recovery.

B. **Age** -

The mean age of the total sample (N = 30) was 55 (median = 54.5) with a range of 36 to 73 years. In calculating the approximate onset of sobriety of these individuals, data show that the earliest began at age 24 and the latest at age 58. Over all, one-third of the total sample entered A.A. at age 40 or over.

It is interesting to compare these statistics with the most recent profile of A.A. membership taken in 1998

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conducted by the A.A. General Service Office (Alcoholics Anonymous World Services, 1999). In a sample of 6,800, the average age of an A.A. member was 45 (up slightly from age 44 in 1996, the year of the previous membership survey). While A.A., in its newsletter for professionals, About A.A. (Alcoholics Anonymous World Services, Summer, 1999), takes note of the "rising number of younger people coming to the Fellowship" as "one of the most encouraging trends" in its recent history, more attention perhaps should be paid to the phenomenon of recovery onset in older adults (50 and over) who are seeking out the program for the first time.

A profile of the sample population in the current study by gender and age reveals that for men, the mean age was 58, while for women it was 52. According to the data, 7 out of 15 men (46.6%) were 40 or older when they entered A.A., while only 2 out of 15 women (13.3%) were 40 or older when they entered A.A.

It should be noted that the range in age illustrated by the sample resulted not from any purposeful techniques but rather emerged randomly as a by-product of the selection of "information-rich" cases to study. If anything, the range in age goes against the grain of the stereotype of a

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long-term population as consisting only of older adults who have less in common with younger A.A. members. In fact, as noted in the A.A. newsletter, About A.A. (Summer, 1999), with the composition of A.A. membership trending increasingly towards younger people, a younger long-term member should not be so unique a phenomenon.

C. Length of Sobriety in A.A. -

For the total sample, the mean length of sobriety was 17 years with a range of 10-29 years. Compare this to the 1998 profile of A.A. membership produced by the A.A. General Service Office where 47% were found to be sober more than 5 years with the average length of sobriety more than 7 years (up from 45% in 1996). Regrettably A.A. does not refine its data beyond this point so it is impossible to discern how many in the General Services group were sober more than 10 years.

A profile of the sample population in the current study by gender, age, and length of sobriety reveals that for men, the mean length of sobriety was 15 years while for women, it was slightly longer, 18 years. Interestingly, one-third of the men under 50 had been sober for 10-13 years, while for women, nearly 47% under 50 had been sober for 10-16 years.

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In general, women tended to get sober at an earlier age (age at onset of sobriety, 24) than men (age at onset of sobriety, 31) and to remain sober well beyond the age of 50 (40% of the women over the age of 50 had at least 20 years of sobriety, while only 20% of the men over the age of 50 had 20 years of sobriety). This fact accords with research results which indicate that gender is one variable influencing the adverse impact of alcohol on health and body systems. For example, because women tend to process alcohol differently than men (usually at a faster rate due to their musculature), they are more likely to suffer physiological damage sooner rather than later.

Twenty-nine out of 30 individuals attended A.A. regularly--from 1-5 meetings weekly. One had not attended an A.A. meeting in four years (she was hearing impaired and complained that this was a problem in meetings), but was in regular contact with other AA members. Out of 30 individuals, 22 (73%) had current sponsors (one said she had a "Board of Directors"), while 13 (43%) actively sponsored others. Many continued to participate in A.A. in other ways--they "qualified" at meetings, spoke from the floor, chaired meetings, volunteered to answer phones at New York

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Intergroup (through call forwarding directed to their homes), conducted informal Step study groups, and even created a neighborhood meeting directory.

D. Race/Ethnicity -

A profile of the sample population by race/ethnic background indicates that 23 were Caucasian, 4 were African-American, and 3 were of Hispanic origin. While it was not difficult to recruit an equal number of females and males to the study, the researcher found it more difficult to attract individuals from the two dominant minority groups--Hispanics and African-Americans--in numbers that approximate their growing proportions in the general population and in the greater New York City area. According to the most recent demographic estimates for the U.S., Hispanics and African-Americans constitute 11.5% and 12.8% respectively of the general population (U.S. Census Bureau, 2000), while in New York City, they comprise 28% and 25% of the population (New York City Dept. of City Planning, 1999).

One African-American (a male, with 10 years) was personally recruited by the researcher. Two others (both female, with 10 and 11 years) emerged through chain sampling and a fourth (also female, with 10 years) was identified

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indirectly through professional contacts. None self-identified as other than "African American" so it was difficult to determine further if any cultural differences existed among them. This tendency to view African-Americans as a "homogeneous population with a single culture" has been cited by researchers in cultural competency (Philleo & Brisbane, 1995) as a shortcoming in research on this group:

> Most of the literature related to African Americans and AOD [alcohol and other drug] use defines African Americans as a homogeneous population with a single culture; therefore, historic and contemporary differences within the group have been largely ignored. Consequently, there is a paucity of data that focus on the diversity within the African-American population in general or the diversity of attitudes and behaviors regarding AOD use among African Americans in particular. This lack of information highlights the problems inherent in research methodologies that study 'race' rather than 'culture' or 'ethnicity' (p. 71).

As for Hispanic subjects, all were male. One (with 10 years) was personally recruited by the researcher, while two other Hispanic subjects (with 18 years and 20 years respectively) were identified indirectly through a professional contact. All were from Puerto Rican backgrounds; two were fluent English speakers and the third spoke a fractured, but understandable English. No professional contacts were required to recruit Caucasian

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subjects.

Repeated efforts were made, but to no avail, to attract individuals of Asian American and Native American ancestry. While the researcher has wide professional and personal contacts in the substance abuse field in New York City, none could locate a long-term recovering individual of Asian American origin. The researcher did attempt a contact with a long-term recovering individual from a Native American background, known personally to her, who at first agreed to an interview but later withdrew from consideration citing a heavy work schedule.

One can only speculate about the reasons for the barriers encountered in recruiting subjects from racial/ethnic minority groups in a city as diverse as New York. While A.A. itself is a truly grassroots democratic phenomenon (A.A. members like to call alcoholism an "equal opportunity" disease), its groups generally represent the demographic composition of New York neighborhoods which still tend to be stratified by race, class, culture, and ethnicity and which remain essentially isolated and distinct from one another. Only in large A.A. gatherings--the famous "Share-A-Day" events and the regional inter-group

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conferences--or in meetings that either intersect contiguous neighborhoods or take place in midtown areas where individuals from differing socioeconomic backgrounds converge for work does one actually encounter a more diverse population that approximates the demographics of urban America. Thus, despite the researcher's wide professional contacts, she had no social ties or ways of cultivating linkages to the small network of New York City A.A. groups, located in Asian American neighborhoods, that might attract individuals of Asian American ancestry. Since no New York City A.A. groups are identified as exclusively attracting a Native American population, it is more difficult to locate individuals from this community.

Finally, the cultural competency literature notes the difficulties that can arise not only in accessing treatment for individuals from different racial/ethnic groups, but in attracting and retaining minority clients. While there has been a fuller discussion of race/ethnicity and cultural factors affecting access and use of treatment, little attention has been paid to the barriers affecting engagement of individuals from diverse cultural backgrounds in the conduct of research on alcohol use, abuse, and recovery.

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E. Sexual Orientation -

A profile of the sexual orientation of the total sample population reveals that 21 self-identified as heterosexual, 8 as homosexual, and 1 as bisexual. Among the heterosexual subgroup, 8 were male and 13 were female; among the homosexual subgroup, 7 were males and 1 was female. The bisexual individual was female. Of the 7 gay men, 3 were HIV positive with two indicating that they had progressed to full-blown AIDS. The range of sobriety among those declaring their homosexuality or bisexuality was 10-29 years (mean length of sobriety = 18 years).

Recruitment of gay and lesbian subjects was a goal of the study that would further ensure a representative population reflecting urban America. While the proportion of gay and lesbian individuals has been variously estimated at 10% of the total U.S. population (Philleo & Brisbane, 1995, p. 197), the researcher had little difficulty in achieving the goal of recruiting a representative sample. That 9 individuals (30%) in the sample acknowledged themselves as gay, lesbian, or bisexual is attributed partly to the presence of a large self-identified sexual minority community in New York City and to the fact that among the

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"information-rich" cases selected for study some individuals happened to be homosexual or bisexual.

The inclusion of this group in a representative sample is an equally important feature of the study in order to counteract the tendency to marginalize and omit this cohort even in discussions of cultural competency (this group is not even mentioned as a special population in the U.S. Dept. of Health and Human Services' Ninth Special Report). Alcohol as a "social lubricant" is still in widespread use among gays and lesbians (Philleo & Brisbane, p. x) and its abuse is especially pernicious in the communities that comprise this richly diverse and complex population (while research data measuring the level of abuse are imprecise--see Philleo & Brisbane, pp. 200-201--some estimates indicate that alcohol abuse among gay and lesbian individuals is higher than for the population as a whole). Thus, while the "coming out" stories of gay men and women have gained a prominent place in the history of the homophile movement, the "recovery" stories of gay men and women "old timers" have yet to be discovered. Nor have the accounts been documented of those recovering persons who struggle daily with HIV disease and of the impact of A.A. on

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their ability to cope with this condition.

F. Relationship Status -

A profile of current relationship status reveals an interesting and complex set of domestic relationships in existence among study participants. Seven individuals were married--four were married to people active in the program (two formed the only couple interviewed in the sample); a fifth was also married to someone who had left the program and had relapsed (the marriage was considerably strained by this and other circumstances). All of the pairs had married prior to their entrance into the program (one couple had met in rehab before they entered A.A.) and all of the spouses, with the exception of the couple whose marriage was strained, also had 10 or more years of sobriety. Two others were married to people who were not in the program.

One woman, who had previously been divorced, had married someone in the program. But her husband had since died. She was the only widow in the sample.

Six other participants were divorced, two from people in the program (one couple had married while in A.A. and were among the divorced), and four from individuals who were not in the program.

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Four individuals were in partnered relationships. In one pair, both partners were in A.A.. In a second pair, the partner had been in A.A. for three years and then left the program, while in two other pairs, the partner had never been in A.A. Twelve individuals were single and unpartnered.

In addition to these domestic partnerships, other relationship patterns emerged among the participants in the study. As noted in Chapter 4, 28 out of 30 study participants were current New York City residents (2 lived outside of New York City, one on Long Island, one in New Jersey). As far as could be determined, 23 out of the 28 lived in close proximity of one another on the Upper West Side of the Borough of Manhattan and attended many of the same A.A. meetings (5 others resided elsewhere in the city). Discernible in this group of 23 were several subgroups--individuals who made up smaller peer networks tied together in various ways--by marriage, gender, age, years of sobriety (in A.A. terms, they belonged to the same "graduating class"), and collateral relationship (sponsor-sponsee).

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G. **Family History of Alcoholism** -

As the alcoholism research continually indicates, one of the most salient at-risk factors for alcohol abuse is a family history of alcoholism. While many people raised in alcoholic homes never develop a problem with alcohol, a "predisposition for alcoholism is transmitted in families" whether by genetics or by a "shared family environment" (Ninth Special Report, pp. 34-35).

In the total sample, 18 individuals (60%) reported alcohol (or drug) abuse in a first-degree relative, that is, in either a mother or father (two cited alcoholism as directly causing their fathers' deaths). Two other individuals described parental drinking, but were unsure about applying the label "alcoholic" to the parent (one parent had committed suicide); one individual's father was a compulsive gambler (an addiction with which the study participant himself also struggled), while three other individuals cited a grandparent as an alcoholic. Of the individuals with family histories of drinking, no parent had ever attended A.A.

Overall, 13 individuals (43%) reported that one or more of their siblings had an alcohol problem, with only

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three indicating that a sibling had some A.A. involvement. One individual had a sister who died of anorexia, an obsessive-compulsive eating disorder that may have had its origins in the family's "alcoholic" household.

Finally, 5 individuals reported having adult children with an alcohol or drug problem, one of whom had died of a drug overdose shortly after discharge from treatment.

H. Occupation -

Participants in the study reported a variety of occupational roles--social worker/psychotherapist (1), nurse/psychotherapist (1), health care administrator (2), occupational therapist (1), actor (3), environmental engineer/student (1), chemical dependency counselor (1), teacher (3), advertising/salesperson (1), human resources executive (1), musician/teacher (1), retired administrative assistant (1), account executive (1), office manager (1), clergy (1), fundraiser (1), retired teacher (1), hardware salesman (1), retired seaman (2), computer network analyst/student (1), architect (1), retired restauranteur (1). Two other individuals, both with AIDS, listed themselves as disabled, though one was considering a return to work because his health had stabilized as a result of new

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medication.

Some had achieved their occupational role as a direct result of their experience in the program; others had long-established careers that preceded their entrance into A.A. A few had recently retired, though nearly all continued to work at part-time employment. Three even became substance abuse counselors as a direct result of being sober, though one eventually left the field while a second decided to focus on providing alcohol and drug education to families in his clergy role rather than continuing as a direct counselor.

I. Drugs of Choice -

A profile of the drugs of choice by age and gender used by study participants prior to their entrance into A.A. reveals age- and gender-related differences in the use of alcohol and other drugs. Among women ages 61 and over, alcohol was the sole substance of choice; with one exception in men in this age range, this was also the case. Also among women 51-60, only one reported use of marijuana, while among men in this age cohort, there was more use of multiple drugs. Finally, in the generation of people between 31-50, individuals were clearly poly-drug users, with both males

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and females reporting use of a greater variety of illicit drugs--cocaine, heroin, compozine, marijuana, peyote, LSD, amphetamines, black beauties, and quaaludes. This age differentiation corresponds with national research data on alcohol and drug abuse (see, for example, two U.S. Dept. of Health and Human Services' studies, Ninth Special Report, 1997, and Summary of Findings from the 1998 National Household Survey on Drug Abuse, 1999).

SUMMARY

This chapter presents a profile of the study's sample by categories--gender, age, length of sobriety in A.A., race/ethnicity, sexual orientation, relationship status, family history of alcoholism, occupation, and drugs of choice. The sample assembled for this study was intended to reflect the diversity of urban America and, broadly speaking, has done so. The chapter also contained a discussion of the issues and problems encountered in recruiting participants into the study and the ways in which this was done in order to achieve a greater degree of representativeness in the sample population under study.

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CHAPTER 7

OUTCOMES

INTRODUCTION

The following chapter contains the outcomes of interviews with the 30 study participants. The chapter is organized around nine major themes that emerged from the interview set--1) reasons for entering A.A.; 2) intensity of A.A. involvement; 3) milestones in the recovery process; 4) non-A.A. supports to recovery; 5) changing views of self and personal identity; 6) alterations in work and professional life; 7) changes in social life and environmental context; 8) development of spirituality; and 9) meaning and significance of long-term sobriety.

Theme 1 - Reasons for entering A.A. -

While the focus of the interviews was on the study participants' experience of sobriety, the interview would not be complete without some reference to their prior history and to the reasons for their entry into A.A. This was the first question asked of each person in order to clarify why they sought help from A.A. when they did.

Taken together, the women's stories of their lives before entering A.A. were remarkably similar. In general,

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they described chaotic, disorganized lives with no real direction or focus. Janice (16)[1] summed up that period with wry humor, "I had debts, not bills":

> I had no existence. I had no life. It was just scrambling and franticness . . . to recover enough, to drink enough. And just this sense of panic all the time. I never had an existence in between and even the times I tried, it didn't last long.

Physiologically, several remembered experiencing seizures, blackouts, tremors, symptoms usually associated with chronic alcohol abuse, while one woman nearly overdosed on prescription drugs. Emotionally, others described themselves as depressed, easily panicked, and isolated with no real interest in social activities and lacking in any emotional connectedness with those around them. Dorothy (25) described herself as suicidal and feeling like she was having a nervous breakdown. Toward the end of her drinking, she could not work or function--"I was this kid, you know, and I looked at life like what am I gonna do when I grow up"?

Infantalization was a recurrent theme. Kate (14)

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1 All names have been changed to preserve confidentiality. The number next to the name represents the years of sobriety.

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and Paula (11) said they too felt like children. Both imagined themselves as small, miniaturized creatures--Kate said she felt like an "insect on a trail," while Paula described herself, much like the woman in Sylvia Plath's novel, The Bell Jar, as trapped like a "fly in a jar." Alcohol had compensated for their inadequacy by making them feel grown up. While some managed to hold responsible, well-paying jobs, others faced bleaker prospects as the consequences of their drinking and drugging took their toll. Susan (11) led a dissolute, homeless life in the Oregon woods, Lilly (10) barely escaped arrest for fraud, Dorothy (25) found herself on welfare, and Regina (12) was fired from a high ranking corporate position because of her alcoholism.

By the end of their drinking, Harriet (23) and Amy (24) had been hospitalized in psychiatric wards for mental problems (their alcoholism went undiagnosed at the time), while four other women had entered detoxes with followup to in-patient rehabilitation facilities. All fifteen eventually found their way to A.A. either through professional recommendation, aftercare, the suggestion of a friend or relative, or as one woman put it, through an

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inexplicable but irresistible impulse. With two exceptions, all remained sober from first exposure to the program, a remarkable achievement given the relapse-prone nature of the disease of alcoholism.

Why had they agreed to enter A.A.? They offered various explanations:

> • I don't know just one morning I . . . got up and called A.A. . . . I just sort of attribute it to Higher Power and let it go at that. (Kim, 29)
>
> • Well, I had nothing. I had nothing to get sober for. I had no reason to get sober other than I couldn't drink any more. It was like the party was over. It wasn't working and it was just making me sick inside. (Janice, 16)
>
> • Why did I choose A.A.? Well, actually I made one choice at a time. I chose to get help. I chose to go to detox. I chose to go to rehab. In rehab I chose to stay sober. And some of the ways that it was suggested were to go to a continuation of the program which was an outpatient thing. Some people went to halfway houses, some people went to therapy. They had A.A. meetings in there . . . and it was recommended to go to A.A. To me, it was a continuation of the process, so it made sense and also I had nothing to do with my time when I got sober. Because all of a sudden, here I was stark raving sober and no place to go and nothing to do. So it was there on a [somewhat] regular basis. It wasn't like going to church, thank God. And so it had its own attraction. (Regina, 12)
>
> • I was tired . . . everything . . . everybody else seeming to have their life together and me not being able to . . . getting sick . . . tired of the headaches . . . tired of the hangovers. . . . I was very tired emotionally. I hadn't lost material things, but nothing was really changing, like I wasn't gaining

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> that much more either . . . . I was tired of having jealous feelings and resentful feelings towards others that had things. (Nina, 10)

Susan (11) attributed her entry into A.A. to "luck" and "predestination"--"I was desperate for a change in my life." A family member talked her into going to a rehab. Gail (14) had a fight with her alcoholic husband and called a friend for help--"I was miserable and didn't know how to dig myself out of a vicious cycle that my marriage had become. I was at an emotional and spiritual bottom." Kate (14) realized she had "crossed the line" in her drinking only after a series of painful occurrences--hearing her young child announce to a friend that "my mommy drinks wine all day," listening to her own drinking buddy comment on how her drinking had gotten out of control, learning that her liver enzymes were high, and worrying about how she would care for her daughter whom she had accidentally dropped several times. Diane (13) was guided gently to A.A. by a sober friend who took her to Overeater's Anonymous, bought her a copy of Alcoholics Anonymous (the A.A. "Big Book") and prayed that she would get the message. Amy (24) entered A.A. because her boyfriend thought she needed it. She complied because she thought he wanted somebody to go to meetings with. For the next three years, she binged on

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alcohol--"I had delusions of control between periods of drinking." She finally "bottomed out" in a hospital after a breakdown, although she never disclosed to doctors that she had been drinking and they never picked up on it--"it took me ten horrible years to get sober. I was a drunk at 19. I knew it even though I didn't want to say it."

By contrast, the 15 male participants told more dramatic stories of reckless behavior fueled by alcohol and drugs. Unlike the women, many more went through cycles of relapse before they fully committed themselves to sobriety. Victor (17) described himself as an "adventurer" who liked to "live close to the edge." He had repeated problems with the law which were related to his addiction and drank even when he was prescribed Antabuse (disulfiram), the drug designed to produce such severe physiological reactions that the alcoholic would not give in to the impulse to drink. He had attended A.A. briefly eight years earlier and spent nearly a decade in what he called a self-inflicted "downward Hell" before he admitted he had an alcohol problem. James (10), a man with a history of violence, dual addictions to crack cocaine and alcohol, a prison record, and a life lived on the streets and in abandoned buildings, characterized

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himself as a "menace to society." At the insistence of his ex-wife and mother-in-law, he had attended A.A. at first in the late 1970s without much success and quickly returned to his more familiar street life. In a serendipitous moment, which he attributed to the "grace of God," only when he called a faith-based social service organization for help did he find himself ready to make changes in his life.

Matthew (19) had been hospitalized with alcoholic hepatitis and drank again despite repeated medical warnings not to do so and a brief stint in the program. He even went to a rehab to "escape A.A.," but relented when "it dawned on [him] to make a decision not to drink." Bernard (13) had suffered severe stomach pains and realizing that, in his words, "you can only stretch a rubber band just so far," he "snapped" and agreed to enter a hospital program (his own physician had failed to diagnose his alcoholism). Although his wife, Gail (14), had joined A.A. sixteen months earlier, her appeals to him to attend meetings went unheeded until he entered a hospital program and admitted "out loud" that he needed help.

Tom (17) and Arthur (14) came to A.A. through Al-Anon, the 12-step companion program to A.A. for the families of

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alcoholics founded by Lois Wilson, the wife of A.A.'s co-founder, Bill Wilson. Tom had sought out Al-Anon as his alcoholic wife's "avenging angel" only to discover that he too had an alcohol problem as did his father before him. Arthur went to Al-Anon because he had grown up with an alcoholic mother, though he never admitted that he had a problem with alcohol or a compulsive sex addiction. For fourteen months while in Al-Anon he did not drink, but he soon relapsed and, complaining of intestinal bleeding and heart palpitations, was diagnosed with hepatitis. It was during this period that he realized that when his drinking stopped his sexual acting out also ceased. This insight led him to attend A.A.

Gregory (10) had entered A.A. a year before, but relapsed twice. He had been diagnosed with HIV disease and this precipitated a new round of self-destructive, almost suicidal, drinking and drugging--"if I'm gonna die, I'm going to enjoy it." Now his "whole life became very small, tiny, around the same people, around the same thing night after night." Only after his supervisor confronted him at work and his family intervened did he agree to return to the program:

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> Basically alcohol and drugs had beaten me down. My life was going absolutely nowhere. And I'd reached that point where either I . . . did something about the drinking and the drugging or . . . I saw myself dying very quickly. So I chose . . . A.A.

While Gregory credited many friends with trying to help him over the years, he remembered one moment, his epiphany, in which he was forced to make a decision:

> . . . the biggest was waking up that morning and just being on the precipice and looking . . . do I go this way or do I go this way? I have a choice. I really saw it clearly. I have a choice. Do I wanna go take care of the problem, go back to A.A.? My life had actually gotten better. I felt physically [and] . . . mentally better . . . do I wanna go back and see how can it improve or do I want to . . . full steam ahead and just die? And so the reaction was, you know, losing everything . . . who I was, what I was, and ending up on the Bowery or dead. And ending up on the Bowery is one of my big fears. And yet I was near. I really was.

Jose (20) and Ricardo (17) came to A.A. with long histories of chronic alcoholism. Jose, the son of an alcoholic mother who later stopped drinking through her son's influence but who never attended A.A., had been in five detoxes. His last hospitalization was in a psychiatric ward where he was diagnosed, not with alcoholism, but with a primary mental disorder. He never revealed he had been drinking:

> My problem was alcohol. And I thought I was going into a detox. You see, because every time I went into a detox . . . I wanted them to keep me in the hospital

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> for a good while, because I didn't want to drink. In a hospital, I wouldn't drink. But once I was let go, forget it, that urge came and I had to drink.

Jose described himself as a "hog" for alcohol, with "one foot in the cemetery." But after this last experience, he decided he would try not to drink. A friend offered to take him to A.A. As it happened, he had already attended an A.A. meeting weeks before, drunk, where he had attempted to speak to the group about how to drink without getting drunk! On his return appearance, he recalled how the group had bluntly told him to "zip my lip and open my ears." He listened this time, went to meetings, and never picked up another drink.

Ricardo described in broken English how he had entered a hospital detox, "nervous," "skinny" "shaky." Advised by his doctors that he needed a liver transplant, he contemplated leaving the hospital so he could "die drunk." But an alcoholism counselor told him if he would stop drinking and ask for help, his liver would repair itself:

> He told me, if you let me help you, I can help you, but if you don't let me help you, I cannot help you. Which is true, for any person. That I understand now. During that time, I don't not [sic] understand that.

Richardo recalled the moment that he realized he was an alcoholic--"the day I say that word ("I'm an alcoholic"),

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that was saving all my life. That I admit, I am an alcoholic. I never admit it [to] anybody that I was an alcoholic." His hospital experience taught him a lesson about the universality of alcoholism that he never forgot:

> I saw all kinds of people--pilot, policeman, wife of the doctors . . . high class musician, all of them with me in the hospital. I was the only Puerto Rican in there. I and two black guys. That was different nations. They had people from England in there. Alcoholism doesn't discriminate, rich and poor, and any kinds of race.

Moreover, he remembered that while the hospital physician had prescribed Librium for his nerves he was told in rehab not to take it. He stopped taking Librium "because you're gonna lose the alcohol or you're gonna gain another habit." This was the second time that information given to him by a medical professional was contradicted by the alcoholism treatment professional.

Others reported quieter moments of self-reflection that led to their entry into A.A. Carl (13) recalled lying in his bed one morning without any reason to get up--"I just lost my enthusiasm and I figured I could lay there and die or I could get up and do something and I associated it with drinking." A month earlier he would not have made that connection, though he knew he was an alcoholic. He was

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ready to seek help in A.A. Three years into his sobriety, he was diagnosed HIV positive. It was his cumulative experience in the program that helped him to cope with this new challenge. Norman (12) knew about A.A. through a woman he had lived with who was in A.A.--"there was always a part of me that was very curious and I think that was because there's always been a very large part of me that questioned everything I was doing and was not happy with." His curiosity led him into the program.

Edmund (23) knew he had an alcohol problem and through his work was involved with professionals in the addiction field. While his drinking was proving an embarrassment to him and his employers, he rejected any attempts by friends to get help. In fact, he was skeptical of friends who had gone to A.A. especially those who claimed to have stopped drinking without any palliative medications. But when he realized that A.A. in New York was different from A.A. in his midwestern hometown ("too parochial" and "congregation driven"), he relented and fell under the influence of several "persistent" and "determined" friends who introduced him to his first A.A. sponsor.

Raymond (21) was advised to go to A.A. by his physician

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five years before he actually quit drinking. "Of course, I didn't think I was an alcoholic. I just drank a lot. I just handled it very well." While he had attended a few meetings, he did not feel comfortable in the program--"all I ever heard said was that it was smoky, dingy, ugly basements and . . . I heard about killings and detoxes and strait jackets and insane asylums." He told himself he was "fine" and thought, "maybe I can help some of these people, but they couldn't help me." So he left A.A. But in retrospect, he admits a "seed was planted." For more than two years, he stopped drinking, but he "fell apart." He recalled:

> . . . it was then . . . it was so bad that I had to go to A.A. I knew there was no other place to go to. I did not go because I was an alcoholic. I didn't think I was an alcoholic. But I remembered the few meetings I went to, men speaking, about how I felt at that time. And I just wanted to dump on them. And as the saying goes, I hung around long enough and the disease washed off on me. I caught it from these people and now I'm one of the people I couldn't stand listening to.

Ironically, the physician who had first recommended that he attend A.A. subsequently told him that after two years of not drinking he was not an alcoholic and therefore he could take a drink to relax. But he did not--"I was already brainwashed. I would not . . . not take a drink." He repeated this emphatically and deemed it "miraculous" that

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he had not picked up a drink.

Fred (13) had watched his drinking and drugging escalate after the death of his mother in 1977, while he became "more reckless" sexually. Not even a promising singing career, which he soon abandoned, could assuage his "unbearable" emptiness. He took a job as a bar manager which only exacerbated his use of alcohol and cocaine. He first entered A.A. in 1980--"I knew that there was some massive, unsolvable problem in my life and, you know, it was the last house on the block; it was a desperate attempt to try something." While he attended meetings and learned a lot, he admitted he was not "surrendered or committed to the idea of really stopping all usage. That took a long time to get through." He also resented the idea that he "would have to stop everything for any results to occur."

The next five years were "nightmarish." He alternated between periods of sobriety and periods of relapse when a "level of self-hatred that I had never encountered before came out." He described himself as "completely out of control, just wild usage and wild behavior and really borderline suicidal recklessness with the amount of drugs

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and drinking that I was doing and the inattention to things like rent and the responsibilities of work and relationships and family." Everything went by the wayside. "It was a period when I was either going to kill myself or get better and I was gonna force the issue, on some unconscious level." Still he went to meetings and "took advantage of the theory that you can go to A.A. simply with a desire, rather than having already stopped." He reflected, "It's almost like I didn't want to be caught being committed. I didn't want to have a position. I didn't want to be a person in relation to another person. I just wanted to be left alone."

By 1985, he was homeless, alternately sleeping in Central Park or on friends' couches, with no job, and no money for food. A lover had abandoned him, his family had rejected him, and he had no career left to pursue. "My life was down to a very simple question, did you drink today or not? What do you want to do? There were no other considerations." This was also a period, he was later to learn, when he became sero-positive. It was then that an A.A. friend shared his experiences with him and offered him a place to stay (the floor of his apartment) and to help him

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detox:

> I don't think I can underestimate the importance of that . . . very practical loving act from somebody who wanted nothing else from me. That really got through to me. Something inside finally snapped and I thought maybe I can accept this help. Maybe I am worth it.

Thus began his more serious and lasting attempt to get sober and stay sober in A.A.

Finally, Harry (15) recalled how he "stopped drinking on a very average drinking day. There was nothing worse on that day than on any other day." He remembered having hangovers and chronic diarrhea, but being unable to give up drinking all the years before which for him was "very medicinal":

> But there was some part of me that realized that I was losing it. I don't know how much it was the chronic diarrhea or the fact that I picked people up that robbed my apartment or . . . that I was losing out by being drunk, losing out generally on my life. And to me it's a very spiritual thing.

He recalled a trip to Yugoslavia, a holiday in Dubrovnik, and being "drunk, very drunk" and going for a walk alone:

> And I just remember feeling miserable that this was so beautiful and I wasn't really appreciating it because I was drunk and I never had, I get emotional now for some reason. I never had that . . . kind of insight before. You know, the usual insights I get were well wow, isn't being drunk great 'cause I can act out and feel free with people. So that was the first time that . . . I had an insight that I was losing out by being drunk.

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He remembered sharing this at a meeting and the pain that accompanied the insight:

> I stopped drinking, you know. I put down alcohol and the next day I looked in the mirror and I was looking at a person who needed a drink . . . . And I think that's what it is. I mean without booze I'm a person who is defective . . . in the sense that I'm neurotic in a lot of areas that alcohol helps me deal with and I think that's why it's painful.

From this moment, a profound change took place which he still has difficulty explaining:

> I don't understand . . . the series of events that brought me to get sober in that moment when I did. I have no idea why . . . it wasn't a day earlier or a day later, or two years earlier when I really wanted to stop drinking. When I stopped drinking I'd given up trying to stop. So it was like a period of six months or a year where I actively tried to stop and I couldn't and I just gave up trying and somebody said something and, you know, I said 'I'm an alcoholic' and they said 'do you want help' and I said, 'yeah.'

And so began his journey in A.A.

Theme 2 - Intensity of A.A. Involvement -

Intensity of A.A. involvement included current attendance at and participation in meetings (i.e. rates of attendance, types of meetings attended, and level of intensity of participation), sponsorship (being a sponsor or being sponsored), using the program "tools" (ex: working the steps, reading literature, making phone calls to A.A. people, making 12-step calls), and doing service in or

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beyond meetings.

Intensity of involvement in A.A. for study participants did not fit any predominant pattern. While one might have assumed that overall attendance at meetings would be inversely correlated with longer-term sobriety, that is, the more years participants had in the program the fewer meetings they attended each week, actually attendance, though varying with individual need and preference, from once a week to almost daily, remained remarkably high. Among study participants, 29 out of 30 (97%) attended at least once a week; 19 out of 30 (63%) indicated that they still attended at least 3-4 meetings a week and of this number, 7 (37%) said they attended 5-7 meetings a week. In fact, Kim (29), the individual with the most years of sobriety, attended almost daily. Among males, Raymond (21) and Edmund (23), the two men with the longest sobriety, attended nearly every day or from 4-7 days a week, respectively.

Only Harriet (23) said she had not been to a meeting in four years (this was learned only in the course of the interview), though she kept in regular contact with her A.A. peers (two of whom, Edmund [23] and Harry [15], were also

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among the study participants) who still continued to attend meetings. She cited as her reasons for not attending the fact that, like her mother before her, she was now hard of hearing and had difficulty following what was said in meetings. She did not know American Sign Language (ASL was not used at home by her hearing impaired mother during her childhood) and so could not avail herself of meetings with sign language interpreters. She also complained that the "tenor" of meetings had changed. When asked to explain, she said everyone was now so young, they talked too much about drugs, and she was not a "drug person." At 72, she was the only person in the study to criticize A.A. meetings for the increasing emphasis on alcohol and drugs, an indication that the so-called "generation gap" in A.A. between those who were addicted only to alcohol and those who were polyaddicted was perhaps moderating.

Study participants cited many reasons for maintaining active attendance at meetings. First, meetings helped them to stay sober by serving as a bulwark against their potential for relapse despite their years in the program. As Kate (14) said, it keeps the "denial from creeping back." She commented, "It helps to build up protection. If I don't

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go to meetings I may go in another direction. If you stop going, at some point you'll change your mind." Carl (13) expressed it this way--"It [the craving for alcohol] could come back, if I didn't go. I would drink again. I'd forget that I'm an alcoholic, and if I forgot I'm an alcoholic I could have a drink. I'd be putting myself in danger again."

Second, meetings seemed to provide them with various psychological supplies such as personal strength, comfort, safety, hope, good feelings, courage, confidence, validation, and structure. Norman (12) used the metaphor of A.A. as a kind of psychological way station to describe what he derived from meetings--"it's a comfort . . . like going to the filling station. I used to wait until my tank was empty and then I'd go to meetings; now I get a lot more mileage to the gallon. Now I know what to do." Susan (11) employed a more vivid metaphor to describe the psychological impact of meetings on her:

> I'm not going to play Russian roulette with my life. I believe if I make meetings on a regular basis, work the steps, try to be a good human being . . . that will help me like myself and as long as I like myself, I'm worth living. As long as I do those things, I've got a 95% chance of staying sober. If I were to try to stay sober just by calling people and living a good life, I'd put my odds down at 70%. This is my life we're talking about. I don't see any reason to play. And I happen to enjoy the meetings too. That's not why I

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> go. If it was just enjoyment, I'd go only to [she mentions the name of a N.Y. meeting] . . . . But this is my life and what price is an hour or two a week? [A.A. gives me] . . . a sense of hope that tomorrow will be a better day. Unless I work on myself and do the things I've learned through the program a sober person should do, I have a chance of having a really shitty life . . . whereas for the price of one or two hours a week, I've got a chance of being happier a lot of times. A.A. gives me a better chance with the life I do want to have.

A frequently heard comment was how much meetings were an antidote to negative thinking which many equated with their alcoholism. As Emily (23) commented:

> . . . if I slack off from meetings I begin to get negative. I notice that very quickly. I feel sorry for myself and I feel overburdened, why me. All those things come back full force, amazing.

Meetings also provided needed structure to individuals whose lives had become chaotic. Fred (13) cited the importance of A.A. rituals--every meeting started with a preamble, people identified themselves as alcoholics, every meeting had a set format:

> . . . it's ritual that protects the individual. By participating in the ritual . . . , we all know how it starts and how we process and how it ends and we can all relax into . . . the safety of that.

Third, A.A. had become an intrinsic part of their lives. Edmund (23) called the program the "core part of my existence . . . not an addendum. It's second nature to be present and a participant in the sober living of A.A." This

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sentiment was echoed by Fred (13) who said that A.A., not his birth family, had become the "center" of his life. Raymond (21) said it had become part of his "structure"--"it's a natural way of life and a natural necessity in life to go to A.A. and to live the A.A. way." Arthur (14) noted that "A.A. has been absorbed into the way" he lived and described it as a "huge part" of his life. For him, attendance had become automatic, something that he did in spite of himself:

> Throughout the years I have found myself going to meetings when I had no intention of going . . . or I didn't feel like it. From day one, I have had the sense this is the one thing that I didn't do. I participate in it. I participate by showing up but I didn't do the recovering. It's something outside of me. And I found it in the rooms and that's where I tend to keep looking for it.

Paula (11) described A.A. as her "ground" and her "foundation"; Dorothy (25) called the A.A. program her "rock" and her "balance" which gave her values by which to live:

> You know, no matter what was going on, I would run back to the meetings . . . and talk about it . . . and it gave me a whole lot of values . . . . That was a time in my life when I was struggling with . . . all the 'wants' . . . and then I learned through this experience that I always had gotten what I needed.

For some, A.A. had become so internalized that even in

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the absence of a meeting, they could recall it in memory and it would soothe them. As Kim (29) noted, "when I feel squirreled up, just the fact that I've thought about it and that I've planned which [meeting] I would get to seems to help." Nina (10) reenacted a meeting in her head when she could not attend one and this provided satisfaction.

Internalization of the A.A. experience was further equated with the formation of a sense of self. Matthew (19) regarded A.A. as the source of his identity. As an expatriate with strong emotional ties to his former homeland, A.A. had become his substitute "family." He relished the "familiarity" of coming to meetings where he would be recognized. Harry (15) derived not only an identity from A.A. but status from his longevity in the program. Regina (12) credited A.A. with having nurtured her personal development--"I was raised in A.A. . . . I really kind of grew up in A.A." Fred (13) saw meetings as a place for the enrichment of his inner life where he heard "something that sounds like my inner voice."

Fourth, attendance at meetings provided a powerful connection with others. It reduced the isolation many had come to equate with their active alcoholism and offered them

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a chance to support others or find support for themselves. For Kim (29), a gay woman who never felt she belonged anywhere, attending meetings gave her a "place to belong"--"I hate groups. I'm never really very comfortable in large gatherings, unless it's all A.A." Harry (15), a gay man, commented that while it was hard for him "to feel a part of almost any experience," he felt "more a part of A.A. than anything else" he had ever felt in his life, even if he did not always feel "a part of certain groups within A.A." Susan (11) spoke of the "sense of community" she found in A.A. meetings which also gave her the "sense of belonging somewhere." Harriet (23) described her relationship to her A.A. peers as a form of "kinship." Even though she no longer attended A.A. meetings, she maintained more intimate ties with people in the program than with her own birth family. Emily (23) saw her attendance at meetings as an admission that she "[could not] do it alone." For her, an A.A. meeting signified a profound "spiritual connection" with others that made her feel a "part of the human race":

> I don't feel that anywhere else. In other parts of my life I feel a little bit of holding myself back because I'm not a totally known entity. But I feel like a known entity in A.A. . . . that's a spiritual experience of being accepted as I am, where I can be fully myself. I'm not ashamed. I'm not holding

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> back . . . . I don't have that experiential thing any place else that I have in A.A. and what it means to hold out your hand to a newcomer or to somebody who's suffering . . . [or] just share in other people's sharing of themselves . . . .

Fred (13) said that attending meetings made him feel "useful." Jose (20) said he liked the idea of being able to "share [his] experience to help others." About the importance of attending meetings, he commented, "if no one goes, there will be no A.A." Support of others in the program brought other benefits as well. For Fred, it meant recovery of another kind:

> I go to A.A. to . . . recover more of myself . . . . I'm very clear the primary purpose is to stop drinking and help other alcoholics to achieve sobriety. But . . . included in that is . . . [that] it's important to bring the contents of your life to A.A. and the people that have done that, I have benefited from and so . . . I try to do that as well.

Fifth, others looked forward to the A.A. meeting as a chance to socialize and be recognized. Matthew (19) noted, "Without A.A. I would be dead. I love to be known. I love to know people. I love to see people I know. I look forward to meetings as a social event." Raymond (21) liked meetings because they were "social" and "therapeutic." Also they provided an escape from his work.

Finally, A.A. meetings were regarded not just as a place where one could learn how not to drink, but as a venue

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for a learning experience that led to profound personal transformation. Raymond (21) said he learned a lot from "watching people and listening to their revelations." Bernard (13) commented that he heard "great native intelligent things said by sober people and by not so sober people; it's a great oasis in the middle of a crazy town." James (10) had difficulty putting into words just what he learned, but he knew it had a powerful effect on his behavior:

> I get some 'je ne sais quoi' that makes my life more livable, makes me more capable of dealing with life. Everything I know I got through A.A. I have no evidence that my life will become better if I quit going to meetings. I have 10 years of evidence that my life becomes better when I do go to meetings.

Gregory (10) spoke of the changes he experienced in his thinking from attending meetings:

> If I don't go to meetings for my thinking, I'm in a lot of trouble. I can slip back into negative thinking and my perception of the world becomes very narrow again. I need to be around other alcoholics so that I guess identify or just see that I'm not the only one in the world that has these particular issues.

Edmund (23) remarked that A.A. had given him a set of principles and guidelines that shaped his behavior as a responsible adult and "citizen on the planet":

> One of the real revelations of being sober and maybe from the literature and . . . from watching other

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> people but certainly from watching my own life is to realize that it's possible for me to have many, multiple motivations about any given action or objective . . . . It's my responsibility to choose the one which is going to be appropriate and gratifying for me . . . . That's what I consider being adult is about. Did A.A. give me that? Absolutely. . . . They gave me the opportunity to focus on my behavior and my attitudes and look to the . . . means and the end . . . and to realize . . . that the fact that I have sometimes chosen the appropriate thing doesn't mean that within me were the choices which are less desirable . . . .

Arthur (14) and Carl (13) saw meetings as a place where they learned to socialize with others and practice their social skills. As Arthur commented:

> When I stopped drinking, I . . . did not know how to relate to anyone. I was terrified of people. So I think one of the first things that I had to learn was how to be sociable. . . . I think I got practice at social skills in A.A., very practical things. And I think probably some of that has to do with our story telling. . . . after revealing most of my secrets in life, and the world doesn't end, and I'm not judged, I mean in an appropriate forum like A.A., I think that it gives you, in a strange way for me, it feels like a clean slate and I can go out there and start over.

Emily (23) noted how much her perspective had changed as a result of her being in the program:

> I have a full life today. It's very reliant on my being in A.A. I would not be able to maintain a perspective without going to meetings (the half empty half full glass). It's just like refocusing, looking through binoculars and just getting things into a better focus if I go to meetings. It's a reminder of where I came from and a reawakening of gratitude for what I have and a sense of wonder about my life . . . . It's a primary thing in my life. I wouldn't

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have a life if I weren't sober.

For Gail (14), A.A. was "irreplacable. I can't imagine anything better. It isn't just by putting a drink down. It is by going to A.A., that I'm changed. That the change is not only possible but probable for anyone." Even Lilly (10) who questioned why she still attended found renewed purpose in going to meetings. As she commented, "I ask myself that question sometimes [why she still attends]. I try and hear one thing that I can take out of there like what I did at the beginning. I always go to meetings to stay sober. [But] I might hear something that helps support my need for change."

Study participants were also asked about the types of meetings attended and the nature of their participation in meetings. Needless to say, they emphasized the importance of attending A.A. meetings. When asked to express a preference for which type (ex: Beginners', Step, Open, Closed, Big Book, Traditions), many cited Beginners' and Step meetings as their first choices.

Beginners' meetings were favored for two reasons. First, one learned the most and was reminded of the most from them. As Carl (13) commented, "It reinforces what I know and teaches me things I forgot." This is what is known

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in A.A. as "keeping it green." In Beginners' meetings, one would be more likely to hear an A.A. "drunk-a-log"--a member's personal story of what it was like before and after one entered A.A. The significance of hearing a "drunk-a-log" was not to be overstated. For a newcomer, it is the beginning of their bonding with others (newcomers are encouraged to identify, not compare their stories with a speaker) and with the ideology of the program (Rappaport, 1993). For long-term members at least a decade or more away from their last drink, it was a key factor in maintaining sobriety and helping to sustain identification with the A.A. "program." As Janice (16) commented:

> I'll go to an A.A. meeting and . . . I'll listen to somebody with some horrific drunk-a-log, you know, driving their car through living room windows, and ending up in jail, and hiding bottles. It's like I start relaxing. It's like a lullaby to me. I mean the more I can [hear it] . . . I think to myself I must be a drunk. Only an alcoholic would hear this and relax. Everybody else would be on the edge of their seats going, oh my God . . . . But I hear this and there's this part of me that goes, oh yeah, oh yeah, like a lullaby . . . .

Second, it was important, as some long-term members said, to attend Beginners' meetings out of a sense of reciprocity and obligation, as others had done before them, to show newcomers that the program worked (in the words of

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an A.A. slogan, "you have to give it away to keep it"). The obligation to return to others what had been freely given to them was a fundamental aspect of the program's service ethic. Dorothy (25) commented that she was ashamed that she could not get to Beginners' meetings. She felt guilty that she was not giving back something of what she had received when she was a beginner--"long-term sobriety was there for me at Beginners' meetings and where am I"? For some, however, the motives were more self-serving. One person was honest enough to admit that he attended Beginners' meetings to impress newcomers because this made him feel important.

But while Beginners' meetings were where one learned the "basics," that is, "don't drink, go to meetings, get a sponsor and call him or her regularly, monitor your 'HALT' (i.e., "don't get too Hungry, Angry, Lonely, or Tired")," Step meetings provided deeper lessons that went beyond not picking up a drink. For many, this was a kind of "advanced" level A.A. Alice (26) commented:

> From early on I went to Step meetings. At the beginning, I realized even if I didn't understand the Steps, there was a great deal more to A.A. than not drinking. I have gone to Step meetings on a regular basis through my entire sobriety; there's a real philosophy of life. I have learned so much about life and myself in an accepting way. I was very slow. It took me several years to do a 4th Step. I've only done

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> things to give me relief, not because I'm good. The pain of holding on to things motivated me to do it.

But while these study participants were faithful meeting attenders, they repeatedly expressed sadness at not seeing more of their peers at meetings. Alice (26) addressed this issue and how she and others dealt with it:

> It's unfortunate there are not long-term sober members though I know a lot of long-term members. I get together once a month with long-term sober people . . . but people don't feel the need to go to meetings. They feel content, but it's unfortunate. I remember when I first came in someone who has [sic] ten years was mind boggling.

Emily (23), who said she attended anywhere from 2-5 meetings a week, offered this rationale for her reduced meeting schedule:

> As my life filled up with work, family, relationships, I needed less than constant involvement in A.A. I really thoroughly rely on A.A. but it doesn't have that degree of intensity. But in some ways I'm much more appreciative now of it and I see how I cannot do without it. And I mean that in a very happy way . . . . I think I would not be able to maintain a perspective without going to meetings.

Study participants were asked about the nature of their participation in meetings. Even with ten or more years in the program, many actively "qualified" when asked to do so, that is, they led meetings in which they were the featured speaker. However, a persistent theme was the difficulty some had, as long-term members, with "sharing" or

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participating from the floor. Amy (24) described this as the burden of being the "wise old thing"--that "old-timers" think they should say something profound and not have any problems. She blamed this on the alcoholic's tendency toward perfectionism from which, she admitted, she still suffered. Dorothy (25) spoke of her struggle to overcome her reluctance to speak:

> Sometimes the ego can get in the way and you don't want to . . . talk about what's going on with you. I recognized that a while back. I don't find it difficult, but rather disconcerting. People are apt to be influenced by my 25 years and say adoring things to me when I talk in a meeting. On the other hand, if you don't say how long you're sober, I would think it's important that people would say you could stay sober for 25 years. That's important. When people did that when I was new, I would say 'wow,' I knew it could be done. So I'd try to do that too. Then they think you don't have any problems. So I quickly dispel that by crying all the time . . . .

Others complained of a lack of connection between newcomers and old-timers which they attributed to a kind of sobriety gap. Some sought to overcome this gap by making a conscious effort to reach out to newcomers and A.A. members with less sober time. Interestingly, Jose (20) noted that the reason why he preferred to attend Spanish-speaking meetings was his perception that there was more closeness in these meetings--"when a newcomer arrives they don't let him

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sit by himself"--and that no such gap existed between old-timers and newcomers in these meetings.

Others offered different explanations for their reticence. First, years of "sober reference" had produced an estrangement of self--the younger person who had entered A.A. long before seemed unrecognizable now to the older sober person of today. Dorothy (25) reflected on such an estrangement in herself:

> . . . my peers and I [have] been talking about this. None of us want to speak. We're all having a hard time speaking . . . . Why is it? Because it gets harder and harder to bring back that person. I haven't been drinking in 25 years. That's a long time. It's a lifetime. It takes a certain amount of effort to bring it back, you know, when you don't feel like doing it. It's not easy to do it. I have no relationship with that woman. I didn't know who she was.

Second, there was the experience and maturation that came with many years of sobriety. Victor (17) explained it this way:

> . . . most people with longer sobriety say . . . I've said it all and you just lose the . . . compulsion to get your hands up . . . . It's just that you sit back and you say, you know, I used to say things with such conviction and earnestness and . . . insight. Well, I've been there, I've done that. Most of what I might share about I've heard myself share about. They seem like platitudes . . . . But I know so many people who say they hardly share at all anymore. Somebody used to put their hands up and say I have 14 years, 17 years, and I'm forcing myself to stick up my hand because I almost never talk any more. Why is that?

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> Well, I think . . . you're more assured . . . and comfortable with yourself in a sober sense. . . . it's just like you get older, you get a little wiser.

Sometimes the experience of being an old-timer led to a certain impatience with newcomers. Carl (13) admitted his annoyance--"Occasionally I wanna shake somebody and say, it's not important. You'll get over it, you know. At a Beginner's meeting, I occasionally want to do that. But no I don't." Dorothy (25) complained about the "psychobabble" she heard in meetings:

> The problems I have are with how people are conducting the program and how they are behaving in the rooms sometimes and what the crap they're talking about, all the psychobabble stuff. And they get up and talk psychobabble . . . . They don't qualify, they don't tell their story. Those are the things that upset me in A.A. And a lot of us talk about that . . . because we go to meetings and they'll say . . . the meetings suggest we qualify, that is, tell us what it was like, what happened, and what it's like now. . . . when I don't get that I feel emotionally gypped, you know.

Harriet (23), the oldest female study participant (she was 72) whose drug of choice was only alcohol, objected to hearing about drugs, a favorite discourse of younger A.A. members who were more likely to have entered the program polyaddicted.

The subject of sponsorship produced a series of mixed responses from study participants. About half of the women and a little more than half of the men currently had

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sponsors, though not all were actively in contact with them. Some had, and were still having, extremely positive experiences with sponsors. Dorothy (25) said she had, not one sponsor, but a "Board of Directors" with whom she consulted regularly. Kim (29) said she had waited until her 9th year to get a sponsor and "it changed everything."

Where responses were positive, sponsors were credited with having exerted strong and lasting influences on study participants. They taught them the basics of sobriety, served as role models, set guidelines in difficult times, offered direction and feedback, talked to them about the program and the Steps, listened to their personal inventories (the 5th and 9th Steps), provided structure, and encouraged responsibility as well as personal agency. As Kim (29) who had come to sponsorship late in her sobriety commented, sponsorship was not to be confused with therapy:

> . . . in therapy I'm dealing with inner problems. I think . . . with a sponsor it has to do with . . . drinking and not drinking . . . as the starting point . . . . And I think the best sponsors stick to the program . . . stick to talking about the 'Twelve and Twelve' [the A.A. Step book] and the 'Big Book.' . . . in therapy I can deal with feelings and what to do about them and where they come from . . . . With an A.A. person, with my sponsor, I have to deal with what am I doing, what action am I taking to get out of myself. In therapy, it almost demands that you get more into yourself at

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> least part of the time, but in A.A., there's a great deal of stress on getting out of yourself, you know . . . utilize, don't analyze. And . . . if you're stuck in something, call up somebody who's . . . worse off than you are and help them out . . . and talk to beginners . . . . I really love that slogan about . . . you cannot think your way into good action, but you can act your way into good thinking.

It was her sponsor who had asked her if she was working. By that she had meant more than just working to make money to pay the rent. Kim (29) continued:

> . . . [she] was talking about structured time during the day, taking responsibility for myself, probably taking [the] responsibility of . . . showing up at meetings.

Accounts of relationships with sponsors, in fact, were often very poignant. For example, Arthur (14), a gay man, had chosen his sponsor, Larry, because he had heard him share his tormented sexual history and he had identified with it. As sponsor-sponsee, they were together for several years until Larry died of AIDS. Subsequently, Arthur became a sponsor and worked with Evan, a young man who also succumbed to AIDS. Evan's family did not understand his recovery from alcoholism and Arthur was now a "bridge to understanding all of that [and helping the family cope] with it." Emily (23) found similar inspiration in the resilience of her two sponsors as they dealt with their own difficult personal issues:

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> I've seen them go through tremendous losses of family members and dealing with . . . serious health issues, changes in their professions, all kinds of stuff, and be sober and steadfast and I still sit with them at meetings. And that's amazing to me. They haven't decided that they don't need A.A. . . . the hard things that they have had to deal with in their lives have not knocked them flat. They haven't picked up a drink so they have had the most strong and abiding influence on me. It's their consistency that they're still here.

For some, the bond between sponsor and sponsee was strong enough to overcome other obstacles. After their sponsors left New York permanently, several still maintained long distance phone relationships and even managed occasional visits over the years.

For others, however, sponsorship was a mixed blessing. Some felt betrayed by sponsors and never chose one again; some only came to appreciate their influence well after their relationships had ended; some found them too controlling and fired them; some could not handle the intimacy of a sponsor relationship; and some watched their sponsors relapse and their roles reverse (James [10] became his own sponsor's sponsor!).

Many study participants were themselves sponsors, but their experiences varied too. Most took their responsibilities seriously. For example, Gregory (10) conducted informal Step workshops for sponsees in his

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apartment; Arthur (14) held a memorial service in his home for his sponsee who had died of AIDS. But sometimes these relationships took a darker turn. One study participant was remorseful over having exploited a relationship with a vulnerable newcomer which dissolved after their disastrous affair (this is known in A.A. as "13th stepping" and, though not uncommon, is severely frowned upon).

The extent and degree of study participants' continuing commitment to A.A. was exhibited in other ways. Many spoke about their use of A.A. "tools" (i.e., the strategies recommended in meetings to establish and maintain sobriety) which had been suggested to them when they were newcomers and which had since become a regular part of their daily lives. Besides meeting attendance, they maintained regular phone contact with A.A. friends; they read A.A.-approved or A.A.-related literature (the Twelve Steps and Twelve Traditions [A.A. World Services, 1983], the A.A. "Big Book," Alcoholics Anonymous [A.A. World Services, 1976], and the Twenty-Four Hours a Day [Hazelden, 1975] book were three favorites mentioned frequently); they used A.A. slogans and recited familiar A.A.-related prayers (the "Serenity Prayer" was a favorite); they worked on Steps with sponsors (in the

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wry humor of Matthew [19]--"my family would have given me every . . . possible thing, but they had no idea I needed the 12 steps. . . . if they thought that that's what would have . . . helped me, they would have certainly given it me"); and they socialized with newcomers in coffee shops (known in A.A. as "fellowshipping"). Several male study participants even spoke of their attachment to A.A. artifacts as a kind of talisman--Jose (20) carried an anniversary coin in his pocket everywhere ("when I can't find it, I go crazy"); Bernard (13) kept a coin on his bedroom dresser and felt comforted by the sight of it everyday; Carl (13) sometimes carried the miniature Twenty-Four Hours a Day book with him.

For many study participants, volunteering to do service was another way of demonstrating their commitment to A.A. Generally, they seemed to do so for altruistic reasons. As Matthew (19) explained--"I want to give back . . . to Alcoholics Anonymous a lot of what I've been given because it sure as hell was a revelation to me." Kim (29) attributed the maintenance of her own sobriety to doing service of any kind. In her view, service was "just about the most important thing" in the program--"I just really

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believe that you gotta . . . give it away to keep it. And I want to keep it. So I'll just keep giving it away." Janice (16) jokingly described her whole life as designed to "promote my sobriety and if something feels like it's not, I have to examine that." While nearly all the study participants explicitly or implicitly endorsed the value of service to their recovery, Dorothy (25) worried about a lessening of focus in meetings on the idea of service. She attributed this tendency to "therapeutic influence"--"People just want to unburden themselves and then go on home. It just feels differently to me . . . . Maybe I'm just in a different place."

Service work took many forms both inside and outside of meetings. In meetings, study participants had occupied various positions as A.A. "trusted servants"--chairperson, treasurer, secretary. Sometimes the experience tested their own sobriety. Fred (13) described a two-year commitment as Chairperson of a particularly raucous New York meeting that attracted street people:

> It became this huge enterprise with 36 meetings a week. It was like running a small business where all the employees are drunks so we can't fire any of them. It was a milestone in my personal development. [He thought to himself] 'My God, I'm running . . . the most dynamic triage in the city . . . .' I mean it was

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> an emergency room--the money problems, people stealing, encouraging people to do service, helping people. . . . it's a strange thing to be in a position of some authority in A.A. because . . . then you catch everyone's unresolved anger.

Other study participants made coffee (as Kim [29] commented, "you never . . . forget making the coffee"), set up chairs, and cleaned up after meetings. Several helped to start new A.A. meetings (Diane [13] organized a Mothers' meeting after the birth of her child), some in venues where none had existed before--one in a union hall and another in a small country town (Gregory [10], a gay man, started a gay A.A. meeting despite local resistance from some non-gay program members). Raymond (21), an orthodox Jew, founded an A.A. group in a New York synagogue out of concern that holding so many A.A. meetings in church basements would discourage orthodox Jewish alcoholics from attending because their religion forbade them from entering churches. He too had to overcome opposition but of a different kind. Synagogue officials stereotyped alcoholics as street people and feared they would damage synagogue property.

Outside of meetings, they made 12-Step calls (not a very popular activity; one study participant said visiting with an active alcoholic almost made him drink again); served as General Service Representative; attended A.A.

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regional and national conferences; chaired a suburban Intergroup and volunteered for its hotline and Speaker's Bureau; helped to organize a day-long Women's Alkathon Meeting; did volunteer work in a local rehab as an alumna; qualified in special institutional settings like prisons and detoxes; fund-raised to establish meetings in prisons; answered phones at the A.A. Intergroup Office (one study participant was even "fired" from this service for his "relapse in attitude"--he abused the xerox machine!); and for those who could not sleep, volunteered their home phones for call forwarding from Intergroup during late night hours. Other sobriety-related activities included driving people to meetings; holding informal group sessions in their homes to study the Steps or the "Big Book" (one gay man even started a meeting in his apartment for his A.A. peers on the issue of unhealthy relationships which was based on the book, Women Who Loved Too Much); using their home computer to publish at their own expense a neighborhood meeting schedule; distributing coins anonymously to anniversary celebrants; and even giving out A.A. literature to the "squegee men" on New York streets while driving to work. One study participant, a member of the clergy, led recovery

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retreats for church congregants.

Theme 3 - Milestones in the Recovery Process -

Another goal of the interviews was to ascertain the depth, breadth, and scope of study participants' experience of recovery in A.A. The purpose was to determine whether or not there was a pattern to these experiences, or even the perception of a pattern at work that helped to deepen and solidify a commitment to sobriety. This perhaps would serve to explain or account further for why these individuals chose to remain sober for so long. To accomplish this goal, study participants were encouraged to identify key markers or milestones, either chronologically or in terms of intensity of recall, and to explore their significance to the development of their long-term sobriety.

Four individuals had difficulty responding to this prompt, while two others said they did not think of their recovery in terms of milestones or a chronology, though they did offer their reflections. In general, responses took two forms. Some chose to respond with a chronological recitation of external events. For example, first anniversaries were significant for some because they were surprised they had stayed sober for one year. As Bernard

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(14) commented, one year "wasn't a lot of time, but it was a lot of time for me." Kim (29), the study participant with the most years, recalled attending a Bill W. Dinner in 1969 (also in her first year). In what by now has become an annual New York A.A. ceremonial event, she heard Bill Wilson, A.A.'s renowned co-founder, speak. But it was not his presence that had left a lasting impression on her:

> What happened that night that really meant something to me was . . . looking around the room . . . [at the] people out there . . . how many people there were . . . and saying, my God, we oughta all be drunk and here we are . . . not drunk and having this wonderful time. And then when . . . they said the Serenity Prayer and . . . it seemed like it was candles, maybe it was matches, I don't know, but . . . the whole room was quiet, and . . . lit up like that, more than it seems to be these days or maybe it was just my impression of it then. But just the fact that there I was in this . . . group of people, all who . . . left to their own devices would be pissed to the gills . . . . It was just kind of monumental.

Others remembered the birth of a child, the death of a significant other (or as in Arthur's [14] case, of both a sponsor and a sponsee), the acquisition or loss of a job, the failure of a marriage, a business reversal, a move to a new apartment, even the accidental taking of a drink that provoked panic. Many said that the pain of the event forced them into another level of "surrender" (a familiar A.A. concept embodied in the 1st and 3rd Steps) that only

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intensified their identification with others, led to a greater self-awareness or self-acceptance, and deepened their commitment to the program. Not drinking, in turn, brought about enhanced self-esteem and increased self-efficacy. Needless to say, not drinking through these experiences also meant that they were profoundly in touch with their feelings. This was what Arthur (14) had experienced after the deaths of Larry, his sponsor, and Evan, his sponsee:

> . . . the common thread in them all [the milestones] is fellowship with other recovering alcoholics helping them or allowing them to help me. So something as simple as an anniversary . . . or being there at the end of the life of my sponsor and my sponsee . . . . One of the things I remember being amazed at when both of these people died was that I did not feel necessarily depressed. I felt profoundly sad, but my sadness was mixed with gratitude that these people had been in my life and their deaths were not threatening to me, in the sense of throwing my own mortality in my face. I was just so much more aware of being alive and that they had helped me find a way to stay alive . . . . I don't know how to explain that, to be very sad and very grateful at the same moment. But I was very aware of it.

Lilly (10) experienced a similar sadness but found personal meaning in her brother's death from alcoholism and lung disease:

> . . . six months into the process of me getting better, my brother died. And my brother, he would have been . . . he lived 'til 49 years old, which I thought

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> was very tragic. He never left my mother's house . . . active alcoholic . . . had his lung removed. They told him, you don't smoke, he smoked. At the end of his life, he was catching . . . there's oxygen in the house . . . he comes in and smokes . . . . But at the end of his life he would catch a cab from my mom's house to the . . . store to get his alcohol because he was so weak. So he received some money or whatever. I don't know what the disability . . . whatever the deal was. But he received it and went out on a mission. He came home and died in my mother's bed. . . . that's when I was six months clean. . . . I was very . . . sad and I kind of felt like . . . what a wasted life. . . . I was taught how to use that half glass thing to make it a full glass. You don't look at it as half empty, you look at it as half full. So . . . rather than seeing his life as a wasted life I kinda looked at it as . . . I don't want to go out like that, you know. So that gave me, I guess, an increased energy or motivation to stay stopped and stay in the recovery process.

Others chose to respond not by mentioning external events but by recalling the "process" they had undergone, which was sometimes prompted by external events, but much like Lilly's (10) experience was represented by a change in thinking or a shift in awareness. Matthew (19) and Nina (10) described the process as a "journey," a metaphor rich in spiritual allusion. Janice (16) called it her "internal journey." Emily (23) said it was her "inner" milestone. For some the "process" or "journey" was gradual, a subtle but deepening shift that altered their perceptual field and from which there was no turning back. This was Janice's recollection of one epiphanal moment in her "internal

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journey":

> Between my 4th and my 5th year of recovery . . . I had done one or two 4th Steps. I thought I was kinda digging in and really working the program . . . . I moved here to New York so I lost my home group. I had to get new people in my life. I had to get new sponsors but it seemed as though . . . I had to start all over again. All the unfinished business that I thought I had taken care of came back in spades . . . financial insecurity, fear of people, low self-esteem . . . . I think I even started having anxiety attacks and this was the first time since . . . I didn't even know if I was aware of having them before. It felt brand-new . . . . I thought, what is this all about. You know you've done a 4th Step. I have sponsors. I go to home groups. I do service. I guess it was a matter of . . . taking it all to a new level, rethinking, relooking at myself and being a little more honest than maybe the last time. I think until I experienced that, and I have since, kind of a renewal, a new level. People call it 'bottoming out' in sobriety. To me, it's learning to live with the 'ism.' It's a living, breathing, perpetual progressive disease that I have, not that I had. Recovery, I think, has to be a living, breathing being in itself. If I'm not keeping up, you know the disease will kinda come and take over and I think this was the first time in recovery that I really experienced that, that I have to keep growing, I have to keep working on myself, you know, not incessantly, not to the point of being self-obsessed, but I have to be taking my own inventory and reaching out, growing, willing to grow, willing to be teachable.

For others, however, the shift seemed seismic--a swift, abrupt, and painful upheaval that forced them to make a choice between old behavior that they knew was alcoholic and a new way of living that required "rigorous honesty" and unremitting self-examination. Interestingly, for Norman

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(12) and Emily (23) this period in their sobriety occurred sometime between 6 and 9 years, when they reached a critical turning point and "bottomed out" further on old ideas and behaviors which no longer worked for them. This new "surrender," which they viewed as a spiritual turning point, seemed linked to deeper personality changes. As Emily commented--"I often see people at around that time. It never surprises me when I see people at around 7, 8, or 9 years in the throes of something. I think, wow, there they go." She too had experienced her own upheaval at 9 years. She described it as the abandonment of her "old self," a "deep bottom of letting go of the way I wanted to live in the world which was kind of a false way." Thereafter, her life took a different turn:

> At 9 years sober, I went to church for the first time sober although I had been seeking for some kind of spiritual direction and I went into a different profession and I looked for something very different in relationships particularly in terms of men and so actually about three years later I got married and that was kind of nice and I'm still married. So there really was a bottoming out on . . . old ways of dealing with things and an opening up of a very new sense of surrendering of my life and really the idea of wanting to live in service, a really strong sense of a Higher Power and a relationship with a Higher Power and everything changed after that, a very profound change when I look back on it.

Norman (12) recounted a similar experience in his second

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five years:

> I stopped going to meetings for . . . a three year period in that second five years . . . not a dead stop, but I'd go to a meeting, you know, once or twice a year. I stopped calling my sponsor . . . . I guess that's . . . what happened in those five years, owning up to who I was had to do with not being able to lie to myself anymore. You know, and that had to do with . . . I'm not 6 feet tall . . . and I'm not Robert De Niro, I'm not Bogart. I'm from the Bronx and that was where self-honesty . . . really kicked in. I just couldn't bear to go to meetings because I'd come out of meetings totally, completely depressed.

Theme 4 - Non-A.A. Supports to Recovery -

In addition to A.A., study participants made use of adjunct resources to facilitate the recovery process. These included medical and therapeutic interventions, attendance in other 12-Step programs, and other healing modalities. They were asked about their experiences with medical and mental health professionals, especially whether the latter understood or endorsed A.A. and what they knew or understood about alcoholism and recovery. Also queried were participants' attitudes toward prescribed medications, where recommended, and the efficacy of such help.

Responses from study participants showed that their initial encounters with the medical and mental health communities respecting treatment for alcoholism ranged from negative to positive. Those who had contact with medical

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personnel prior to entering A.A., regardless of whether they themselves wanted help, reported finding these professionals often ill-equipped to identify the basis of their symptoms. Jose (20) recounted a history of five admissions to Bellevue Hospital where his condition was misdiagnosed--"they never picked up on my drinking because alcoholism wasn't well-known at the time." Ricardo (17) recalled that doctors never connected his symptoms to his drinking; nor were they able to answer his questions about his medical condition. In fact, he remembered being told that limiting himself to three beers a day was deemed an acceptable amount by his doctors. Bernard (13) said that, after he was admitted to an alcoholism rehabilitation facility, his long-time private physician apologized to him for failing to diagnose his condition as alcohol-related. "Most doctors get one half hour in medical school about alcoholism," he recalled his physician telling him. Well after he was discharged from rehab and had begun attending A.A., Bernard was surprised to hear his doctor advising him that he could resume drinking. Reflecting back on their conversation, he commented, "Unless a doctor is in A.A., they [sic] know nothing about it. You can't know what A.A. is unless you are in the program."

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Some health professionals appeared unsympathetic to study participants when they presented with an alcohol problem. Fred (13) remembered angrily walking out of a hospital after a nurse "lectured" him about his hepatitis. Harriet (23) recalled her first admission to a major New York hospital in 1974. Although she tried to tell medical personnel about her drinking, it was to no avail. She was diagnosed with depression. She remembered that her doctor refused to put her in an alcoholic ward because he did not like the population. At the time, she did not protest the diagnosis--she was in fact depressed--because she had wanted to stop drinking. However, she remembered that her psychiatrist seemed more interested in her early childhood than in recommending her to a rehab or to A.A. She commented, "Just psychiatry isn't going to do it. Seeing a psychiatrist wasn't helping me stop drinking." Even when a medical doctor did diagnose the problem correctly, as in Raymond's (21) case, and suggest that he attend A.A., there was a troubling breakdown in communication. While it took Raymond five more years before he actually stopped drinking and attended A.A., years later when he reported to his physician that he had not had a drink in at least two years,

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the doctor advised him that he could take a drink to relieve stress on the theory that "if you go 'x' years without drinking, you're not an alcoholic and, therefore, it's OK to drink." Raymond, by now firmly committed to A.A. (which favored the abstinent approach), was appalled at the advice--"My doctor didn't know about alcoholism, although he knew about A.A." Finally, Gregory (10) recalled that, perhaps because he described himself as a "social drinker" to his medical doctor, he was never advised about tapering off or stopping. Only one study participant, Matthew (19), who had been hospitalized for alcoholic hepatitis, reported being repeatedly warned by physicians that "if you drink, you will die." Needless to say, in true alcoholic fashion, it took several relapses before he decided to heed their advice.

Interestingly, while these experiences occurred more than a decade ago, study participants were somewhat divided over whether or not medical professionals were better informed today about alcoholism than had been the case in the past. While three individuals indicated their belief that the situation was in fact changing, three others said they continued to make special efforts to educate their

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private physicians about alcoholism and recovery, because of their persistent misconceptions about alcoholics. A recent survey conducted by the National Center on Addiction and Substance Abuse (Press Release, May 2000) of how primary care physicians deal with substance-abusing patients would seem to support these study participants' perceptions that physicians were ill-prepared to diagnose alcoholism. Moreover, according to the survey, few physicians (3.6%) felt that treatment was "very effective" for alcoholism. Dorothy (25) commented: "I always tell medical doctors that I'm in the program so they could see that there are recovered alcoholics out there who do live responsible lives. It's just carrying the message and educating professionals." In her view, she did this out of frustration with the professional community's poor track record of working with alcoholics--"Why does any of us stay sober when the medical professionals, psychiatric professionals, and clergy couldn't do anything and suddenly two drunks [Bill Wilson and Dr. Bob Smith, A.A.'s co-founders] get together and wow." Emily (23) described similar personal efforts to educate medical doctors:

> I tell doctors I'm in the program. They write prescriptions for me I don't want [valium or sleeping

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> pills]. They don't always get it. But it's my job that I get it. I say things because I think maybe they'll get educated in it eventually. I have to take responsibility for my sobriety.

Encounters with mental health professionals proved equally mixed. Thirteen out of 15 females (87%) and 10 out of 15 males (67%) indicated that they had sought counseling or psychotherapy over the course of their recovery. Some study participants reported frustrating experiences with social workers, clinical psychologists, or psychiatrists, while others spoke of more rewarding interactions. In general, study participants complained that more analytically trained therapists knew less about alcoholism, A.A., and recovery. Some said that while they received competent help for other problems, they had to educate their therapists about these topics. In a few cases, the analytically-oriented therapist either discounted their problem with alcohol or indicated that he or she was not interested in hearing about it. Diane (13) recalled overhearing some people in A.A. report that their therapists tried to talk them out of attending meetings. In one instance, Tom (17), who had been in group counseling, said he eventually left the group because he felt that the counselor's message--"everything you do is OK"--conflicted

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with what A.A. had taught him, namely, to take responsibility for his behavior.

Victor (17) complained of counselors who had studied the field but had little personal experience of recovery:

> I don't think that they can even achieve the gut understanding that you have when you're a recovering drunk. They have knowledge in a sense, but when I speak to these people I always get the feeling that they don't really know . . . . I always had the feeling I could hoodwink them, get over on them. . . . I don't disrespect them . . . , but . . . if I had to choose I'd always choose a therapist or a counselor, say an alcoholism counselor, who was in recovery . . . because you want that level of no bullshit and . . . you can't have that level. I don't think you can with a therapist about other things, but when you come to alcoholism, it's an experience they haven't had. And that experience is central to what keeps me sober.

Where therapists seemed open to learning more about A.A. and encouraged their patients to attend or where they clearly specialized in treating alcoholics, study participants reported having had a more positive therapeutic experience. Carl (13) and Fred (13) both felt that therapy and A.A. were complementary and went "hand in hand." As Carl commented: "the insights of one are insights in the other. They both belong to one big self-help category." But Janice (16), who had undergone therapy, was more cautious in her assessment. With characteristic irony, she

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offered the following observation--"therapy has helped, but it won't keep me sober. It'll give me a lot to talk about at the bar."

While eight study participants who initially attended rehabilitation programs spoke positively about their early experiences, fondly singling out individual counselors who helped them, Alice herself a nurse and psychotherapist recalled a recent troubling encounter with the Alcohol Service in a hospital setting. Her experience demonstrated that much more needed to be done about the training of health professionals who treated alcoholics. When she attempted to work with a man diagnosed with chronic alcoholism (he had been in 8 detoxes and 5 rehabs), the Service professional blamed the patient for abusing the system. Over the course of many visits, Alice talked with her patient at length helping him to reconstruct what happened each time he had relapsed. She encouraged him to go to A.A. and to try to stay sober "for a day at a time." Months later, she met the man on the street and learned that her interventions had indeed helped her patient who now had 9 months of sobriety in A.A. Alice commented:

> People in the mental health field don't understand alcoholism. My own experience in the program has

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> helped me to help patients. . . . I think I understood something more of his dynamic.

She described another experience of working with a homeless woman in a hospital program where professionals "didn't understand the process":

> I understood her incredible fatigue and her anger. I understood how difficult it is to come off of a substance. Some people get angry with people who are substance [abusers] and have a relapse, but it's a process with people. Some people need to test it out. They are not sure if they are alcoholics. It has helped me to understand also knowing the program. This woman said to me if I could stay sober for a year I'll be OK. I said, 'well how about for a day.' I told her that. Where did I get that?

In addition to therapy, study participants made use of other resources to support their recovery. Some chose 12-Step programs like Al-Anon, Narcotics Anonymous, Sexual Compulsives Anonymous, Overeaters Anonymous, and Adult Children of Alcoholics. Fred (13) attended the Caron Foundation and found this experience helpful in dealing with family issues. Amy (24) attended Food Addicts, a program for bulemics.

Finally, eight women (one was diagnosed with a bipolar disorder and had been hospitalized several times prior to getting sober) and five men (one of whom had been hospitalized for depression during his recovery) suffered depressive symptoms at some time in their recovery, a not

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uncommon complaint among alcoholics. Four women and four men were currently using an anti-depressant (ex: Paxil, Zoloft, Welbutrin).

But among all study participants, opinions about taking anti-depressants were decidedly mixed. Some, like Carl (13) and Kim (29), felt that if medication for depression was warranted and prescribed, it should be taken and carefully monitored. Others, like Harry (15), who had been on anti-depressants for several years, were not sure they had helped--"the answer is not in the medication or the therapy." Amy (24), who had a bipolar disorder, was ashamed of having taken drugs like Ativan and Prozac which she termed "risky." She complained that while her doctor knew a lot about addictions, he himself smoked non-stop in their sessions. She did not feel that the help she received was compatible with her recovery. Though she knew she needed medication to stabilize her condition (she was currently taking Welbutrin and Deprocate), she had become secretive about her history of prescribed drug use in recovery, choosing to hide it even from her husband who was also in A.A.

Still some were adamant about taking any

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anti-depressants. They viewed them as tantamount to using alcohol to solve their problems. Instead, they opted to use the A.A. program to get them through difficult times. As Dorothy (25) commented, "Taking Prozac is like putting band-aids on one's sobriety. It's dangerous. You won't get through to the other side if you take drugs." Regina (12), though sympathetic to those with mental health problems, remained wary of medication for a different reason--"Some people need to take medication for specific mental conditions. But alcoholics need a quick fix. The lesson for me is don't go for the quick fix and make sure you know what you're doing." Even Susan (11) who was currently taking Paxil had reservations about it:

> It's like taking a spin on a roulette wheel. On Paxil, life got more colorful under the light. But there's a piece of me that's hardcore A.A. You shouldn't use a substance. I cringe that it isn't sober. But if I weren't on it, I would drag myself through a black pile of mud.

<u>Theme 5 - Changing Views of Self and Personal Identity</u> -

An important question asked of all study participants was to describe what internal changes, if any, they had experienced since they had stopped drinking and entered A.A. In response, all alluded to a profound transformation of self that they had experienced over their years in the

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program. This change seemed to take place irrespective of therapy, although as we have seen in the previous section (see Theme 4), for many therapy became a positive adjunct to this process, generally helping to facilitate and nurture it.

This transformation took many forms. Some experienced it as a movement from a "false self" to a "true self" or as a return to a more natural or authentic self. Often it meant a lessening of narcissism, grandiosity, and intense obsessionality with fantasy. But this intrapsychic shift was not achieved without personal struggle. The struggle was alluded to in the narratives of both male and female participants regardless of age, race, or ethnicity. The stories of Norman (12), Emily (23), and James (10) vividly illustrate the dynamics of this intrapsychic drama and are representative of the many internal changes reported by study participants.

Norman (12) described the increasing pain he felt attending meetings while clinging to a fantasy of himself as a larger than life "cool" character:

> In those early years all of the things that I had previously built up as being important, as thinking those are the things that gave me value and made me feel like . . . I was a man or that I was worthwhile or

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> I always had to feel like better than you, even though I would act, be friendly to everybody. There was a part of me that needed to feel better than other people, bigger. I always had to do bigger things. My girlfriend had to be . . . some beautiful model. I couldn't have normal relationships with women because women were part of the trappings. I had to look cool. I had to dress cool.

Norman fueled this fantasy by becoming a partner in a New York nightclub where he could act out the scenario each night. But the fantasy soon collided with the reality of being sober:

> The first five years was really rediscovering who I was . . . and finding out that it wasn't the club that made me . . . special. It wasn't that . . . maybe I was smarter than some people because I'm dumber than a lot of other people and it wasn't that . . . I had done wild and crazy things and it had nothing to do with what the woman looked like who was with me . . . it takes a long time to get rid of all that old stuff. Most of it you're not even aware of.

It took Norman another few years of painful self-examination to reconcile his fantasy self with his real self:

> I would describe those years as reality . . . meaning, you know, accepting who I am, who I really am, and coming to terms with . . . both with my fallacies and with my strengths, being able to . . . say, hey I'm good at this, I'm really good at this particular thing that I do without, . . . bragging . . . objectively seeing who I was or who I am and then living with it, you know, kind of getting to know myself for real and really looking back . . . like the 4th step really means something when you look back with some time. It's sort of like for me really owning the person who I was.

The end result of this process, of what Norman called his

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"incubation period," was his decision to return with renewed enthusiasm to the profession for which he had originally trained--architecture--but had once abandoned in pursuit of his alcohol- and cocaine-driven fantasy.

Emily (23) spoke of a similar internal struggle between an entrenched but false self-image and a newer, more "emergent" sense of who she really was in the world. It was Norman's story repeated but with different pronouns:

> I thought I could be my old self but sober and it didn't work and the [A.A.] principles were just not deep enough in my life and I had to really hit bottom and I don't think everyone has to hit like a serious bottom, but I hit it. For me it was a deep bottom of letting go of the way I wanted to live in the world which was kind of a false way. I wanted the facade. I wanted ego gratification. I wanted a relationship that had no substance, but the guy was very good looking, you know, all the old crap that just wasn't going to work in a sober life.

For Emily, "hitting bottom" occurred in her 9th year of sobriety when she too felt compelled to come to terms with the discrepancy in her self-image. Through a series of what she called her "inner milestones"--a gradual "deepening of trust in the world" and a "strengthening of relationships with other people" which she gained through her A.A. program along with therapy and the search for a deeper spiritual faith, she found a pathway that led to a more integrated

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self and a more purposeful life filled with "long-term commitments and a sense of rootedness in the world." As a result, she left a high profile job in publishing to teach basic skills in a program serving poor women. She also ended an abusive relationship and some years later formed an enduring relationship with a more appropriate life partner.

James (10) had once envisioned himself as untouchable, the "ice man," who "showed up for the violence . . . and for the drama":

> . . . it was always hard to get close to me . . . . I had the two parts of my personality [at home he read books, but on the street 'it was about knives and guns'] and I didn't think that they went together . . . , because . . . I walked out in the street and I drank to be cool, you know. . . . I carried . . . this picture of who I was supposed to be.

What altered his perspective was the "change" wrought by his sober life:

> I was beginning to be able to relate to people 'cause when I showed up I had to work, and very hard for a lot of years, . . . to be independent of people and by the time I came into A.A. I had achieved that pretty much. I used to consider myself the 'ice man,' couldn't touch me. But what I realized as I hung around was that, yes, nobody could touch me, nobody could reach me, I had the wall, but I couldn't get out either. 'Cause . . . the few times when I wanted . . . to reach out to somebody, I didn't know how. And . . . that was a shocking revelation and if it hadn't been for the people in the [A.A.] rooms I don't know how I

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> would have . . . , 'cause they just kept being there. . . . it's the people . . . they hung in there until and when I was ready and I was able . . . . I had so much stuff that I was running from. I had this whole lifestyle . . . that alcohol had enabled me to live. I couldn't have done it without alcohol, but then on the other hand I wonder now why I wanted to do it at all.

The transformation of this "ice man" with the self-deprecating humor surprised even the "ice man" himself. Though he still described himself as an "emotional cripple," he realized that his task in recovery was "to get a relationship with myself." How he accomplished this became the story of his sobriety. He illustrated the point with an anecdote about setting out to confront a co-worker who had disrespected him. The man had a reputation for violent behavior and was also said to have had AIDS. As this was the kind of encounter that had always attracted his attention, James, with his customary bravado and grandiosity, was not daunted by the challenge. In fact, if anything it only spurred him on--"I was going to show him what not caring was about because I cared less than he did." Only this time he experienced a momentary insight that made him hesitate to strike back:

> . . . that's when I realized that it wasn't about bravery or any of that stuff, 'cause I couldn't care less, 'cause the person that cares less has less to lose, you know. And these are little revelations that

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> came to me which . . . should have been obvious to a blind man, . . . but I . . . always like to say that the obvious escapes me immediately. So it took a while . . . for things to sink with me.

Reflecting back on this experience, James realized, to his own surprise, that whereas his life as an active alcoholic and drug addict had been filled with physical violence, in sobriety he had never been in a fight--"not that I wouldn't have wanted to." Other occasions presented similar challenges, but he seemed to have developed more impulse control and an ability to sublimate his violent tendencies with the result that his life had become more normalized:

> . . . I'm aware that I'm handling things differently. The first thing that I have to deal with in these situations is myself. . . . My first impulse was always . . . to smack somebody upside the head and . . . slide them up against the wall and see if they want to rethink that statement. And I would have to deal with me. And then I could deal with the situation. So I think now . . . I kind of look at how I might have handled things as opposed to how I do handle things and maybe how I could have handled them better. I try to learn from situations. . . . everything is not in an emergency mode anymore. Because it used to be in emergency mode, because violence was always so close to the top. And it's not that way anymore. I mean still if you scratch, it's there. But [I've] become more . . . normal . . . . And the impulses . . . don't come as quickly anymore. I have other tools that . . . I mean I will still sometimes wish very much that I could just beat this person to a pulp, but I know that I can't . . . but it's kinda nice to play with the fantasies sometimes.

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When asked what "tools" he used to control his impulsivity, he cited the development of a capacity to empathize with others and a newly acquired ability to learn from his experience:

> . . . I can reason with people . . . I can attempt to compromise. I can make suggestions. But I can only do all of that . . . after I try to put myself in their place for a little period, you know.

With a history of violent behavior, often drug-induced, that led to several prison sentences, it was not an easy transformation for the "ice man." But clearly ten years of sober experience was having an impact. As a result, the "ice man" seemed to be developing an enhanced ability to self-reflect and tolerate interiority (what psychoanalysts call an "observing ego"), regulate uncomfortable feelings and fluctuating mood states, and monitor his own actions and behaviors, always with a new-found capacity for empathy:

> What I tend to do now . . . and . . . this is just becoming apparent to me because of the few things that happened recently. But what I tend to do now is . . . put myself in the other person's place for a few minutes . . . or try to. . . . 'cause sometimes I get in my own way. Sometimes I become angry and when I become angry it takes a little while first, 'cause I realize when I become angry first I have to deal with me . . . . I have a really hard time dealing with stuff while I'm angry, so I try to deal with the anger. But I also try not to get angry and I find that if I'm understanding, then there's not usually a reason to get angry. . . . sometimes people's actions and attitudes

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> can puzzle me, but then you just . . . be grateful that you're not that person. But most of the time I try to, you know, put myself in their place and then you can't really be angry. 'Cause you don't really know what's motivating people.

He attributed this emotional education to his experience in A.A. and his willingness to ask for help:

> A.A. made me teachable. . . . because before A.A. I wasn't . . . I didn't even attempt . . . it made me willing . . . it suggested that I keep an open mind. So I had to develop an open mind. . . . the willingness was . . . difficult because . . . I had to admit that for 38 years I'd been wrong. . . . and then I had to learn to look at it as not 38 years wasted, you know. And all of this was a lot to grapple with . . . when you're doing it without a drink, you know. But the willingness was the key 'cause . . . and then like I said . . . I had help.

The experiences described by Norman, Emily, and James were not unique to them. Many other study participants reported similar transformations in selfstates over the course of their sobriety. For some, identity confusion became clarified through the acceptance of the label "alcoholic" which seemed to provide a framework and container for the acquisition of a core identity. Harriet (23) spoke of how much she embraced the idea of being labeled "alcoholic" because it made her feel "entitled" and "special":

> I made a big thing about it all the time. I kinda like that . . . because it was mine. I didn't have to share . . . that part. I didn't have to share with

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> anybody outside of the program. You know . . . I've alluded to this . . . but I've always felt that people wanted pieces of me all the time . . . . It was my family, they wanted this from me or that . . . . I had to help them . . . and I didn't have to do anything for anybody. I could do this for me . . . .

Ownership of the label "alcoholic" seemed to enhance her self-efficacy. As a child and later as an adult, she was passive, easily intimidated, and preoccupied with her mistakes. But her experience in A.A. improved her ability to assert herself with family and in work situations and made her less obsessively self-critical:

> I feel very protective of myself . . . . I don't get myself into situations that I used to. I'd get myself so involved, 'oh what did I say that for, why did I do that.' I don't do that anymore.

Raymond (21) listed his three proudest accomplishments as being an "American," "Jewish," and an "alcoholic." The latter, in particular, generated a fantasy which he knew could not be realized because of his commitment to A.A. norms--"I want my picture on the front page of The New York Times telling the whole world about it, but I can't. It means nothing to them and I can't break my anonymity." But this was a far cry from the "roguish" identity derived from Hollywood movies which he had constructed for himself when he was drinking. For Raymond, A.A. meetings had become so internalized that they were part of his core "structure."

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Attending meetings was "automatic" for him, "like breathing," and A.A. norms were inviolable.

Dorothy (25) spoke positively of the total identification she had with the label "alcoholic" and the self-acceptance she had gained from her years of sober experience. Though she struggled with recent setbacks in her health, she seemed to draw strength and an ability to cope from her identification as an "alcoholic" and her experience in the program:

> . . . I'm glad I'm an alcoholic. I'm glad it's who I am today. And I am here today because of my experience with active alcoholism and then in recovery in A.A. Those two have been primarily instrumental in developing who I am. I kinda like who I am, you know. . . . I accept myself with my failings but . . . I still like who I am. And I put my head down at night and I'm OK with me. It's been hard being me lots of times. It's been hard these last four years with all this stuff [her medical problems] but considering the alternative I can't be anyone else.

For others, identity confusion became clarified through a greater acceptance of their sexual orientation. Eight study participants had self-identified as gay (7 males) or lesbian (1 female) and one as bisexual (female). But while more than half had been "out" to friends and family prior to becoming sober, many came to A.A. still struggling with issues related to their sexuality--internalized homophobia,

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sexual compulsivity, and for three men, the added stigma of being diagnosed HIV positive. Fred's (13) experience was typical.

Fred had entered A.A. thinking he had no difficulty with being gay. But he soon realized the depth of his denial about his own homophobia:

> I had a great deal of self-hatred for being gay, and I had a great fear of other gay men. I heard someone in A.A. say that if you grew up in America you think that you can . . . do the dirty deed but you can't really love another man. That's the message that we all got.

What helped him come to terms with his homophobia was the experience of observing other gay men in A.A. deal with the AIDS epidemic, either as AIDS survivors or as helpers "in primary care positions, in supportive positions, in professional positions." These men became his role models demonstrating a level of courage and selfless giving that caught his attention:

> What went a long way towards convincing me that a gay man is capable of love was seeing these gay men loving other gay men through . . . the absolute nightmare of dying of AIDS. . . . it just became an irrefutable . . . pageant being played out in front of my eyes.

The lesson of this experience was not lost on him:

> You know, it had . . . a very deep effect . . . there's a thing in A.A. about let us love [you] until you can love yourself, and the fact is . . . for me it worked in an almost opposite way, and it was that . . . I

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> started loving people because I couldn't help it. . . . Gay men were no longer predator or prey. They were . . . human beings who I've grown to love . . . .

Through loving others, Fred slowly began to learn to love himself. He was especially moved by his friendship with Phillip, a gay man who was later to die of AIDS. This was the first real friend that Fred had ever had:

> Through the course of him getting sick and dying over a period of years, that . . . close relationship went a lot further towards giving me some peace about being gay [more] than anything else that happened. And the . . . core of our friendship was two recovering alcoholics in A.A.

The experience of being with Phillip up through the final moments of his death had a lasting impact on Fred:

> I know it changed my life . . . irrevocably from that moment on . . . and very specifically about my relationship to myself . . . as a gay man. . . . it informed me as to the humanity, the profound humanity . . . that is in the experience of being gay.

Fred's friendship with Phillip would fortify him when the time came for him to deal with his own AIDS diagnosis:

> There's no doubt in my mind, you know, the subject upon which I have developed and deepened my experience of my life more and more . . . is the subject of AIDS and the people around me dying and myself getting sick and facing death in a variety of ways. You know . . . to be sober and present in the way that I am and therefore available for such big experience, life, human experience, has changed me again and again . . . . I'm still me, but I'm not me. You know, by virtue of having been there for specific friends when they died and having been there for myself.

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Now his AIDS diagnosis and the subsequent treatment regimen he would undergo forced him to attend to himself in ways he had never before imagined:

> I needed for myself the kind of attention that an infant needs. . . . I very clearly see that this was a . . . period of literally loving myself in a very practical way like I was an infant.

The intensity of this experience led him into new levels of self-acceptance and personal growth:

> I feel more self-accepting of every area of myself . . . physically and emotionally. It was an enormous period of development to go through . . . just to pay that kind of . . . minute attention to my physical well-being . . . . And when circumstances was [sic] presented to me, I didn't ask for it and I wouldn't ask for it for anyone else, but having been presented it and having had the experience of A.A. . . . of being present for what's going on in my life, it turned into an important developmental period of my life.

Like Fred, other gay study participants generally reported finding a level of safety in A.A. meetings that was missing from their experiences in the outside world. As a result, they credited A.A. with helping them achieve a greater degree of self-acceptance as homosexuals. For example, Harry (15) described A.A. as a "very compassionate, understanding organization" which played a role in his coming out to his family. Gregory (10) described himself as homophobic and easily intimidated when he first came into

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the program. Though he still felt somewhat uncomfortable in regular A.A. meetings talking about his sexuality, he had grown so secure in himself that he had become more assertive on his job when faced with homophobic comments from his co-workers. He had even started a gay meeting in a rural area where he owned a vacation home. He credited his work on the Steps and his reading of the St. Francis Prayer with providing an insight that eventually led to a shift in the way he viewed himself in the world:

> In the 5th Step . . . it defines . . . the St. Francis Prayer. [It] . . . tells you what humility really is . . . and what [sic] you truly are being able to use that to your own advantage. That jumped out at me one day . . . and I went . . . wow . . . it's like I began to understand I had a problem with that. . . . I was looking around and going, 'oh, they don't like me . . . because I'm gay, because I'm Hispanic, . . . because I'm skinny, because I'm wearing the wrong . . . and I had to stop and go, 'hold it.' They don't . . . even care who, what, where, when, how. It had nothing to do with them. It has to do with how I see myself and how I hold myself. That was a 'wow' into the program and it was like 'wow.' That's really what the program says. It's an inside job. It had nothing to do with what was going on in the externals. It's how you hold . . . I learned how to . . . what I hold inside and how I hold it inside.

What he discovered in this epiphanal moment was not just how he felt but how he projected what he felt to others. The insight not only enhanced his self-efficacy, it empowered him:

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> It's how I present it to the world. I was not presenting a very nice picture of myself there for a while. I was presenting, yeah, I don't know if the world picked up on it, but I was able to see it. I didn't like myself because I was Hispanic, I didn't like myself because I was gay. I didn't like myself because I thought I was fat. I didn't like myself because I thought I didn't belong . . . . All of that slowly just fell away. It's like it's OK to be who I am . . . in fact I like who I am today. I like being Hispanic. I like being able to speak two languages . . . . My homophob . . . you know, I'm still afraid of presenting it at different places . . . but I do it. Now I don't hold myself back. If I need to talk about [it] . . . at a meeting or wherever it is appropriate, I talk about it. And I determine where it's appropriate.

Similarly, Matthew (19), Edmund (23), and Arthur (14) all spoke of how A.A. had helped them come to terms with their sexuality. Some credited gay A.A. meetings with bringing about this change, while others cited the program's injunction to be honest. As Harry (15) noted, A.A. had given him an "excuse to be honest with people about being gay."

As Fred (13) had found new strength and inner resources to deal with his HIV disease from the legions of young men he had witnessed in A.A. cope with the same condition, so too did Gregory (10) and Carl (13) use the program to their advantage to deal with their diagnoses. With the help of cutting-edge drug treatments, both men were no longer dying from AIDS. Instead, they were living with AIDS. As Gregory

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commented, this demanded a new level of self-acceptance and self-care:

> Back then I was dying from AIDS . . . . Today I happen to have AIDS . . . it's just part of me. You see, the program helped me to accept that . . . helped me to see that I just have AIDS. It's . . . something I have to deal with, something I need to constantly be on the guard and . . . take my medicines and do all the things I need to do in order to keep it at bay or arrested . . . as long as I possibly can.

Living with AIDS meant facing a new set of challenges. Gregory used his experience in the program to negotiate this next phase:

> I'm on medication. I'm doing the cocktail. . . . I'm being responsible for that. And it was the program who [sic] turned me around saying it's a bridge back to life. . . . I need to get a good life. I need . . . to set certain regiments [sic] into my life.

As a result, he set careful limits for himself--get enough sleep, keep to a schedule, and maintain monogamous relationships.

Carl (13) too found his experience in A.A. a valuable resource for coping with his AIDS diagnosis. At 3 1/2 years of sobriety, he learned he had ARC (AIDS-Related Complex); at 9 years, he had progressed to full-blown AIDS. Without A.A., he thought he would have done a "poor job of coping . . . a terrible job of coping. . . . I think I might have ended my life thinking what's the point." But with

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A.A., he too found new levels of inner strength and an enhanced self-efficacy:

> The tools of A.A. are the same tools I use in terms of having AIDS. . . . The slogans that I hear, 'let go and let God.' . . . I can't control AIDS. I can follow what the doctors suggest, make my own decisions and hope that things will turn out OK. That's not terribly different from A.A. I have a sponsor. I can follow his advice, make my own decision, and hope it turns out OK. The faith I've developed that things will be all right keeps me going and that works in the program and it works with AIDS. And I don't think that I'm a victim which is important 'cause I used to think I was a victim all the time.

One of the most important changes he noticed was in his help-seeking behavior:

> I can ask for help when I need it. And a lot of times I need help with this. . . . it's frightening. But I can ask for it and I can get it. I can get when [sic] I need. And I'm not negative about it. I don't think that I'm gonna die tomorrow which before I got sober I'm sure I would have been [sic]. I was at times so negative about things. I thought the worst. So really all the stuff I learned in A.A. I just use the same things when it comes to AIDS and it works.

He noticed too that his ability to identify his needs had improved. When he realized that he needed more time in therapy to discuss the changes he had to make in his life because he was "not getting to what [was] important," he was surprised that he was "able to identify [his] needs and ask to have them met." As he commented, "that [wasn't] the kind of insight that I was used to having."

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Interestingly, while these gay men reported positive experiences that helped them achieve a deeper level of self-acceptance and an ability to cope with a difficult, life-threatening illness, the two women (one self-identified as lesbian, the other as bisexual) gave less positive accounts of their experiences in A.A. as members of a sexual minority. Kim (29), who described herself as "out" before she came to A.A., but coming "from a different place and time," disliked gay A.A. meetings because she found people too angry. For her, attending A.A. had more to do with her alcoholism than with being gay. Amy (24), on the contrary, told a more tortured story of her struggle to achieve self-acceptance as a bisexual woman. A.A., she felt, did not make it easier to accept what she termed her "sexual complexity." Her ongoing battle with bulemia and her smoking made her question the validity of her 24 years of sobriety.

Theme 6 - Alterations in work and professional life -

Study participants were asked to describe what changes, if any, had occurred in their work or professional lives since entering the program. All 30 reported experiencing some form of change in this domain. In many instances, the

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change was either directly attributed to the impact of the program on their lives or facilitated by their use of program "tools" (ex: the Steps, sponsorship, meetings) to cope with unanticipated reversals or difficult decisions relating to work goals.

Approximately one third of the sample indicated that they had made a major career shift after entering A.A., while nearly a quarter reported a deepening commitment to their work. Others, with unstable work histories, embarked on newly established careers which they undertook after completing their education and training in sobriety. Several were either in the process of completing their credentials or contemplating a return to school. Finally, a small proportion of study participants faced job loss, the prospect of retirement, or the need to declare themselves disabled as a result of serious health problems. They too indicated that the program and the people in it, especially sponsors and peers, played a key role in their decision-making and ability to cope.

For the 10 study participants reporting a major change in occupation, a dominant response pattern emerged. Many spoke of their growing realization that occupational choices

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made when they were drinking no longer reflected who they were as sober people. For example, several had occupied positions they had regarded as grandiose and ego-inflating--they were paid well and rewarded with high status. But once in sobriety they viewed their work as meaningless, empty, and unfulfilling. They found themselves disillusioned with private sector employment claiming it appealed to narrow self-interest. Now in sobriety, they sought out work in the non-profit world because of its appeal to a newly discovered sense of service and social responsibility activated by their years in the program. The experiences of Arthur and Regina illustrate this pattern.

In his drinking life, Arthur (14) described himself as an "entrepreneur/salesman" who had worked in the glamorous world of the theatre. But in sobriety he had "difficulty defining a sense of occupation" until he found spiritual and occupational satisfaction in helping others. His experience of helping a sponsor and sponsee who both died of AIDS led him into health care. Eventually he joined an organization that trained him for pastoral-type work with the critically and terminally ill. He discovered that his experience in the program of learning to handle his feelings had amply

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prepared him for the emotions stirred up in clinical training. While he delivered pastoral care for several years as a member of a hospital team, he found that his business skills, especially his talent for fund-raising, could also benefit the organization that had trained him. Today, "more interested in working with a cause in a useful organization than in trying to make a killing," he devotes more of his time to non-profit capital development.

Regina (12) reported a similar experience. With a long history of employment in for-profit companies, she had held a job in her early sobriety with many perks--high pay, high status, and a limousine at her disposal to take her to and from work. But soon she found that her work was "all about me feeling better about me and a need for a title or exterior achievement where the world would say I'm OK." Now the job seemed hollow and meaningless--"I was my title." She looked for work more compatible with her sober self and, like Arthur, she found satisfaction in the non-profit field--"it allowed me to be who I am so I could be real in an environment." She attributed the change in her direction to being in the program and to her deepening interest in Buddhism which was stimulated by A.A.'s emphasis on

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spiritual development. Today, she views herself as more "outgoing," less driven to control others and solve their problems--"I try to be more balanced at work, take vacations and not be a workaholic." She describes herself as a "change agent," more interested in the development of others than in controlling them. She works with organizations and individuals to "coordinate activities and events so that they work well together."

Other study participants rediscovered personal goals they had abandoned (or had been too fearful to attempt) during their drinking years in pursuit of occupations they had now outgrown. Even this group chose work that had a service orientation. Norman (12) left a "fantasy" career as a night club owner--a "success with no work"--and returned to complete the licensure requirements to become an architect. In doing so, he learned that "process" was more important than product in career, family, and relationships--"to be able to really earn the ability to do what it is that you're doing, . . . to have a career you have to do a lot of bathrooms and have shitty clients . . . but I want to do a good job for everybody."

Amy (24) took up human services after a long career as

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a journalist and editor. Fearing she would be a danger to others because of her own unstable mental health history, she had long ago abandoned her goal of becoming a social worker. But in her 15th year of sobriety she found the courage to return to school for a Master's degree in social work:

> . . . it turned my life around and gave me a place where I felt connected to the world and I feel I belong. I feel like a true contributor, authentic. I feel like a real person who can truly give understanding and appreciate other people's struggles without being maudlin.

Paula (11), fearful of any long-term work commitments, finally gave up her "fantasy" pursuit of an acting career and developed an interest in arts education for children, a field she thought she would never enter because her mother had been a teacher. Jose (20) left a career as a seaman to become an alcoholism counselor for his union. He later worked in a program for victims of domestic violence where he found his counseling experience valuable in gaining the confidence of battered women. Lilly (10) had an established career in hotel and restaurant management. But by the fourth year of her sobriety, she realized she had been living out her father's unfulfilled fantasy of wanting to be a chef, trying to please him. She too decided to pursue a

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career as an alcoholism counselor and acquired her counseling credentials. Today, she looks forward to attending social work school.

Another group of study participants continued to pursue well-established careers in their sobriety. But nearly all reported that sobriety had engendered a deepening commitment to their professions accompanied by a renewed purpose to be of service to others. The experiences of Gregory, Matthew, and Edmund are representative of this group.

Gregory (10) had been a teacher for many years, an occupation he had grown more weary of since learning he was HIV positive. Thinking he would take early retirement for health reasons, he asked his A.A. friends for help in considering his options. He was impressed with their way of helping--they only asked him questions; they never told him what to do. New AIDS medications had revived his energy level and his interest in his work. At the same time, his A.A. experience had changed his decision-making process--now he weighed more carefully what was the next right thing to do. After a brief sabbatical, he decided to return to work and to enroll in graduate courses where he enjoyed the intellectual stimulation of his classes and renewed contacts

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with colleagues.

As a member of the clergy, Matthew (19) had professed a commitment to his church which had taken him to several continents in the years before he stopped drinking. Once sober, he even trained and worked for a time as an alcoholism counselor. But he quickly realized that not only did he want to return to his church work but that being a sponsor in A.A. suited him more than being a professional counselor, which he found too stressful. Now more committed than ever to his congregants, he preferred "walking people on their spiritual journey," and was even open about sharing his alcoholic history and subsequent recovery in A.A. with them. He reported that his willingness to share these experiences had encouraged others in his congregation to seek him out for help with their family alcohol problems.

Finally, Edmund (23) had a long history of working as an executive in the health care field. While he held positions and lost positions, he still maintained a firm commitment to work that, as he said, "benefited humanity." As a result, his interests shifted to mentoring others preparing to enter the field and serving on boards of non-profit organizations.

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Still another group of study participants had arrived in A.A. with unstable work histories. Many had held marginal jobs that allowed them to continue drinking and drugging. None had given much thought to setting long-term career goals. Five individuals fell into this category and nearly all told the same story. James (10) described himself as "unemployable" when he first came into the program. A high school drop-out (he had attended a well-known New York secondary school for academically gifted students), he had developed a serious drug and alcohol problem that led to a chaotic life on the streets, frequent encounters with the police, and a prison record. He entered A.A. as a client in a faith-based social service organization that had offered him work while he tried to rebuild his life. With continued sobriety, he managed to become a supervisor at his job and was encouraged by his mentors in and out of the program to think about returning to school. Despite his fears, he passed his General Equivalency Diploma (GED) exam and took the next step by enrolling in college. Today he was studying computers and had found a job as a systems analyst. Ironically, he saw this as a throwback to what he had always wanted to do

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before addiction claimed his life. But given his erratic history, he had difficulty taking his academic success seriously--"I was a thug; now I'm in the Greek letter society"!

Susan (11) told a similar story of an aimless and potentially reckless existence (she too had an arrest record) fueled by alcohol and drugs and lived, not on urban mean streets, but in the Oregon backwoods. She worked when she could in menial restaurant jobs. Once in the program, this time back in New York, she was faced with the problem of not only where to live but what to do with her life. With the help of sponsors and A.A. peers, she found shelter in a Manhattan single room occupancy hotel and enrolled in an employment training program for recovering alcoholics. This experience eventually led her to attend college where she qualified for entrance into a challenging and nontraditional field for a woman--civil engineering. Today she was finishing her studies and working as an engineer in what she described as her "dream job"--"I'm like this total professional success story":

> I don't think you go through what we went through to get to A.A., much less go through what you have to go through to get sober, and don't emerge with the

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> ability . . . to do pretty much whatever you damn well put your mind to.

Janice (16) recounted a somewhat similar story minus encounters with the law. Describing herself as "unemployed, almost unemployable" when she came to A.A., she could no longer work in her old field (the fashion industry) and stay sober at the same time. Like James (10) and Susan (11), her life had become "unmanageable" (cf. A.A.'s 1st Step) owing to her alcohol and drug abuse. As a sober woman, the only job she could find in the small New England town where she got sober was as a dishwasher. She took it as her first sobriety job. Years later when she moved to New York, she eventually found work in a field for which she had few qualifications--as a photographer's assistant. Today she had a full-fledged career in the same field--"I have a career. I have no idea where it came from"--with potential opportunities of being head-hunted for employment in the burgeoning world of e-commerce. Sobriety had helped her to establish limits for herself and further infused her life with a sense of purpose that she had not had prior to her entrance into A.A. Although she worked in the corporate world, she was very clear about what gave her life meaning. She had recently turned down an offer of a well-paying

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managerial job in a leading "high-tech" corporation because she thought it would be incompatible with her A.A. program. She had already been a manager in her current company but had asked for a transfer because her duties conflicted with the kind of sober life she envisioned for herself:

> I found it very difficult to work the program and be a boss. . . . I just couldn't deal with all the people stuff in that capacity, hiring, firing, with people who were like earth people. People who were nasty and back stabbing . . . . It made me very unhappy. I was constantly bringing work home in my head. And it was taking over my life. You know, I'd lay on my couch all weekend and obsess about it.

Unlike those study participants who left the for-profit world for jobs in the non-profit sector, Janice stayed and found a different kind of meaning in her current work that reflected the service ethic she had acquired in A.A.:

> . . . that I can even handle this job is a sign of my recovery. I could type and talk on the phone at the same time now. I mean that's pretty good . . . that I could stay with a conversation and finish my thought. And I negotiate . . . big deals and money . . . . The interesting thing . . . is that I represent other people so when I close a deal . . . I get excited for the [person]. . . . Even though I'm gonna make some money on it, . . . that's not my first thought. I think to myself, 'wow, he never thought of this when he took this picture. Wait 'til he hears about this job.' So I guess in that way my recovery comes in because I still have a sense that I'm doing service in a way . . . .

Moreover, the lessons she learned in A.A., especially about

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how to manage her own behaviors, seemed to have transferred well into her work life:

> I realize whenever I let go of something even at the office, that's when it . . . takes care of itself. So I do practice my daily living basically when I practice my job and things just kinda move right along. . . . Even my boss is . . . spooked, the way things come around. . . . I'm just grateful and I keep working. And I don't take credit necessarily. I mean even I had a big job basically fall out of the sky and land on my head last week. My boss is the one that found out about it and she told me about it and I said, 'oh thank God'. . . . She goes, 'I think in your case, [Janice], you're right.' But yeah I couldn't a done this even 5 years ago. I couldn't a done it certainly 10 years ago. It would have been no way . . . . There are even days today I wonder sometimes can I do this? If I go in there and I'm tired, I'm in a bad mood, and I'm cranky with everybody. I think this isn't why you're here. . . . So, you know, you just straighten out or go home early. . . . I think my whole life sometimes . . . is to promote my sobriety and if something feels like it's not, I have to examine that.

Nina's (10) work history was also unstable. In and out of jobs while she was drinking and drugging ("I never lasted in a job for more than a few years"), she ended up in a rehabilitation facility where she was to meet her husband who would come into the program with her. For the first time, she also came face to face with her painful childhood history of rape and incest. While she married and had a child in sobriety, she still felt uncomfortable about her lack of career. While she used to inflate her resume with a

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college degree, in fact she had never been to college. In sobriety, she could no longer face lying about her background. Now in a part-time job for five years which also gave her tuition benefits and, with the encouragement of her A.A. sponsor, her husband, and her therapist, she enrolled in a local college where she discovered a talent for autobiographical writing.

Finally, and perhaps most poignantly, Diane's (13) story illustrates how much A.A. had an impact on the career aspirations of a study participant. Diane had been a waitress in New York restaurants before she came to A.A. While she had attempted college, her drinking and drugging took its toll on her and she had dropped out. She had met a man in a bar and married him. Soon after she came into the program. A few years into her sobriety, she became pregnant. But the infant was born severely disabled and would die before he was two years old. Because he had required constant care, Diane's time was taken up with rounds of medical appointments and therapeutic rehabilitation. After her son's death, she needed to reassess her life. With the help of A.A. friends, she did something she had never done before--she became more

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goal-oriented. Inspired by the experience of seeing how much help her son had received from rehabilitation counselors, she decided to pursue a similar career. Overcoming her fears about returning to school and a visual handicap that had sabotaged previous attempts at an education, she found a college-based support program that could help ease her transition as an adult into academic life. Four years later, after much hard work, she graduated and began her career as a rehabilitation counselor working with children. She brought a special sensitivity to her work since she too had once parented a disabled child. She reflected on her success with some irony, "if I had been using, I would never be [sic] able to do this."

The last group of eight study participants faced more difficult and challenging issues in their work lives--job loss, the prospect of retirement, or the need to take permanent disability because of a serious health problem. While each struggled with these life transitions in varying ways and with varying degrees of success, they all credited A.A. and their A.A. support system with help in their decision-making and ability to cope.

Faced with job losses, Dorothy, Harry, and Victor had

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chosen to handle it in different ways. Dorothy's (25) ambitious plans for her own business had fallen apart. Her business reversals also drained her savings. But she did what she had learned to do in A.A. She consulted her "Board of Directors," her euphemism for her strong A.A. support system. Reaching a new level of acceptance of her situation, she decided to return to working for others in order to pay off her creditors. However, though her work life brightened, she recently had to cope with some difficult health problems which temporarily disrupted her work life. Again, she was forced back on the program and the help of others to find new coping resources.

Like Dorothy, Harry (15) faced some serious business reversals--the loss of his long-term business venture and the resulting legal problems which lingered unresolved for many years. What followed was a long bout with depression because the business was, in his words, his "anchor" and his "identity." He sought professional help for the depression and took medication for several years. Despite the shame and humiliation over his losses, drinking was never an option--"the only worse thing that can happen is if I started drinking." When a relative suggested that now he

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had a reason to drink, he still retained his sober perspective and responded--"No, I had an excuse."

Like Dorothy and Harry, Victor (17), an artist and educator, faced a similar difficult work setback--the recent loss of his job. Given his long-term sobriety, he felt disappointed in himself because he still struggled with his hair-trigger temper (his "curse") which had cost him jobs in the past. But he continued attending meetings--"A.A. has never failed me"--and considered his options among which was the possibility of getting additional psychological help.

Tom (17), Bernard (13), and Ricardo (17) faced a different set of choices--whether or not to leave long-standing careers for retirement. For Tom and Ricardo, acceptance came easily and both felt good about their decisions. Circumstances, however, forced Bernard into retirement from his very public career--it was difficult for a man his age (he was 72) to find steady paid work in his profession. However, he could volunteer his services for his union. When he drank, he was never invited to participate in union business. Now as a sober union member ("I think sober"), he was asked to assume a leadership role in helping to create a Code of Ethics for the membership.

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Both Carl (13) and Fred (13) faced a different dilemma. Each had been diagnosed as HIV positive and each had progressed to full-blown AIDS. The outcome was the same--with the decline of their health and their energy levels, they no longer could hold demanding full-time jobs. Carl credited A.A. with giving him the "courage to change," namely, that it was all right to leave a job and retire on disability. This was especially difficult for him since he was in his forties and had looked forward to a longer work life. Today, with the help of a full regimen of AIDS wonder drugs, he had managed to overcome several setbacks. He attended A.A. meetings as often as he could and maintained regular contact with his A.A. support system. Like Carl, Fred was forced to retire on disability at a comparatively young age--in his early forties. In a work-oriented and highly competitive society, he fully understood the consequences of his decision--"I could feel useless and meaningless." But he had managed to use his A.A. experience to find meaning in his present circumstances--"I am uniquely useful to many alcoholics simply by virtue of my existence." Having accepted his current situation, and with the help of new AIDS medication which gave him a "new wind," he

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determined to commit himself anew to A.A. meetings:

> I wanted a meeting that met consistently and that was not predominantly gay, not endangered. . . . I was gonna go there and . . . get what I [needed] to survive AIDS. This was really the plan. . . . it was almost a ruthless assessment of my situation and what was available to me. I was going to try to get from A.A. what I needed to continue to live. And, you know, A.A. was the way to go. . . . And the plan was to find somebody, or some group of people to love, some people . . . who were alive and in life and vibrant and growing, you know, who I could . . . meld with, by virtue of being sober and in A.A. together . . . and maybe that would entice me back to life, get me going in the other way. And, you know, it's the astonishment of life that that actually worked.

Today, Fred had become what A.A. members often call in their own phraseology a "power of example" to others--"I've become a sort of high profile person in A.A. . . . so it is sort of pervasive through my life, you know." What he valued most was the opportunity to do 12-Step work with others:

> What I am sure of [is] that it has . . . contributed to my own personal development and recovery. You know, to work with others is . . . always beneficial. It . . . gives me something. If nothing else, then just a recommitment to my own recovery.

Theme 7 - Changes in social life and environmental context -

Study participants were asked to describe what changes, if any, they had experienced during their recovery in their relationships to significant others which included family, friends, and other loved ones. They were also queried about

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the extent to which they had developed a social support system either in or out of the program. Finally, they were asked to describe changes in their environmental context. This was interpreted to mean changes which had occurred in their activities and interests over the course of their sobriety.

Many study participants reported prior histories of damaged ties to family members--parents, siblings, partners, and children. The situation was painful and more complicated for those 18 participants (60%) who had come from alcoholic homes where they themselves had been subjected to physical abuse, emotional neglect, even incest and rape by a parent, guardian, or other adult figure. As Susan (11), an Adult Child of an Alcoholic (ACOA) reported, we were the "elephant in the living room" family, an ACOA euphemism for a dysfunctional household where everyone knows there is a problem but no one does anything about it.

Nevertheless, despite these traumatic backgrounds, many reported having made significant attempts to repair these relationships with some having more success than others in doing so. For example, Gregory's (10) parents had divorced when he was sixteen. He recalled a strict,

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fearsome father who drank nightly and with whom he did not have much contact for another 26 years. Although he never told his father that he was gay or that he was HIV positive or in A.A., the program, especially his work on a 5th Step with his sponsor, gave him the courage to seek out the older man and try to reestablish communication with him:

> I [didn't] have to say anything. I [didn't] have to do anything. Just hello . . . . And I'm glad I did because I was able to look at him and let go of a lot of those fears. If I wouldn't have been sober, if I would have still been using, I wouldn't [have] been able to do that. . . . We didn't become . . . father and son, bosom buddies or anything, but I was able to call him up a couple of times and just . . . talk.

The program also gave him the confidence to renegotiate a conflictual relationship with his brother. His experience in A.A. taught him that he had choices and that he had the right to set boundaries even if it meant distancing himself from his brother.

After years of estrangement from his family because of his drinking which included being thrown out of the house by his own mother, Ricardo (17) proudly described himself today as her "best son." Because of her active substance abuse, Lilly (10) could not be at the bedside of her dying grandmother, which she regretted. But in sobriety she was able to reconcile with her mother and attend to her needs

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when the older woman became terminally ill. She spoke movingly of having written her mother's obituary and how much this had meant to her.

Norman (12) told a similar story of estrangement from family brought about by his drinking and drugging. In sobriety he found the Steps helpful (particularly Steps 8 and 9) in bringing about a rapprochement with loved ones which he suggested was a way of reestablishing a relationship with himself:

> . . . one of the gifts of sobriety I would say is my ability to hold on to real relationships, real friendships . . . and even go back to some relationships that I . . . pushed away like . . . some of my cousins. I have a relationship with my family. . . . they play a big part in my long-term sobriety because I'm able to maintain long-term relationships . . . . I think . . . my cutting off my family . . . had to do with me cutting off myself.

Norman's overtures to family members included attempts to reach out to his sister who was also struggling with an alcohol problem along with an eating disorder. Although he confided to her about his own alcoholism and the fact that he had joined A.A., he was careful to practice one of the fundamental principles of the program embodied in A.A.'s 11th Tradition--"Our public relations policy is based on attraction rather than promotion . . . ." Thus, he did not

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try to influence her to join the program although he suggested Overeaters Anonymous for her eating problem. Eventually she did find her way to A.A. and he thought his membership in the program might have served as the example that prompted her decision.

But not everyone was successful in repairing these damaged familial relationships. For some, it was enough to discover that their anger towards family members had lessened. Victor, Kim, Susan, and Nina reported a shift in feelings and a far greater acceptance of the difficulties they faced. Victor (17), for example, described years of intense hatred of his father only to find that with sobriety he now saw him as a "sad old man." After many years of conflict with her family which she had experienced in sobriety, Kim (29) spoke of how she had been trying to accept the fact that they were not going to change--"I don't know how much I'm gonna change, but I can sure change . . . my reaction to what's going on." Though Susan (11) was willing to talk to her family and had more "guilt contact" with her mother, the metaphoric "elephant" was alive and well in her family's living room. While Nina (10) could forgive family members for their abuse of her as a child,

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she still struggled to overcome painful memories of a darker, more traumatic past.

Spousal relations and other partnerships changed in complex ways for study participants over the course of their sobriety. For two study participants, sobriety provided the opportunity to heal their relationship which had been damaged by years of drinking. Gail (14) and Bernard (13), the only A.A. couple interviewed in the sample, had been married to each other for many years prior to their entrance into A.A. Though the marriage had been strained by their drinking, they managed to stay together as first Gail and then Bernard got sober. Interviewed separately, each reported that the marriage had only grown stronger as a result of their sobriety. As Bernard commented, "I think we're more adult . . . . One of the curses of alcoholism is childishness." Each attended meetings regularly and had a sponsor, but like other partnered study participants in the sample, they preferred not to attend meetings together citing this as "too confining."

Others formed relationships in sobriety, some with A.A. members, some with partners who were not A.A. members, that seemed to endure. Seven study participants fell into this

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category. Alice (26) had divorced her first husband when she was just a year sober. Subsequently, she met Ken who was in the program. After living together, they married and for the first time Alice had experienced real intimacy. Unfortunately, Ken died, but to her surprise Alice, who had been lonely for most of her life, reported that she no longer felt that way. After many years of disastrous affairs extending even into her sobriety, Emily (23) met and married a man who was not in the program. The marriage proved to be a happy union. Carl (13), the only partnered gay male in the sample, had met Howard in A.A. They had been living together for seven years. Eventually Howard had left the program because he was not only bored but also he did not think he was an alcoholic. Carl, however, continued to attend meetings. For a time their relationship was clouded by Howard's changed attitude toward A.A., though the pair, as Carl described it, were able to reach an understanding:

> . . . as long as he doesn't drink and take drugs in my presence, and he doesn't do it at all, but particularly in my presence, that's important. . . . I didn't feel he respected me going for a while and that was a boundary issue that we had to spend some time on.

For others, however, membership in A.A. did not

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necessarily ensure a successful relationship. In fact, relationships deteriorated especially when a partner relapsed. Tom (17) was married to Beverly who had preceded him into the program. For a time he had attended Al-Anon before he realized that he too had a problem with alcohol. He entered A.A., but unfortunately his marriage was further strained by Beverly's personal problems. Eventually she relapsed. Though still married, they lived apart under the same roof. Tom continued to attend meetings, but his wife did not.

Victor (17) had been divorced before he became sober. Seven years into his sobriety, he met and married a woman in the program. They had two children. But the marriage fell apart after Victor discovered that his wife had relapsed and was having an affair with another man. Victor was still sober through this turmoil.

But even when both partners remained sober in A.A., relationships could still founder. Norman (12) and Joan also met in A.A. and subsequently began living together. Soon after they had a child. In Norman's mind, they were the "model A.A. couple" with the "model A.A. child." But when problems arose in the relationship, Norman found it

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difficult to attend A.A. meetings and maintain "fellowship" with other A.A. members who had known both of them as a couple--"it was all, a lot of it was a lie and I couldn't bear that lie going to meetings." For several years, he stopped attending A.A.--"I couldn't get the program because I was so tied into the fellowship." When he returned to the program, he chose a meeting where people did not know him so that he could feel safe enough to talk openly about his relationship:

> I needed . . . to get the truth out . . . . I wouldn't have had the strength to . . . leave and I certainly wouldn't have had the strength to . . . deal with [what] happened afterwards. You know, I guess I went back to meetings because I get personal strength to just go forward with whatever it is that has to happen.

More importantly, what he found in meetings was not solutions to his problems but a renewed sense of self-agency that helped him to end a relationship that he found dishonest:

> I don't go to the program for solutions. I go . . . for . . . reinforcement for the solutions that I find for myself . . . . I still go there and, you know, find reinforcement for the truth about myself . . . . I still go to meetings and . . . I'm listening and I hear things that bring out the truth about me. And that's what I get from meetings, more than anything else. I don't get the answers. I don't get solutions. I don't get how-tos. What I get is, I go there honestly and openly . . . [for a] connection with [the] truth in myself and I get it . . . .

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Study participants also described the tentative steps they had taken to reconcile with adult children after years of drinking. Of the thirteen study participants with children, three had become parents after they got sober. Two had been step-parents to children in their drinking years (each was married to someone with a drinking problem), while the remaining eight exhibited a mixed pattern of relationships to their children. For example, Ricardo (17) admitted he had never shown love to his children when he drank. Now he was grateful for their show of affection and their requests to him for his blessing, a cherished custom in keeping with his Hispanic roots.

Like Ricardo, Bernard (13) had been estranged from his four sons during his years of active drinking. In sobriety, he had tried to make himself more available to them. For a time it had seemed as if he had achieved some success. He reported a greater calmness in their interactions--"we're easier with each other." But sadly the pattern of alcoholism, as a family disease, was to repeat itself in two of his sons, one of whom (his eldest) tragically committed suicide shortly after his discharge from a rehabilitation facility, while the other (his youngest) still struggled to

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control his drinking. Bernard's stoic reaction belied his true feelings as he recalled watching his older son descend into alcoholism:

> . . . he would get up from a dinner table in a restaurant somewhere and go to the men's room five times. He wasn't going to the men's room . . . he was going to the bar, you know. I've seen that happen . . . I mean being an alcoholic. I know how those things work, you know. You go get your extra drinks.

Ironically, Bernard had received the news of his son's death while he himself was in treatment during his first year. Now, 13 years later, he watched helplessly as his youngest son showed signs of the disease:

> . . . [he] has disturbing resemblances to his older brother, you know. He's getting bloated . . . and we just hope he gets some help eventually.

When asked if he had actively tried to intervene on his son's behalf, he replied:

> . . . it's not that I'm, you know, gonna be the 'holier than thou' father . . . it's just that you can't do it. To me, you can't do it that way. I'm not gonna 12 Step [him] . . . and you have to want the program anyway rather than need it so. It may come around. The other guy [his eldest son] did, you know, [but] it was too late unfortunately.

For some study participants, reconciling with children was not a possibility. Though James's (10) relationship with his ex-wife and former in-laws had changed, he was still estranged from his five children. He was particularly

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frustrated that his teenage son was showing signs of the kind of rebellion--he had already been arrested for marijuana possession--that had marked James's own troubled adolescence. Jose (20) regretted the fact that he had no relationship with his older adult children, though he spoke proudly of a warmer relationship with his sixteen year old daughter who had never seen him drunk. Lilly (10) recounted her sadness over the "unhealthy" state of her relationship with her incarcerated son and the problems she was having with her teenage daughter.

But while mixed patterns characterized relationships with loved ones, study participants reported significant and positive changes in their social support networks since entering A.A. Janice (16) described her social life prior to coming into A.A:

> There were no people. There were bartenders and there were drug dealers, but there were no relationships. There were no friendships . . . . I didn't know how to do it . . . so it's been sponsors and friends that I'm most grateful for . . . .

Emily (23) too expressed her astonishment at the "almost complete transformation" that had taken place in her support system since she had come into the program:

> I have a few friends from when I was drinking, but that's about it . . . . You know, part of my drinking

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> life was that I really wasn't connected to people, so by the time I got sober there was really nobody left except for these particular friends of mine that I'm really very close to.

Dorothy (25) also commented on the significant change that had taken place in her social life:

> . . . you start off going to A.A. every day of the week. If you had friends outside, they kinda went by the wayside. And most of us hardly have any friends left, just some acquaintances. So real honest to God relationships . . . were created and started in A.A. and if I couldn't work out my problems with people in A.A. I couldn't work them out with anyone else there either.

Many indicated that their closest friendships were with other A.A. members. These friendships had been formed over a long period of time and generally remained stable. Only a few could identify long-standing supportive friendships with non-A.A. members that survived a study participant's entrance into A.A. Moreover, only two people--Lilly (10) and Victor (17)--reported maintaining relationships with individuals who drank or drugged excessively. Interestingly, in both cases, they tended either to minimize the other person's substance use or rationalize it by saying that they had never seen the person drunk or drugged. Victor's rationalization of his friend's substance abuse even extended to his own behavior. At one point, he admitted that he had kept a "nonalcoholic" beer in his refrigerator

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as a summer refresher and insisted that it was not a "slip" for him to drink it. In general, however, most study participants would have agreed with James's (10) observation regarding support networks--"it's oxymoronic . . . , if you drink or drug you can't be much support to anybody."

Study participants formed special bonds with other A.A. members. Some relationships were more unidirectional, that is, the flow of support seemed to come from one direction. For Tom (17) whose marriage was severely strained by his wife's drinking, these attachments served an important purpose of supplying him with the needed support that he missed in his failing marriage--"It was really important to me to maintain the quality of my life, that I be around people in A.A. and I hold fast to the program." When Dorothy (25) needed assistance with specific problems, she turned to her "Board of Directors." Each had his or her own area of expertise and would be available to her as she needed them--"There are no secrets and I can't pull the wool over their eyes. They know me." For Matthew (19) who had left his homeland to settle in the U.S., A.A. had become his substitute family--"it's like we make our own family . . . we're in the same leaky boat together." He too

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developed a special "bond" with other A.A. members that he found lacking in his family of origin--"they don't have that capacity for communicating grace." In his words, his A.A. friends "decorate my day" and provide him with lots of "tribal support"--"I just call people [when] I'm not getting fed enough."

Janice (16) found that her A.A. relationships also gave her something special:

> It's not a give and take. I don't go to them because they owe me . . . . They give me perspective . . . . They help me to stay honest . . . . They also love me unconditionally.

One relationship in particular stood out for her. Roger was a gay man who had befriended her and together they formed a special attachment which was cut short when he died of AIDS. For Janice whose pre-A.A. "relationships" were with bartenders and drug dealers, forming a friendship with Roger was a unique experience. What had begun as unidirectional had blossomed into something more reciprocal. Now both seemed to benefit from the exchange:

> I think he taught me about friendship in ways that I had no idea I had to learn . . . . I learned you can have an argument with someone you care about and it doesn't mean it's the end of the relationship. I learned a lot about myself. I wasn't going to run away. I could be whoever [he] needed me to be and put myself aside. I realized what [he] needed was more

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> important than my own feelings. I'm gonna give him what he wants. This was my 'gift' to him.

Reciprocity, in fact, bound most study participants to their support networks. This was not unusual as it was in keeping with A.A.'s emphasis on the principle that "you have to give it away to keep it." Even the most cynical of alcoholics, the "ice man" James (10), internalized this lesson--"The people I'm closest to are in A.A. even though at first I thought they were all liars and jerks and trying to con me." What the "ice man" learned was that he was afraid of people--"I didn't want to need people." Moreover, much like Norman (12), he discovered that developing a relationship with another human being led him to develop a relationship with himself. The principle worked both ways--"if you don't care about yourself, you don't care about others." Now he dedicated himself to a new task--"it's my job to carry the message."

For many study participants, an A.A. support network was unlike any other relationship. As Tom (17) commented, "I don't have friends the way I have . . . friends in A.A." Jose (20) used a more vivid metaphor to express the same idea--now he had "real friends," not "bottle friends." Many spoke of the special understanding they shared with other

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A.A. members. Bernard (13) noted that he could not talk about the A.A. program with non-A.A. people--"they don't understand the program." Harriet (23), who had not attended an A.A. meeting in four years, still managed to speak to an A.A. friend daily and cherished her "kinship" with A.A. members--"we're cut from the same cloth." Such closeness was something she had missed in her own family--"I didn't have that kind of friendship in my family. . . . I think the people in the program . . . understand me better . . . than people in my family." When asked to explain what it was that made her feel so understood, she replied--"that thing inside, that need to drink, I feel is true of anyone who is recovering from alcoholism." Kate (14) also cited a shared "understanding" with other A.A. people in her life that was not there with family or non-program friends. In contrast to Harriet's use of the term, she defined this as an "understanding of codependency." Carl (13) alluded to the special "understanding" that he experienced with A.A. people which he missed even in his most intimate relationships. He defined this as the ability to "identify" with one another--"they know the more bizarre little things [that] can upset you." Arthur (14) spoke of the absence of

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"normal, social taboos" among A.A. members and how difficult it was to communicate with so-called "civilians":

> I mean when we ask each other how we are, we wait for a real answer. And other people don't want the answer. They don't want the real answer. Or they're not prepared to deal with the real answer. . . . most A.A. people have asked me how I am and I'm in distress in some way. I can share with them. And they'll either share some of their experience or they'll just listen. Civilians seem to think that they have . . . to give you some kind of intellectual response to this emotional distress. That I find exhausting.

Similarly, Fred (13) reflected on the "family sort of closeness" he had found in A.A., which was a far cry from the abusive relationships he had known in his family of origin--"I felt like I was being understood. I felt like I was being heard." This was especially important to him since he had to face the dual stigma of his AIDS diagnosis and his alcoholism:

> If I didn't have these people in my life, if I wasn't connected in a very intimate sort of way to these people, I wouldn't leave the house. This is what keeps me going.

Convinced by his reading of AIDS literature that the "familial-like support of a very close, intimate network of people" helped long-term survivors of AIDS, he set about to develop a wider "circle" of people--"I already had it in A.A. and I just went to it more. I created more of it for

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myself in A.A. . . . . It gives me a reason to live." He found that taking this action coincided with what the A.A. literature (especially Step 4) had taught him about alcoholism, namely that the alcoholic needed to learn how to "form a true partnership" with other people:

> So many gay men have difficulty with or put enormous amount of stock into a relationship whether it works or not, especially sexual intimate relationships. And A.A. has taught me I can get . . . an enormous range of my emotional and spiritual sort of psychological intimacy needs met by all kinds of people in all kinds of appropriate ways in A.A.

Study participants experienced other benefits from their social support networks. Amy (24), who had struggled with her manic depression, credited A.A. friends--"the only people I've known over the years have been in A.A."--with literally helping to "walk" her through one of her worst episodes. She cherished their "shared language," though she acknowledged that even with years of sobriety, she still had difficulty maintaining a "balanced" support network. Diane (13) spoke movingly of the support she had received while caring for her severely disabled infant son--"they were there when my son was born and when he died." This was unexpected given her previous experience with friendships which now seemed "superficial" to her--"When I got sober,

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99% of people I knew were gone." Kim (29) recalled how, during a recent hospitalization, A.A. friends had brought a "meeting" to her bedside and helped her to celebrate her 29th sober anniverary.

For some study participants, the development of a support network within A.A. provided an opportunity to hone and refine social skills, once lost to drinking, in readiness for use in the larger world beyond A.A. The program became a kind of symbolic interactional space where recovering alcoholics could practice or reclaim those skills. For example, Emily (23) spoke of the importance to her of "peers having peers":

> . . . it connected me first to A.A. and then I could extend it to outside and because I wouldn't have a life if I weren't sober . . . . I wouldn't be able to do anything if I were drinking.

Similarly, Dorothy (25) recalled how she had learned to relate by watching and imitating A.A. people:

> . . . I'm an observer. I came into A.A. and I watched everybody. And I checked out those who seemed to be pretty comfortable and I did what they did. I think that's still the case. We always have a lot to learn from somebody.

As much as study participants described changes in their social networks which helped to develop their relational skills and broaden their perspectives, many also

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reported significant changes in their activities and interests over the course of their sobriety. Where alcohol and drugs had once been their sole preoccupation and the social lubricant for their interactions, sobriety presented a new challenge--what to do with unstructured time. Moreover, with sobriety came the realization that addiction had fostered a self-centeredness and a restricted, if not socially and spiritually impoverished, lifestyle.

The service ethic promoted in A.A., especially the example of others--sponsors and peers--actively engaged in the most humble of meeting tasks (i.e., making coffee, arranging chairs, setting out literature, doing clean up) was recalled as the first and most painful reminder of just how narrow their world had become. Even after 29 years in A.A., Kim cited service as the "most important thing" in the program. She particularly remembered performing a meeting-related task--"you never . . . forget making the coffee . . . and it's usually something you do for your own sobriety." For many, such humble service in A.A. spurred a movement away from a preoccupation with self and contributed to an awakening of a social conscience that in turn found new expression in the world beyond A.A.

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Both female and male study participants reported such a transformative pattern taking hold in their sobriety. Despite the fact that she had worked as a helping professional throughout her drinking life, Alice (26) admitted that she used to be "so self-centered." She had never given much thought to supporting social causes. Now she found herself contributing money to social welfare organizations. Emily (23) described the shift in herself as a movement toward more active participation in socially responsible causes:

> I think the difference between myself today and myself as a drinking person is that when I'm interested in something today I do something about it and I get involved in it and I learn about it in as many ways as I can either experientially or by reading, talking to people. . . . so there isn't this gap between what I care about and how I'm actually spending my time.

Unlike her drinking days, today her interests ranged from homeless families, welfare reform, teaching, gardening, and even contributing time and effort to her church.

Kim (29) reported involvement over the years in a host of activities designed to "get me out of me." Though A.A.-related, they extended beyond her own meeting attendance to "commitments" to answer phones at New York Intergroup, bring meetings to hospitals and other

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institutional settings, start a "Big Book" meeting, and conduct Step-study groups in her own home. All the while guided by a fundamental A.A. service principle, she commented--"you gotta . . . give it away to keep it. And I want to keep it."

Janice (16), who had once counted only bartenders and drug dealers as her "friends," now described a less narcissistic, more prosocial sober self with interests in theater, concerts, and museums. In sobriety, she even helped neighbors in her apartment building, something she had never done before--"I kinda make myself available if people need help. . . . it's this . . . sense of community almost that I never had before and these are people that don't know that I'm in A.A." She also became active in her church and in AIDS fund-raising:

> These things I never would have done, ever, well I might have thought of them. I doubt I would have thought of them, but had I thought of them I would never have been able to do them because I wouldn't have been able to physically show up and get it together.

For Janice, this activity was a far cry from the "life" she had lived drinking and drugging:

> I mean I have a life. I get mail . . . . It sounds so silly. You know, I get bills. I had debts, but I didn't get bills. I had no existence. I had no life. It was just scrambling and franticness . . . to

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> recover enough, to drink enough. And just this sense of panic all the time. I never had an existence in between and even the times I tried, it didn't last long.

Sixteen years of recovery had produced a radical transformation in the way she presented herself to the world--"I think my whole life sometimes . . . is to promote my sobriety and if something feels like it's not, I have to examine that."

Much as female study participants reported changes in their interests and activities, many males did so too. Arthur's (14) experiences with an A.A. sponsor and sponsee who had both contracted AIDS and died of the disease led him to abandon a career as an entrepreneur and take up work with the sick and dying. He credited his A.A. experience of speaking in public with helping him to become a more articulate spokesperson for social causes. In sobriety, he joined the boards of several activist organizations and used his previous business experience to help fund-raise on their behalf. He also remained committed to his A.A. program and opened his home to groups of fellow alcoholics who met to discuss related addiction issues. Gregory (10) described a similar transformation in the scope of his activities. Once consumed by his life as a barfly, in sobriety he became an

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advocate for gay issues and AIDS-related causes.

Other male study participants reported becoming more engaged in activities that supported A.A. and recovery. Harry (15) published a neighborhood A.A. meeting directory at his own expense. At one time he too volunteered to answer phones at New York Intergroup and even distributed anniversary coins to newcomers who had reached the three-month mark--"I like the idea that I'm doing service and I like the idea if somebody becomes aware of it." Matthew (19) conducted alcohol-related retreats for recovering women. Raymond (21) volunteered to answer phones at Intergroup, founded a meeting in a new venue (a synagogue) and continued to contribute to charities--"it's part of my religion." A veteran of the Second World War and an unabashed American proud of his wartime service, he even found time in sobriety to join a patriotic organization. Tom (17) became active in regional A.A. activities and brought new energy into stewardship projects in his church. He reflected on the internal transformation that had spurred all this activity:

> I wouldn't be able to do that . . . the focus would be all on me and not what had to be done or . . . not what is needed to be done . . . . There would be no sober approach to it if I didn't do that. They wouldn't want

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me there otherwise because I was . . . too arrogant. During his drinking days, Bernard (13) had been an inactive member of his union's board. Now more than a decade into his sobriety, he was asked to take on a critical role--to head an Ethics Committee and draft a Code of Ethics for union members.

Jose (20), also a union member, had started an A.A. meeting at his union's headquarters. For a time, he even had become an alcoholism counselor having trained in the very program which had recruited him as a research subject when he had been drinking! No longer a counselor, he still felt compelled to do volunteer outreach work to street people with alcohol and drug problems. After 10 years in the program, even James, the "ice man," had melted and developed a social conscience. He became interested in prison conditions, a subject he knew well from personal experience in his previous life, and lobbied local politicians for more funding for education in prisons.

Theme 8 - Development of spirituality -

A.A. literature promotes the idea that alcoholism is a "threefold" disease--physical, mental, and spiritual (see, for example, Steps 2, 3, 5, 6, 7, 11, and 12 which emphasize spirituality). Given A.A.'s encouragement to members to

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develop a spiritual life, study participants were asked to comment on the relevance of spirituality to their sobriety and to describe how this dimension manifested itself, if at all, over the course of their sobriety.

For many prospective A.A. members, spirituality is a controversial subject. Newcomers to A.A., reading the famous "window shades" that hang in every meeting room on which are printed A.A.'s 12 Steps and 12 Traditions, often complain that A.A. is too "God-focused." Some confuse A.A.'s spiritual message with religion and use this as an excuse not to return to meetings. Those who choose to stay either embrace the suggestion, find it irrelevant, or seek out meetings openly promoting a more "agnostic" or "atheistic" perspective. Interestingly, A.A.'s sensitivity to these complaints led it to devote a chapter in its "Big Book" to the concerns of the agnostic (A.A. World Services, 1976; see Chapter 4, "We Agnostics").

While study participants expressed varying opinions about the importance of spirituality in their lives, none disavowed it completely as inessential to their experience of getting sober and staying sober. With the exception of a few participants who had difficulty articulating their views

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or thought the subject was best left unspoken, many were eager to discuss their own spiritual development. In fact, a majority saw it as central to the maintenance of their sobriety. Several even commented on this interrelationship. Dorothy (25) indicated that it was "difficult to separate [her] spiritual life from [her] long-term sobriety." Janice (16) noted that without spirituality, she could not have stayed sober. Bernard (13) thought that the two went "hand in hand." And Carl (13), the AIDS survivor and one of the few who was raised as a non-believer, saw his sobriety animated by a faith acquired by his active attendance in A.A. and sustained by the example of others who had faith. When asked how A.A. had given him that faith, he replied:

> By coming back and . . . showing up . . . at meetings over the years. Seeing that people had faith and that it did good things for them. Most everything I've gotten has been just from coming to meetings for a long time. And seeing people leading good lives . . . and things work for them makes me want to have that stuff too.

Many study participants were careful to draw a distinction between religion and spirituality. Some did so out of anger over troubling experiences with the organized religion of their childhood. Others expressed resentment over inherited dogmatic beliefs that either induced guilt

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and foretold punishment for unaccountable sins or no longer seemed relevant. Still others felt cast off and abandoned by the faith of their forebears after years of destructive drinking, while a few, who had entered A.A. firm in their religious beliefs, were surprised at the evolution in their own thinking. For all these study participants, spirituality would take many forms--the discovery of new spiritual practices (ex: meditation, prayer, even conversion), the enrichment of older firmly held beliefs, and for some, the liberation from oppressive formal "religious" teachings of their childhood. A few, however, either remained skeptical, struggled still to find a faith that worked, or discovered their spirituality in nature, in the connections made with others in A.A. meetings, or in the desiderata of everyday life.

James (10), the "ice man," recalled painful childhood memories of drunken clergy who forced him to learn the Ten Commandments with a razor strap. Religion for him was "man-made," while spirituality, as he came to believe, was the "individual's relationship with a Higher Power." A.A. was not his "church," but much to his surprise he conceded that it had given him, in the language of A.A.'s 11th Step,

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a "conscious contact" with something outside of himself. Ricardo (17) was raised as a Catholic--"I love God and I love the Catholic Church." But he hated priests--"They have rules which I don't like." For this reason, he would not attend Mass, although he prayed in churches when no one else was around. In his view, A.A. was a "very spiritual program" which he preferred because "A.A. doesn't have no [sic] rules." He attributed his long years of sobriety to an external locus of control--"God gave me a chance [and] God would see me if I took a drink."

Norman (12), the son of Holocaust survivors, had entered A.A. having rebelled against "his father, religion, and the Holocaust"--"I didn't want there to be a God, because there were so many questions that were unanswerable like why, you know, did the Holocaust happen? Like many newcomers to A.A, he recalled how the "God stuff" in the Steps had at first alienated him. He recounted the following experience that led to what he called his "spiritual awakening." Early in his sobriety, in a fit of anger over something he could no longer remember, he had smashed his hand on a brick wall and had broken it. His sponsor gently suggested that perhaps, in a perverse way, he

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was asking for hope. He encouraged him to pray and ask for hope. Shortly afterward, Norman found himself attracted to a woman in the program. She ignored his blandishments but remained friendly. To his surprise, he learned that her name was "Hope"! Norman was stunned into a new revelation, but not the kind he had expected:

> . . . when she said that, it was like that was my spiritual awakening . . . it just clicked . . . it just made all the sense in the world and I went 'god damn, he [his sponsor] was right' and . . . right away I'm thinking I should have prayed. I should have asked for a lot of hope and then she'd come with me that night and I'd get lots of hope and not just a little . . . . He was saying all he needed was a little bit of hope and that's exactly what I got and I just went like, 'oh God, my Higher Power has got a sense of humor.'

For the first time, he was able to distinguish between spirituality and religion--"a real center point in my whole recovery [was] seeing for me the difference . . . . " Religion was "dogmatic" and "separatist," while spirituality opened up a new horizon that connected him to others:

> There's no difference between me and you. I may be Jewish, my background is Jewish and yours may be Catholic. I don't know, but there's no . . . the God, it's the same thing. You know what God is, if it's a he or she or what, you know, doesn't matter, but that there is something. You know, it's like knowing that there's something that ties it all together, whatever it is . . . .

Arthur (14) felt that he had always had a strong

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religious bent and had attended church as a younger man. He would even postpone drinking when serving on church committees. But like other study participants, his "theology was a relationship with a very punitive God" with whom he was trying to "get good." A.A. made him realize that he didn't have to be "good"; rather he had to be "willing." When he admitted he could not stop drinking (in A.A.'s terms, that he was "powerless"), he received help. Later he returned to his church and "heard the same message for the first time in 38 years." Like Norman, Arthur used revelatory language to describe this transformation--A.A. was an "awakening." A perceptual shift had occurred; surrender and help-seeking were now components of a spiritual experience:

> I mean that change in my thinking. That instead of saying to God, 'I'm going to change to be acceptable to You, but please don't punish me for what I did last night.' I mean that now I go and say, 'I need help. I want to do what You want me to do and I want You to help me not to do the things You don't want me to do.' Instead of thinking that I somehow can do it. I firmly believe that my alcoholic genes are still alive in me and certainly the thinking is in my brain. It's that surrender that is the healing, but the healing is temporary, daily. And I think for me that's what they mean by maintaining our spiritual condition, is that surrender, the constant surrender that I'm powerless over this.

Arthur defined spirituality as more than religious practice.

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He even suggested that spiritual growth produced personality changes that led to a surrender of untenable aspects of an old self:

> I now think of talking to my sponsees as spiritual . . . or to my sponsor. Because . . . it's my experience that when I'm truly trying to help another alcoholic and not distracted by my own stuff everyday, that something is passing through me that is more than me. I find myself more patient than I'm normally inclined to be. I find myself more articulate than I'm normally inclined to be. I find . . . myself saying things I didn't know I knew. And all of that for me is a part of spiritual practice.

Fred (13) was raised a Catholic and while he liked the "big ceremonies" and maintained a "sort of genetic connection" to the Church, he no longer identified himself as a Catholic. Years of drinking, drugging, and high-risk sexual activity--the "free-for all" that had been his life--had left him physically, emotionally, and spiritually depleted and strangely disconnected from himself:

> I think you could look at my entire life as . . . an ordeal . . . or an adventure that I had been thrown into without being asked, from the moment I was born 'til I landed in A.A. . . . in some ways [it had been] foisted upon me, and in some ways [it] just sort of landed on me . . . and I went along with it. But I had not been a participant.

He first entered A.A. in 1980 out of desperation to "try something," but it took five more years of profligate living and an HIV diagnosis before he resolved to

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"surrender" and accept help:

> What made it different this time . . . was that all else in my life had been cleared away. I had no lover anymore. He had thrown me out . . . the chains were locked. I was not working and unable to work. I had no thoughts of any kind of career . . . . My family wouldn't talk to me. . . . My life was down to a very simple question, did you drink today or not? What do you want to do?

An A.A. friend gave him a place to sleep and gently reintroduced him to the program including A.A.'s 3rd Step prayer. Fred credited this as the beginning of his spiritual transformation which also seemed to have induced in him a profound intrapsychic shift. In halting phrases, he recollected this experience:

> I think what happened, it was the first . . . I had a real . . . it was the first time I had experienced myself, experienced my own sort of deep life's need for there to be a power greater than me, for . . . for these words that I was saying to hit somewhere something. . . . I mean I still say that prayer . . . . I say it almost everyday of my life. . . . It hasn't changed the nature of the universe or the nature of any power that's in charge. What it's done is that it has changed me. . . . it changed my experience of my life.

Once disassociated from himself and his own experience, he described a new internal and more integrated selfstate--"I'm now present in a way that I wasn't before":

> I think the guy that I was, that's a guy who needs a drink, who really needs a drink. And the guy that I am, I certainly don't need a drink. And I have my

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> own . . . I'm here in my own life. And I just can't imagine a moment where I would choose to drink. . . . that was the absolute point of beginning of my own personal development. And, you know, that experience of having gone . . . through this surrender and having reached a point where . . . if I just surrender I get everything, I mean everything I really want which was simply based on, if I'm in my life, then I get my whole life. If I'm not in my life, I get nothing.

In this reconstituted selfstate, he was to experience a range of feelings once unavailable to him:

> I was now in my life, . . . it no longer became about where my life had always been about excitement and grief and denial . . . of such, you know, loving and fearing. Now it was about my experience of grief and my experience of excitement, my experience of happiness. It was now . . . there was a new factor and it was me and . . . I liked it. It made all the difference.

The experience of self-consciousness, a connection with self, became the basis of his connection with others. Smiling at a newcomer in a meeting became a spiritual act, the power of which he recounted again in faltering language filled with revelatory imagery:

> I have a full recognition of how important I could be to them. I have a knowledge of . . . my delight at being useful to do that. I have a very serious, grateful acknowledgement of the fact that I am sober and that I . . . I have a duty to pass it on. . . . just the happenstance in God's world that we ended up here together. . . . I think in that moment I have a greater opportunity of realizing, of having a . . . a conscious contact with . . . with, you know, . . . a sense of a . . . of a power greater than me than at any other moment. But I don't think that

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> necessarily means that there is, you know, there's more God in my life at that moment or I'm being more of a spiritual person. It's just . . . it is the, you know, the miraculous sort of moment that . . . most gets my attention and that I most appreciate. Just saying hello to somebody . . . acknowledging the connection, sort of under God that somebody else who, like me, just . . . wants some help, just wants some help.

Experiencing this connection with others was, he insisted, at the "core" of how he maintained his sobriety.

Other study participants spoke of early spiritual yearnings having been thwarted by the destructive bent of their drinking. Interestingly, though from different faiths (Catholic, Protestant, Jewish), they used the same language to describe their alienation and reported nearly similar transformative spiritual experiences, again using revelatory imagery, over the course of their sobriety. Janice (16) remembered feeling lost--"I [felt] as though God [had] forgotten my address . . . like maybe he [was] done with me." Once in A.A. she received the "grace of God"--"There's nothing different between me and a wet brain in a hospital bed except that I received grace." She particularly resented the fact that therapists never understood or accepted the spiritual aspects of recovery:

> One of the greatest gifts of sobriety, the fringe benefit, has been a relationship with my Higher Power. I had a sense of it as a child, but I thought I'll

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> deal with Him later. . . . In A.A., you don't have to believe in God to be an alcoholic or be in recovery, but it's been my experience . . . the ones that don't believe in God. I have yet to meet an agnostic who has successful long-term sobriety.

Janice had explored several religious traditions, none of which felt right to her--"it's up to me to do the homework and that's a change." She found more comfort in reading A.A.'s "Big Book"--"that's where the answers are and the help is there."

Like Janice, Paula (11) recalled feeling that when she drank, "God wasn't paying attention to my case." A.A. had taught her that:

> I have some kind of purpose. I have no clue what it is. It's the curiosity. I need to show up to find out what it is.

A depressive who took prescribed medication, she credited A.A. with having deepened both her optimism and her faith:

> . . . it's more up to me and I have to keep the channels open. . . . I have a real three year old's sense of God as [an] all-loving Higher Power. We're put on earth to be here for each other and relate to each other.

At the end of her drinking, Alice (26) too had wondered "if God forgot about me." Once in the program, she began her "spiritual journey." She read the works of Thomas More, went on retreats, and consulted a spiritual adviser who turned out to be knowledgeable about A.A. and alcoholism:

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> What happened was the sense of stopping the destructive bent and being able to go on a journey based on spiritual principles and honesty about what am I capable of doing and being able to do, something that I like to do and that I have some capability [of doing].

When asked to enumerate what she meant by "spiritual principles," she offered the following definition:

> . . . to look to ourselves, to who we really are, to be honest, to live and let live . . . . What we learn in the program is look to yourself and your behavior and take responsibility for yourself.

She too described her experience in revelatory imagery. Her sobriety was a "gift from God." Like Fred, Alice's "spiritual journey" had a psychological dimension but of a different kind--"That my life is so much more integrated than it was. That . . . divisiveness is gone. I'm a whole person." Even her understanding of her religious upbringing had changed:

> I grew up learning about sins. I remember learning that drunkenness was sinful. I used to think that being drunk was a sin, but I've come to realize that drunkenness alienated me from what was good from other people. That was the sin. My separation from God. I believe that God is in all of us. I was alienated from that spiritual center. It's a matter of understanding. A.A. is a program based on spiritual principles. It says we shall come to know God and call Him by name.

Kim (29) described a strong "religious life" as a child lost to her as an adult in a haze of alcohol. Entering A.A. was a "miracle." It was then that her "spiritual life"

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began:

> Spirituality . . . has something to do with God and things that you can't touch . . . . All the stuff like acceptance and . . . love and caring for people and the . . . feeling that's . . . in the room . . . is from some spiritual realm.

While Kim had difficulty finding words for her experience, she knew that "something in [her had] changed." But abstinence was not enough to solidify this change:

> You have to work the Steps and you gotta read the literature. And I think once you start doing that, it just opens us up to all kinds of stuff. I mean you become curious. I don't know how you . . . could not be and then you start searching.

Her own search led her to convert to Episcopalianism when she was 13 years sober.

Dorothy (25) related how her devotional life had been subverted by her drinking. As a result, she entered A.A. with a "hollowness" and an "empty hurt." She was at first reluctant to discuss her spiritual life as if talking about it would have made it magically disappear:

> I think you live the spiritual life. You live it, you breathe it, you don't talk it. Lots of times I think when people talk [about] it so much you run the risk of losing it.

Eventually she described a dramatic moment in her first year when she entered a church she had left years before to ask for help:

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> I asked God to take care of me. And my sobriety turned. It was dramatic. And I didn't realize it at the time, but months later I realized . . . what had happened. Because up until that point I resisted the program. I was scared to death of it. I think I still wanted to drink but I wanted to stop hurting. And from that moment on I was in the program. I took the suggestions. I was committed. I surrendered.

She too used revelatory language to explain her transformation. A.A. had become for her a place of "healing" where "miracles of recovery" occurred--"That's why it's a spiritual program." Self-effacing to the end, she was "humbled by others who [seemed] to be more spiritual" than her. Finally, Victor (17) spoke of how he had "hated" God for abandoning him as a boy and admitted he had even blamed Him for giving him drugs. In a somewhat confused narrative, he recounted the surprising discovery he had made when he first entered A.A.--"I have a right to believe in God. He doesn't belong to everybody else." From then on, he came to believe in a "force" out there and felt "blessed," though he could not always explain why.

Still others came to A.A. with firm religious convictions and a set of traditional religious practices. When he drank, Matthew (19), a clergyman, believed in a "punishing" and "punitive" God who had "His rules and they were absolute." When he got sober, his vision of a deity

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changed. He "started believing in a God of a second chance" and incorporated this belief into his spiritual work:

> I don't use that sort of moral guillotine that, you know, some . . . use, you know, ha, ha, you've had your chance and . . . you've screwed up. Therefore, you know, you haven't got another chance.

Now his relationship to this Supreme Being changed:

> I knew that God had forgiven me a great deal but I knew that He was gonna have to forgive me all that stuff that was in my . . . 4th and 5th [Step]. And . . . it forged a sort of relationship where I knew God was just gonna do things for me. I thought I had to do things for God. . . . I used to tell myself, 'well, God, I'm doing this for God.' But it seemed to switch around in sobriety. God says, 'look, I'm gonna do . . . a lot for you and . . . what I do for you is really just a sign of what I'm gonna do more of.' Does that make sense?

For example, in sobriety, he noticed that he had become more peaceful whereas when he had been drinking he was always nervous and fearful--"I didn't know what I was doing to make myself so peaceful." Now his "A.A. God" had given him "a lot more freedom." This was a far cry from his earlier conception of a deity:

> I think my old thinking was that God was out to test me and trick me and perhaps pull the carpet out from underneath me and now . . . I just see this gracious, delightful . . . power, you know, just giving me new things . . . .

For Matthew, a "spiritual journey" in A.A. was unlike his religious experience. Where A.A. promoted an admission of

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"powerlessness" and "unmanageability" (Step 1) as the precursor to a full and meaningful sober life, he believed that his church would have dismissed this as "irresponsible" behavior.

When Tom (17) came to A.A., he had an unshakable faith in his own self-righteousness--"I used to be a fire and brimstone kind of guy; . . . if you did something, you got punished for it . . . [and I'd] be there to act as the avenging angel." In sobriety, he found it difficult to hold on to his absolutist thinking. He experienced the unexpected--his own humanity. Where his arrogance and egocentrism had kept him isolated from others, now he began to experience what several other study participants had also reported in their spiritual narratives--a normalization of self that connected him to others:

> I think I'm becoming more human . . . I'm beginning to have an idea of my right size, who I am in relation to everything else. That's what spirituality has done for me.

While he still exhibited a dichotomous mindset, he welcomed the struggle to stay open to this new experience--"maybe my ears have better opened more . . . and so my heart can hear it":

> I've been part of the darkness enough. I want to get

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> into the light . . . doing what God wants me to do, being productive, reaching out to others, having a sense of community, loving with generosity, without hesitation . . . and with enthusiasm. I'm not there yet, not by a long shot.

Theme 9 - Reflections on the Meaning of Sobriety -

Having accumulated a decade or more of time as sober members of A.A., study participants were in a unique position to reflect on the deeper aspects of their experience of sobriety. They were asked to make explicit their thoughts and feelings about this experience and to interpret its meaning. Specifically, what did it mean to be a long-term sober person? What role did sobriety play in their total life experience? Were they ever faced with an urge to drink? If so, how did they overcome this urge? What kept them, and continues to keep them, from picking up a drink? What do they do on a daily basis to maintain their sobriety?

When asked to explore the meaning and significance of their long-term sobriety, some study participants interpreted this as an invitation to focus on the quantitative aspects of their experience, though this was not the intent of the question. Interestingly, more male than female participants tended to discount the importance of quantifying their years in the program. Harry (15)

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expressed anxiety over the fragility of his experience--"By all logic, I should not be sober. . . . Five minutes from now I really believe something can happen that could cause me to drink." Victor (17) found it embarrassing to contemplate his time--"I'm just a person who's stayed sober for 17 years." Carl (13) was matter-of-fact about his experience:

> It just means that I've done it for 'x' number of years. . . . since I have more experience, I have more insight into certain things and the ability to handle things may be better, but it doesn't mean anything more than that. It doesn't mean anything . . . just that I've been doing it.

Arthur (14) was humbled by his length of time and careful not to ascribe too much meaning to it because of the potential for relapse:

> . . . the longer I'm sober the less I have any answers, the less I understand alcoholism, the more aware I am that it is one day at a time. The more I've had, the more you're around it, the more you see people with long-term sobriety relapsing. So that I don't put much significance on the time . . . . I certainly don't think it makes me immune to anything.

Nevertheless, he felt protective of what he had come to regard as a "profound" experience that left him, an extremely articulate exemplar of long-term recovery, nearly speechless:

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> I mean the time itself means nothing, but the recovery is profound. You know, in a sense I was one of those people who, when I picked up my first drink and had more than enough, I felt like I fit in the world. Ultimately by the end, I felt like I was less a part of the world than ever. Now recovery, being sober, has made me fit in the world again, in a real way. . . . but I realize how hard it is to articulate the process. We experience it and the results of it, but when you ask what it means to me . . . I mean the results are so profound and so pervasive in my life, that it's hard to put your finger on it.

Tom (17) felt that the "quality" of his life was more important than the "quantity" of his time and was not "too overexcited" about having 17 years of sobriety. He was more preoccupied with the "challenges" that remained in his life which needed his attention.

Interestingly, among the women, only Kim, with the greatest length of time of all the study participants--29 years--interpreted the question in quantitative terms and expressed discomfort over quantifying her time:

> . . . a lot of people are . . . impressed. . . . There's something about just having that much time . . . so much time doing anything . . . becomes a little significant. [But] that can get uncomfortable. You don't become a seer. You've just been doing it longer, that's all, you know. . . . it seems to me the only thing you really can have is just more experience and that gives you . . . a certain knowledge . . . .

Like many respondents, she disavowed any active hand in the process of maintaining her sobriety and attributed it to some divine intervention:

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> I'm not the one that's kept me sober. . . . I didn't rack up brownie points. . . . it seems like the whole thing is . . . in the realm of miracles . . . and something that I had very little to do with. I gotta show up. And . . . that becomes important and I think just by staying sober you start taking the responsibility of a lot of things like that for yourself. . . . but mostly . . . it's another day, another year, another something, . . . and every now and then it sort of gets my attention and I think, God, you know, my next anniversary I'm gonna have 30 years, God willing, if I make it. . . . what boggles my mind and gets my attention is just the fact that it happened to begin with. . . . I hope I never lose that excitement . . . that wonder or awe . . . it's a miracle.

When pressed to explore further the qualitative aspects of their experience, study participants gave more affirmative responses. Many used the same kind of inspirational language that marked the answers to questions about their spiritual development. Their sobriety was a "miracle," a "gift," and they felt "blessed." James (10), the "ice man," noted that with experience came a more "positive relationship" with himself as well as with others and an ability to "recognize emotions without running away from them." He recounted an experience of having attended a church christening and reflecting that the event generated a lot of resentment in himself. When he shared this with a friend, a seminary student, he realized how angry he was with his religious background. Jose (20) expressed

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gratitude for what had been done for him and what he in turn could do for others now that he was sober. He recalled how, when newly sober, A.A. members paid his plane fare to attend his father's funeral in Puerto Rico. They ticketed him on American Airlines and told him that if he felt like drinking he should look at the letters on the airplane's fuselage--"A.A."--and imagine that they stood for Alcoholics Anonymous. Ricardo (17) welcomed his "17 more years of life" and his improved ability to communicate with his adult children. Bernard (13) observed that his long-term time meant being "comfortable" and "peaceful"--"There's an inner peace there, I think, that I have, that I never had before"--and that it put him closer to a "Higher Power, a deity, whatever," a concept to which he had never given much thought.

Fred (13) counted himself "extremely fortunate, in a blessed sort of way." He was a survivor--of the gang he ran with in his youth, all were dead except him; of his sober friends with AIDS, only a few like himself were still alive:

> I don't think I deserved this any more than anybody else did . . . just like I don't think I deserved AIDS, just like I don't think I deserved to be in ACOA in the first place or an alcoholic in the first place. . . . neither did I deserve to be sober. But the fact is I am, and I am extremely grateful for it.

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Matthew (19) was "thrilled" with his sober time, though he too minimized the importance of his year count. Typically, his response was filled with wry humor:

> I never thought that I could do it . . . . When I first went to A.A. I thought, 'ugh, I'm not gonna get in with this crowd. I'm just gonna become an affiliate member. I'll get their magazine and . . . I'll give them some money . . . I'll give a check to A.A. I don't wish them any harm. But I really don't want to get intimately involved with them.' And . . . now I can't get enough of Alcoholics Anonymous!

As a clergyman and emigre to the United States, he found a special meaning in his sober time--a chance to reinvent himself in the New World:

> So it means . . . some very important things, you know. . . . I can change . . . or I can be . . . the recipient of change like God can take man and mold me into something wonderful which I certainly never had any intention of being. So . . . what it means is that . . . God can do something for me which I can't do for myself. And I can get out of the way and let Him do it. I was always very much in the way when I was drinking. And I thought I had to do all those wonderful things for God. Now what does it mean to be 19 and a half years sober? It means . . . that beyond my plans of coming to the country to die, because I felt so wretched . . . I've just been given a whole new, really another life, another life in another country. . . . I've got a new passport, a new country, . . . I feel sort of new. And . . . one of these days I may even have a new accent, who knows. I doubt it.

Dorothy (25) spoke passionately about the meaning of her long-term sobriety. All her life she had envied what

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other people had. Now the situation was reversed:

> Now they want what I have. What I have for the most part is comfort with self and a familiarity with a spiritual life.

She recounted a difficult passage in her sobriety filled with interminable health problems:

> When you get through those things, you know the unnamed horrible fears and anxiety in recovery in those earlier years. Phew. You know, I sometimes wonder how we all do it, but we do it and then we get at the other end and there's real rewards, the comfort. I like being with myself.

Then she spoke of the advantages of long-term sobriety and how A.A.'s accumulated practical wisdom became seamlessly integrated into her personal experience:

> Sober experience is a clear advantage. I have a lot more experience than a lot of people doing the same thing. It's clearly an advantage. We learn a lot by that. . . . You know, coming into A.A. you're . . . I have to use the word 'brainwashed,' but we're told things over and over . . . again and finally after 15 years 'oh yeah, that's what it means.' And so all of that repetition, meetings, repetition, the Steps . . . comes into our pores and we live it. We don't talk about it anymore. We just live it. That's some of the advantages. I don't have to suddenly think, 'oh what Step am I going to apply in this case'? You do it, you do it, it's part of your life.

Regina (12) identified her act of help-seeking--her entry into the program--as her "spiritual awakening." "Eternal vigilance" and hard work helped her to keep and maintain her sobriety:

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> What it means though, that 12 plus years, is to grow up and to be . . . a productive member of society from the woman who came in and who couldn't stop drinking for 45 minutes night and day, to be able to help others with estimable things, to be there for people who couldn't be there for me, like my family. To do it as I said gratuitously is, you know, a major spiritual turn around.

Kate (14) spoke of the "normalcy" she felt after years of "trauma and disarray" in her life. Lilly (10) described her long-term sobriety as the "milestone" of her life which gave her "clean reference points." Susan (11) unabashedly celebrated her time in the program--"I'm proud as hell of it. . . . It's the best thing I've ever done and the rightest"--and explained its significance as follows:

> It means that I'm OK and I never thought I was OK. It means that I'm not self-destructing and my life is not a joke or a mess.

Similarly, Diane (13) spoke of having internalized a new kind of life experience:

> I feel like an example to others. I have experience now of how to live. I never knew what it meant to live a sane kind of life and I was insane.

For Nina (10), long-term sobriety meant not only the ability to initiate and carry out the experience but also confirmation that the process itself would work. Given her history of mistrust of others and herself, this was no mean accomplishment:

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> I have a life and that is because of A.A. and that's why I don't want to stay away long because I'm afraid it won't be there. The idea that it's there is a comfort.

Only Amy (24) had difficulty accepting her long-term status. With her identity heavily invested in having a "problem," the longer she was sober, the less she could use alcohol as a problem and as she made clear, "without a problem I have no identity."

As for the role that sobriety played in their total life experience, more than half of the study participants volunteered that it was central to, or as Norman (12) indicated, "at the core" of their lives. Diane (13) described it as "total," as her "gestalt." For some, like Harry (15), sobriety was equated with their core identity--"it's just who I am. . . . I'm a person who doesn't drink, you know, with a history of drinking." An unhealthy obsession with alcohol now rematerialized as a healthy obsession with sobriety. For others, like Gregory (10) dually addicted to alcohol and drugs, sobriety brought with it secondary gains:

> . . . without sobriety there is no life for me. . . . if I wasn't sober today, I wouldn't be alive today. I would be dead either from the alcoholism or the HIV or some combination, by some drug pusher shooting me . . . . I might be a wet brain . . . from the drugs and the alcohol.

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For all, it seemed so internalized as to have achieved the status of both a tautology as in Bernard's (13) wry observation--"if I didn't have sobriety, I wouldn't have . . . a life . . . for it to be central"--and a paradox as in Janice's (16) declaration--"It's my whole life, but it's not my whole day."

But maintaining one's sobriety was not an easy task. One of the hallmarks of alcoholism is its relapse potential. This is what makes it such a frustrating condition for professionals to treat. Alcoholics in A.A. are reminded of one of the major pitfalls of the disease--relapse--and much attention, especially in Beginner's meetings, is focused on how to avoid picking up a drink, again. As Harry's (15) anxiety makes clear ("Five minutes from now I really believe something can happen that could cause me to drink"), no one, not even a long-term survivor, was immune from the potential for relapse. Study participants were, therefore, asked about their "close calls" in sobriety with alcohol and how they managed to overcome the urge to drink.

Two-thirds of study participants reported having had a "close call" at one or more times in their sobriety. Some told colorful anecdotes of how they nearly relapsed through

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either a willful determination to use alcohol to relieve emotional pain or a "legitimate accident" at a party of being mistakenly handed an alcoholic drink. Raymond (21) was so desperate for a drink that once he was ready to imbibe rubbing alcohol. Several reported the substitution phenomenon, well-known to treatment professionals, wherein the urge to act out is so strong that it gets transferred on to other compulsive behaviors such as violence, high-risk sexual activity, eating, smoking, or debting, each of which had the potential for triggering a return to destructive alcohol and drug use. For James (10), the "ice man," a relapse was to commit violence and a relapse "signal" might come at two o'clock in the morning, a time when he used to be on the streets in search of crack and the crack-laden violence associated with the drug. For Arthur (14), compulsive sexual activity was an alternative to drinking but a high risk for infection. For Amy (24), bulemia, her "secret" vice along with smoking, substituted for her urge to drink but "dirtied" and "diluted" her sobriety making her "feel drunk." She poignantly confided, "I have not wanted to be responsible for who I am." For Lilly (10), sabotaging herself meant picking up, not a drink, but shopping--"I pick

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up debt."

More significant, however, is the fact that, despite the urges, accidents, and even the compulsively self-defeating behaviors that ended in recrimination and despair, no study participant had resorted to full-scale alcohol and drug use to mitigate his or her personal pain.[1] On the contrary, their accounts of "close calls" did reveal an array of positive strategies and "tools" at work, all of which they credited A.A. with having taught them, that reversed the tendency to relapse.

These strategies included an ability to identify and review the consequences to themselves or to significant others before acting upon the urge (known in A.A. as "thinking the drink through"); the reactivation of thoughts and feelings associated with past experiences of destructive use (in A.A. terms, "keeping it green"); attending a meeting, help-seeking through a phone call to a sponsor or peer person in the program or through a prayerful appeal

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1 See page 321. Only one study participant reported drinking "near beer" which he minimized. A second study participant reported minor marijuana use in her early sobriety which she discounted as a "slip" though she acknowledged that she would view such use differently today.

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to an unseen spiritual presence (in A.A. terms, "turning it over"); recalling other examples of relapses communicated in previously heard A.A. "qualifications"; using fantasy to sublimate the urge; postponing the urge to act out for a minute, hour, or another day; and making a "gratitude list" for what they had "gained" through sobriety. Some study participants reported powerful feelings of shame, remorse, and fear as deterrents to picking up again. A few recounted internal experiences in which the introjection of someone's voice, usually that of an A.A. member, served as a signal to disincentivize them. Gregory (10), for example, recalled how early in his recovery he was angry at A.A. for "taking away [his] booze." Much against his sponsor's advice that "if you hang out in a barbershop, you'll get a haircut," he chose to test his sobriety by going into a bar. As he stood at the counter watching someone drink his favorite drink, a martini, he suddenly heard a voice say "just get out of here. Just get out of here. Just leave." He remembered how he "had just enough sense to listen to that little voice" inside of him reminding him of the negative consequences of drinking:

> I could hear all the other people in A.A. saying, 'nah, it's not worth it . . . you know exactly where you're

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> gonna end up. You've been down this road before. Get out of here.'

Unlike Gregory, who had introjected the voices of others, Regina (12) had internalized a self-referential voice with a different message. One night in a local disco she was handed a drink and in a fit of "people pleasing" she started to drink it. For a split second, she found herself mute and paralyzed into silence--"it's like I can't say no. The words can't come and nobody can hear." But in a sudden internal cognitive reversal, automatic and swift, something happened:

> . . . one of the tools came through which was . . . 'no matter what happens, I don't drink. Drinking isn't a part of my life' . . . the words came through and I put the drink down.

Susan (11) described a similar experience fraught with relapse potential. In physical pain from a tooth extraction, she fantasized about the pain killing pills in her medicine cabinet. The thought of sabotaging her sobriety was replaced by another thought--"the little piece of me that wants to stay sober said 'you're not far, make a meeting.'" She did so and reinforced this with a phone call for help and an unabashed childlike plea for extra soothing:

> The woman held my hand. We've been there for each other like that. I cried and whined and curled up in a ball, but she was there. She fed me. I think it's

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> just getting me past that danger period, the peak of fear . . . . It was this close.

For some study participants, the deterrence to drinking followed a more unconscious path in the form of "drunk dreams," a phenomenon that has received little attention. Jose (20), for example, reported powerful dreams in which he experienced himself drinking. The sensation was so strong that it lingered well into his waking hours and served as another reminder, however "scary" in his estimation, of the negative consequences of drinking again.

The experience of near relapse would produce powerful insights that seemed to help reinforce the desire to remain sober. Years later, Regina (12) reflected on her experience--"the lesson learned from that was that I had no reason to be in the . . . Club late at night with everybody who was drinking." Susan (11) also remembered the lesson she had learned--"there will always be something bad. Just get through the five minutes of that hour when picking up is a good idea."

Harry (15) had accidentally sipped an alcoholic drink meant for someone else. Fear generated a new awareness, "I would be cutting myself off from my community." Raymond (21), distraught over news of a fire in his apartment, was

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on the verge of drinking rubbing alcohol when the locus of control shifted and he had the following insight--"How you gonna go back and tell people you had a slip? I would be letting down my A.A. people." When James (10), the "ice man," received the tragic news that his son had been shot, his first instinct was to grab a gun and hunt down the perpetrator. Someone intervened, however, and told him to call the local hospital to check on the condition of his son. At that point, he realized that the obstacle to his behaving responsibly was his own narcissism--"not everything is about me."

Even a joyful experience could induce a desire to drink. Norman (12) was celebrating a business success when someone handed him a glass of champagne. At first he had the thought to drink it. But he was able to process the thought--he remembered experiencing fear over the consequences, then hearing a "part" of him, that internalized voice, reminding him that he did not need to drink, followed by a visual memory of seeing where he would wind up if he did drink it. Lastly came the thought that if he would drink, he would never return to A.A. because he "would stubbornly drink [himself] into oblivion." His

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ability to process this information internally and delay gratification led him to the following insight:

> My alcoholic personality wants to do it quick. I didn't want to go through the process of development so when I was feeling that way, you know, which was what I had to feel, I had to learn how to deal with that feeling. You know, it comes and goes. Now I know how, when I'm feeling down about myself, . . . obviously I don't think we ever get rid of that . . . low self-esteem, but . . . I know what to do to stop it . . . .

But study participants need not have been close to relapse to find reasons for staying sober. About one fourth of study participants reported having no urges to drink over the course of their sobriety. Drinking was, as Matthew (19) explained, "not an option" --"there's no going back . . . I've been given some extraordinary gift. I want to stay sober." Or as Gail (14) put it, "I don't drink because I'm a person who doesn't drink. I like being aware. I don't drink because I am so grateful." Where some fully internalized the resolve not to drink, others used external means (i.e., a wish not to disappoint a significant other, the prospect of losing face or material acquisitions) with which to anchor their sobriety.

Besides the many explanations cited in the preceding pages, still other reasons were adduced by study participants in support of their long-term sobriety. A

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need to maintain a kind of competitive advantage over sponsees emerged half jokingly in Carl's (13) narrative--"I'll be damned if my sponsee's gonna have more time than me." In an ironic reversal of events which the "ice man" had not anticipated, James' (10) own sponsor had relapsed and now he had become his sponsor's sponsor! A deep sense of purpose or mission, which conformed to her Catholic upbringing, induced Paula (11) to remain sober and still attend A.A. meetings:

> I always . . . felt like I had a purpose. I was brought up Catholic. Instilled in me was 'this is not my world, this is God's world.' Suicide is not my thing. Anorexia was not God's thing. This is through A.A. that I have some kind of purpose. I have no clue what it is. It's the curiosity. I need to show up to find out what it is.

Pride also contributed to the maintenance of her sobriety--"I don't want to do the first five years all over again. There's the pride thing."

An education in the deleterious effects of alcohol on the body was a sufficient incentive for Dorothy (25) to continue to remain sober, though even she admitted that talking about it could revive her fantasies of using again:

> I don't drink no matter what. . . . drinking is not in my consciousness. I was given this gift. It's not an option. It never has been an option. . . . my education about . . . what alcohol did to me has been

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> complete and my education continues with what it's done to you and everyone else I hear. I've gotta superimpose a skull and crossbones on a bottle of booze when I hear [about it]. . . . There are lots of excuses and reasons to drink but nothing would make me pick up a drink today, nothing. It's like drinking poison. Who would want to do that? No allure. Nothing at all. And yet I could probably, now that I'm talking about it, I can almost taste it. You know, I could bring it back.

Finally, James (10) offered a reason first heard in the work of Charles Winick (1962). The alcoholic simply ages out of his addiction. It would take the "ice man" 30 years to find his way into an A.A. room:

> I don't think I have another 30 some years. I don't know if I have another recovery in me. Staying sober, I found, is not such hard work. You just have to do what you been [sic] doing. Getting sober is hard 'cause then you have to change what you been doing. And that takes a lot of energy. It takes a lot of concentration. It takes will power that I don't know that I have anymore. . . . I just don't know if I can go through the whole process of focusing on whatnot again.

And even after he arrived in A.A., he would test his sobriety by repeated relapses. In an ironic narrative filled with a profusion of verb tenses and mirroring his physical exhaustion, he vividly recalled his early days in A.A. and his pattern of self-defeating behaviors--"22 days again, 36 days again":

> I'll be so glad when I'm not saying 'again' anymore. And if I go back out there I have to go through the 'agains' before I got to the 'yets.' I gotta go to

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> the 'agains.' I would have to go back to my abandoned building . . . or, you know, sleeping on the subways or whatever. . . . I don't know that I have the stamina for that anymore.

Finally, while study participants repeatedly emphasized their commitment to sobriety, they were asked to describe more concretely what, if anything, they did on a daily basis to maintain their sobriety. Kim (29), in particular, welcomed the shift in emphasis from the more philosophical discussion of meaning to the practical level of doing:

> I don't ever give it [why she was an alcoholic] much thought . . . . What I am is overjoyed that there's something I can do about it. And . . . I really mean that. And to me it doesn't really much matter why I'm an alcoholic. I know what I can do to stay sober.

She compared this to the idea of spending the whole day doing research on meteorology to figure out why it was raining and when it might stop:

> However, if you want to go some place, the best is to put on some galoshes and a raincoat and an umbrella and . . . that's kind of the way . . . I feel about . . . being sober and . . . being an alcoholic. I don't know why I'm an alcoholic and I don't give a damn. I know what I can do about it.

Among the practical steps these long-term study participants still took to maintain their sobriety were attendance at meetings; connecting with other alcoholics; believing in a Higher Power; educating themselves about alcoholism; asking for help; staying out of bars and other places where alcohol

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was served; working with sponsors and sponsees; developing a prayer life; reading the literature; "working" the Steps; taking suggestions; remaining active in the program; enhancing sobriety through such adjunctive experiences as therapy; continuing to be honest; and perhaps most important of all, as they had heard so often over the years in meetings--"just not drinking."

SUMMARY

This chapter provided an extensive overview of the outcomes of interviews with the 30 study participants. The chapter discussed nine major themes that emerged from the interviews--1) reasons for entering A.A.; 2) intensity of A.A. involvement; 3) milestones in the recovery process; 4) non-A.A. supports to facilitate recovery; 5) changing views of self and personal identity; 6) alterations in work and professional life; 7) changes in social life and environmental context; 8) development of spirituality; and 9) the meaning and significance of long-term sobriety.

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CHAPTER 8

ANALYSIS OF OUTCOMES

INTRODUCTION

This chapter contains a detailed analysis of the outcomes of interviews using the theoretical framework proposed in Chapter 3. Chapter 8 is divided into three sections. Sections I and II apply narrative theory and a cultural competency perspective to an analysis of the outcomes. Both sections provide a conceptual bridge to Section III which reorganizes the material and incorporates it into a more fully articulated ecological model of sobriety.

I. Building the Bridge - The Narrative as Metaphor

Long before A.A. published its program for recovery in its Twelve Steps and Twelve Traditions (A.A. World Services, 1983) and documented its history and purpose in its basic text, Alcoholics Anonymous (A. A. World Services, 1976) and other official writings, the seeds of what A.A. members often call this "simple program for complicated people" lay in the late night conversations of its two co-founders, Bill Wilson and Dr. Bob Smith. As their biographies indicate, each man had already undergone various regimes standard for

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the day--belladonna treatment, hospitalization, hydrotherapy, even religious interventions through the Oxford Movement--intended to "cure" them of their obsession with alcohol. Until their fitful meeting in Akron, Ohio one night in 1935, an encounter well enshrined in A.A. literature, nothing had worked. The seeds of A.A. were to lie not in professionally mediated treatment protocols but in the simple premise that one alcoholic **talking** to another could possibly purchase one more day of sobriety.

Thus was born a powerful but to this day still insufficiently understood tool for postponing the urge to drink--the simple act of talking honestly and openly about oneself to another alcoholic. While this tool has since metamorphosed into what A.A. members now call a "qualification" (the term used in Northeastern A.A. to describe the act of "storytelling" that takes place in a meeting), the fact remains that a verbal exchange, whether in the form of a half-hour long personal narrative, an encounter with a newcomer, a talk with a sponsor, or a "12-Step call" to a still active alcoholic, remains at the core of the A.A. experience.

This verbal exchange is powerful because it is so

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primal. It is a symbolic reenactment of what is perhaps the oldest speech exchange in human history--the oral tradition. As Mishler (1986) notes, "telling stories is one of the significant ways individuals construct and express meaning" (p. 67). The stories that recovering alcoholics tell one another, however, are not the stories they recounted when they were actively drinking. One A.A. member captured the difference in a public talk to a university class on alcoholism counseling:

> The intuitive understanding the alcoholic receives, while compassionate, is not indulgent. The 'therapists' in A.A. already have their doctorates in the four fields where the alcoholic reigns supreme: phoniness, self-deception, evasion, and self-pity. He is not ***asked*** what he is thinking. He is ***told*** what he is thinking. No one waits to trap him in a lie. He is told what lies he is getting ready to tell. In the end, he begins to achieve honesty by default. There's not much point in trying to fool people who may have invented the game you're playing. (A.A. World Services, A Member's Eye View of Alcoholics Anonymous, 1970, p. 12)

For A.A. members, the "call of stories," the haunting phrase Robert Coles (1989) used to describe the most important lesson he learned in his psychiatric residency training ("more stories, less theory," p. 27), is a strong incentive to attend meetings. For study participants with long-term time, an A.A. story still exerted a powerful attraction that

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re-called them to the program. As Dorothy (25) commented:

> When they tell you their story, you really get to know them and you see their evolution. When people talk about some of their accomplishments, that doesn't mean anything. When you hear where they came from, that starts the main thing.

Over the past decade, A.A. stories have drawn the attention of researchers seeking to validate the contributions of mutual help organizations as competent caregiving networks. Rappaport (1993) uses narrative studies as an analytic and methodological tool to examine the self-help experience as a counterpoint to "professional hegemony," that is, the tendency of medical and social service personnel to view self-help as a form of "treatment" that fails to meet the standards of professional service paradigms. He distinguishes between two kinds of speech acts in the mutual help organization--the personal story and the "normative narrative community." Personal stories are the accounts people give of their individual experiences, while a "normative narrative" is the story that the community has "about itself and about its individual members" (p. 246). Rappaport argues that these community narratives are about "individual change and stability." Such "normative structures" serve to destigmatize members

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and aid in a new kind of identity formation which occurs in the social context of the mutual help experience. Thus, self-help organizations can be understood as:

> . . . a special class of communities in which an alternative identity is provided and that those who become embedded members do so by transforming their personal life stories so as to conform to the community narrative. (p. 249)

Rappaport cites the A.A. "drunk-a-log" as one example of a possible A.A. "normative narrative" that transmits "AA ideology into personal identity." Following Cain (1991), he argues that "over time the drunk-a-logs are constructed so as to become more similar to those reported in the AA literature" (p. 252). What concerns him is how that story is transmitted and why it persuades some people but not others. These are tasks for a future research agenda:

> These are not new questions. They could be framed in terms of traditional research on socialization processes, but today such questions are asked in a postmodern environment. It is now widely believed that personal reality is constructed . . . and that there is an iterative process between the internal and external. The way that we have begun to study this is to conduct research in which we . . . [try] to explicate the details of the community narrative. This can be accomplished in a variety of ways, including extended observation of meetings, conducting focus groups, and detailed reading of available texts. It requires thick descriptions of organizational processes as well as detailed interviews with community members . . . to explicate their individual life stories. It is in the

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> search for relationships across these levels of analysis that the experience of participation in a mutual help community can be explicated in ways that more closely approximate lived experience. (p. 252)

But while Rappaport's framework is suggestive in that it views the self-help process as instrumental in identity formation, it fails to take into account several important elements in the A.A. experience. First, if there is an A.A. "normative narrative," Rappaport does not describe it; nor does he define what he means by an "AA ideology." While there is an historical context behind the formation of A.A. (see, for example, Kurtz, 1979), its origins lie in the personal stories of its co-founders and their followers which are detailed in the second half of the book, Alcoholics Anonymous (1976). Mindful that many of these stories were of "low-bottom cases only" (Twelve Steps and Twelve Traditions, p. 23), to say nothing of the fact that they were stories told mainly by middle-aged white males, A.A. subsequently enlarged its frame of reference to encompass two more subgroups. They included the functional alcoholic, that is, "alcoholics who still had their health, their families, their jobs, and even two cars in the garage" and the "potential alcoholic," that is, "young people" who were "spared that last ten or fifteen years of literal hell

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the rest of us had gone through" (Twelve Steps and Twelve Traditions, p. 23):

> It was obviously necessary to raise the bottom the rest of us had hit to the point where it would hit them. By going back in our own drinking histories, we could show that years before we realized it we were out of control, that our drinking even then was no mere habit, that it was indeed the beginning of a fatal progression. (p. 23)

An examination of the changes in these written stories as published in successive editions of Alcoholics Anonymous might help either to isolate such a "community narrative," if one does exist, or to derive a typology from these stories and their variants.

Second, to posit a "normative" narrative is to denature and devalue the power of individual "lived experience," however fragile (in A.A. terms, "it's a day at a time," "we only have today") as a model for others to emulate. A.A. members do not simply borrow identities when they attend an A.A. meeting, hear a qualification, or actively participate in the sharing. Rather they learn how to recognize, grow, live through, and communicate their own experience, however painful or joyous, instead of escaping from it through the use of alcohol or drugs. Fred (13) tried to capture this process when he commented:

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> . . . it's such an enormous experience to be a drunk and to get sober in A.A. It's such a huge experience that . . . you know . . . I'm . . . I'm forever engaged and . . . and . . . and stimulated by trying to express what . . . what it's been like for me. And that's . . . that's one . . . the truth is . . . my . . . my personal inner reason for going there is to try to express something, express what my experience has been, again and again when I am approaching a meeting. It's to try to hear something that . . . that sounds like my inner voice.

Note the pauses and hesitations in his speech which are indicative of his struggle to make personal meaning out of inchoate experience.

Moreover, to suggest that there is such a "community narrative" is to discourage potential newcomers who, searching in vain for a personal connection or looking for an excuse to continue drinking, may be tempted to leave before they actually hear their stories. In fact, a frequent complaint of newcomers is the difficulty many have "hearing" their stories. One wonders whether this is because of the idiosyncratic nature of the stories, that is, not all A.A. stories are alike, or whether the person is not developmentally ready to hear what is being said. While there is controversy about whether or not identity formation is at the heart of the A.A. experience (see, for example, A Member's Eye View of Alcoholics Anonymous, 1970, p. 12) one of the strategies used to motivate the newcomer is to

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encourage what Bill Wilson called an "identification at depth" (Three Talks to Medical Societies, 1983, p. 11) with the storyteller rather than a comparison. Identification can take many forms--a word, a phrase, the expression of a feeling, an experience, or something larger like the plot of the story. This is not an easy concept for a beginner to grasp who may be struggling with confused emotions and perhaps ambivalence about his or her alcoholism. It is through the identification process that the newcomer begins to build a connection to the "other." By contrast, to compare one's story to someone else's is to focus on the differences between people and encourage the newcomer's grandiosity in feeling that he or she has nothing in common with the storyteller. The result may be that the newcomer will rationalize using and leave the program thinking there is no problem.

Third, Rappaport's concept of a "normative" structure influencing individual identity ignores an essential A.A. message, namely the positivistic emphasis on individual initiative or "action." The paradox of surrender (see Step 1), together with an action orientation, helps to restore individual agency and responsibility but always

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within the context of a mediating force--the "12 Steps" (itself a metaphor of forward movement), a suggested Higher Power, or the help of a sponsor. The A.A. message is not one of passive acceptance of a "community narrative" or of someone else's story, but of the discovery of one's own story (almost a "restorying"), voice (as in Fred's [13] case above), and personal efficacy. Fundamentally, it is a personal story of empowerment. Arthur (14) describes it this way:

> I think the A.A. experience softened me and . . . gave me more confidence. In a strange way, I'm more confident than I ever was drinking . . . . And I . . . have a feeling I was always better at it than I thought I was. But A.A., it's that old thing of, suddenly I'm beginning to see myself as other people always did see me. . . . I think I got practice at social skills in A.A. . . . And I think probably some of that has to do with our story telling. . . . after revealing most of my secrets in life, and the world doesn't end, and I'm not judged, I mean in an appropriate forum like A.A., I think that . . . in a strange way for me, it feels like a clean slate and I can go out there and not start over. . . . And also I do think that I have gained confidence, even to the extent that I still suffer from shyness or feelings of inadequacy . . . , just having heard so many other people's stories over the years, realizing I'm not alone in these feelings. . . . You know, basically I'm just another human being. I don't have to be superman but I also don't have to be a doormat. It's allowed me to become lifesize and set manageable goals, as opposed to the pie in the sky things that . . . now that we talk about it I think a lot of my thinking was I'm either gonna be rich and famous or just give up, but never sort of just be like everyone else.

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Fourth, to deconstruct the A.A. community narrative and link it to individual life stories, as Rappaport proposes, is to perpetuate the kind of "professional hegemonic" stance he so vehemently deplores in his article. Such an overly intellectualized research exercise fails to do justice to what Davis and Jansen (1998) recognized in the A.A. narrative framework as a conceptual shift from a "rational (service delivery) model to a metaphorical (spiritual) understanding" (p. 173). They propose a closer examination of the symbolic communications, that is, language and metaphor, conveyed in the stories and the meanings that recovering people assign to their experiences.

In place of Rappaport's distinction between a normative narrative and individual personal stories (which reinforces a kind of rhetorical split), this researcher would urge consideration of the idea of narrative as a more holistic "root metaphor" (Mancuso & Sarbin, 1983) for the A.A. experience. The "root metaphor" fosters a community of shared meaning among people who begin as strangers to one another (or to adopt an A.A. slogan which captures the paradox inherent in the experience, "A.A. members are friends who have not yet met"). This seems to be more in

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keeping with what long-term study participants reported as one of their incentives for maintaining active attendance. Several cited, for example, a "shared language" and a "way of thinking" learned in the program, although they could not always articulate what they meant by this meta-discourse. Unlike the verbal exchanges between a professional and a client in which meaning is not shared but negotiated, A.A. members seem to speak a special discourse. Jose (20) called it the "language of the heart" which was communicated even when an A.A. story was delivered in a foreign tongue. As a seaman, he often attended meetings in other countries where English was not the native language:

> It doesn't matter . . . if you don't speak a language, you're in the right place. So they took me to a meeting in German . . . . I didn't understand what they were saying, but I knew why I was there. And I knew why the other people were there. They were there for one . . . only one purpose, to stay sober for one day.

Several study participants commented on how much more easily they communicated with A.A. members than with significant others with whom they shared their lives. As Carl (13) ruefully noted, sometimes he could not communicate with Howard, his partner of seven years, who having once attended A.A. left the program because he no longer felt he

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was an alcoholic. Upset one day over having bought a damaged shirt, Carl telephoned Howard only to be reprimanded for calling him at work. He realized his mistake and said that if he had called his "program" friends he would have gotten a more sympathetic response:

> I wanted sympathy and they would have sympathized. People in the program identify more; they know [that] the more bizarre little things can upset you . . . . And I forget that [Howard] doesn't know that any more. He used to know it, but he's not in A.A. any more. A.A. people have an understanding that you can go through, a reaction to such a little thing.

Given the power of the A.A. story as a healing force, what then are its characteristics? The nine themes which emerged from the interviews (outlined in Chapter 7) provide some clues. First, many of these accounts, regardless of gender, age, race, or ethnicity, shared a common "before-and-after" pattern--a period of decline or "hitting bottom" (sometimes painfully slow, sometimes swift) generally followed by a pattern of ascent or rebirth which is represented by their recovery. This pattern, however, was not as progressive as it sometimes has been depicted in the literature. Sarbin (1982), for example, called attention to a "symbolic death and rebirth" pattern in a study of "self-reconstitution" and "conduct reorganization"

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processes in organizations like A.A. But he failed to take account of variations in the experiences of those engaged in these processes over a longer period of time. Identity stability, generally a marker of long-term sobriety, was not always achieved with ease. Several study participants (Janice [16], Emily [23], and Norman [12]), it will be recalled, reported deeper "bottoming out" or "surrender" experiences well after their fifth year of sobriety.

Second, notable in the responses of study participants was the use of "miraculous" metaphors to describe their experiences. Words like "miracle," "reborn", "gift," "grace" were commonplace attributes of this discourse in which the speaker was likely to disavow any personal agency in getting sober. While many study participants employed these metaphors, it is not clear whether their use was borrowed from a more universal "community narrative" or was a genuine expression of their personal beliefs.

Third, the recovery experience was often couched in "process-oriented" language. Study participants described being on a "path" or "journey," allusions with spiritual overtones. Doing the "Steps" gave added impetus to this process which was augmented by other action-oriented

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activities--attending meetings, doing service, calling a sponsor, working with newcomers, answering phones at New York Intergroup.

Fourth, the label "alcoholic" was destigmatized. Many study participants celebrated the fact that they were alcoholics. They embraced this label as a badge of pride and relished the freedom that came with proclaiming it. The destigmatization of the label appears to be a significant step in initiating the process of self-reconstruction that is at the heart of the A.A. experience. In the safety of A.A. meetings, it is a common practice, though not a requirement, for seasoned members to introduce themselves using this appellation ("My name is [Joe] and I am an alcoholic"). One wonders, however, how study participants feel when they disclose their alcoholism to a medical or mental health professional who may be less likely to appreciate the spirit with which it is shared.

Fifth, study participants' accounts contained some common themes which reflected the recovering alcoholic's struggle to achieve better mental and social health. For many, A.A. membership was as much an experience in the reconstruction of a personal self as it was in the

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normalization of a social self. As the themes outlined in Chapter 7 indicated, many described inner states of fragmentation, disassociation, and emptiness and feelings of confusion, depression, anxiety, panic, anger, and numbness experienced prior to their entrance into the program and well into sobriety. They reported fantasies of grandiosity and false beliefs about themselves and, in the case of those of differing sexual orientation, an inability to accept their sexual identity. Through the process of identification, the use of A.A. "tools," therapy, and what for many was the development of a spiritual life (an often devalued element in the making of selfhood), study participants undertook the slow and sometimes painful task of rebuilding and stabilizing coherent personal identities out of shattered and shamed-based lives. The process of bearing witness through meeting attendance, giving personal testimony in a qualification, even being interviewed for this project as a long-term member of A.A. and "survivor" of personal battles, allowed them to shift the metaphor from having been "villains" (a pre-A.A. role) to being virtual heroes and heroines (a post-A.A. role) of their own lives (Mancuso and Sarbin, 1983).

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Moreover, study participants' descriptions of their difficulties with family, friends, partners, children, and co-workers as well as with such authority figures as police, school officials, and work supervisors were commonplace in their pre-A.A. stories. Many described feelings of alienation, anomie, and deep distrust of others. Some even acted out their rage in anti-social acts that led to confrontations with authority figures and eventual incarceration. A persistent theme in their narratives was the extent to which social identity had become normalized. A.A., with its intricate network of peer relationships and sponsorial ties and its varied opportunities for service, became a kind of social laboratory--in metaphoric terms, a "bridge back to life"--where the recovering alcoholic could practice, refine, and test social skills. Extremes in thinking gave way to an ability to reality test and demonstrate more prosocial behavior. As Arthur (14) had observed about the changes in his own social behavior (see p. 381), "basically I'm just another human being. I don't have to be superman but I also don't have to be a doormat."

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II. Crossing the Bridge - The Recovering Alcoholic as Cultural Guide

Ever since A.A. was founded in 1935, it has made repeated attempts to reach out to the professional community through lectures, publications, open meetings, and more recently a newsletter for professionals, About AA, published quarterly. Despite its official position of welcoming cooperation with the professions as articulated in a series of A.A. World Service pamphlets (1970, 1974, 1981, 1983, 1986), its stated policy has been carefully crafted to affirm "cooperation but nonaffiliation." But as the literature indicates, the history of collaboration between the professional treatment community and A.A. still remains uneasy (see Powell, 1993; Rappaport, 1993; Riordan & Walsh, 1994).

Even A.A.'s own published remarks convey a slightly defensive tone about this partnership. For example, in a pamphlet (1974) describing the role of its Committee on Cooperation With the Professional Community (CPC) established in 1971 by the General Service Conference, it defined the purpose of area or local CPC committees as follows:

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> Members of these committees inform those working in the field of alcoholism about A.A.--where we are, what we can do, and what we cannot do. An attempt is made to establish better cooperation between A.A.s and professionals in the field. (p. 26)

Note A.A.'s acknowledgment of the need to improve the level of cooperation between the organization and the professional community. The statement was retained in a 1993 reprint of the pamphlet, an indication that an uneasy alliance still persisted, along with a conciliatory explanation of why such CPC activity was important:

> With increasing activity in the alcoholism field and with more people becoming involved in it, some of them having little or no understanding of A.A., open communication in a spirit of friendly cooperation is more important than ever. There ***will*** be misunderstandings, but they need not divert us from our intention of cooperating with others in the field of alcoholism--being mindful of our tradition of nonaffiliation, and also mindful that the ***only*** inventory we take is our own. (p. 28)

Because this collaboration remains tense, the role that the long-term recovering alcoholic can play in providing a linkage between a self-help entity like A.A. and the professional treatment community, which has both an ethical obligation and an economic stake to uphold, becomes more emphatic. A.A. itself does not discourage the recovering alcoholic from taking on such a role as long as it is understood that the individual does not speak for the

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organization. The following A.A.-promulgated guideline (1974) delimits this role:

> ***A.A.s can also be good*** volunteers ***in non-A.A. programs--as long as it is clear that they do not represent A.A.*** Many A.A. members--lay people as well as professionals--also help alcoholics in numerous non-A.A. ways as volunteers in non-A.A. activities in the alcoholism field. But we do so as ***private citizens*** concerned about the health problem of alcoholism, ***not*** as A.A. members and ***not*** as representatives of an A.A. body or of A.A. as a whole.
>
> For best results in cooperation with non-A.A. community efforts, we need to stop short of structurally or formally linking A.A. with any other program or enterprise, no matter how worthy. (p. 8)

Moreover, it will be recalled that some study participants expressed misgivings about their experiences with professionals who still needed to improve their knowledge about alcoholism, A.A., and recovery. Therefore, such positive collaborative efforts, while educating the professional, might also lessen hostility among those who felt ill-served by well-meaning but misinformed practitioners.

Assuming such a pivotal role is in keeping with a recent focus in social work literature on the need for workers to develop cultural competency in the delivery of services to racially, culturally, and ethnically different populations (Devore & Schlesinger, 1981; Green, 1995; Leigh,

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1998). Alcoholics, whether active ("functional" or "low bottom") or recovering, share with these groups the stigma of differentness, with many having lived lives outside the mainstream of "accepted, dominant cultural norms and values" (Leigh, 1998, p. 5). Indeed, even within ethnic minority cultures, alcoholics face degraded status and devaluation as individuals whose behavior reflects poorly on the group as a whole.

Leigh's work on cultural competency, therefore, represents an attempt to invest the "minority" person with a prominent role as cultural guide in the social work dyad. The "minority" person is now designated the "expert on defining the cultural implications and depth of the problem and . . . the opinions of this expert must be clearly understood before any analysis can begin" (Leigh, 1998, p. 13). The "minority" person, in short, is the gatekeeper to a world heretofore unknown and inaccessible to the social worker.

The key to unlocking this experience resides in the narrative of this "expert":

> The story of a person can be seen as narrative through which the storyteller's perspective is revealed. Narrative is the universal metacode from which cultural messages and the nature of a shared reality are

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> transmitted [Saari, 1991, p. 144; MacIntyre, 1988, p. 11]. For effective helping, it is essential that the social worker hear the content of the narratives, as the content provides valuable information about how people experience others as well as themselves in interaction with others. (p. 13)

For Leigh, the acquisition of cultural competency is not purchased though empathy, a traditional social work skill, but through understanding:

> The social worker must strive for the degree of understanding that can derive only from information provided by a member of the contrasting cultural group. Failure to achieve this means the social worker cannot enter into the senses of the other. The social worker must comprehend the cultural context and meaning of these sensibilities. Only then will the social worker comprehend what it is that the person knows and how that knowledge is used in everyday life. Once meaning is revealed, meaning is known, and caring follows. (p. 15)

Leigh proposes a "cross-cultural practice" paradigm in which the professional and the client switch roles. The professional assumes the role of "stranger" or "learner," while the client becomes the informant or "cultural guide and teacher of his or her culture" (p. 39). In this paradigm, social workers must set aside their professional hegemony and abandon their traditional role as the "cultural gatekeeper and socialization conduit into the culture of helping" (p. 52):

> In the role of stranger, social workers do not know what they do not know. They find out what they do not

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know in the process of helping. (p. 52)

Meanwhile the best informants, argues Leigh, are those who have been part of their culture "for a lengthy period of time" (p. 47). With this criterion in mind, the 30 participants in this study, selected for their long-term sobriety, became informants about a complex, life-threatening illness and gatekeepers, not to a culture of drinking, but to a little known culture of sobriety, while the researcher, however knowledgeable about alcoholism and recovery on the basis of prior education, training, and professional practice, assumed the role of "stranger" in a strange land.

Following Leigh (1998, see his Chapter 4), therefore, the question arises, what does it mean to become "culturally competent" when addressing the needs of a recovering alcoholic? The implications for social work practice of working with long-term recovering alcoholics is the subject of Chapter 9 in the current study. Much like the preparation for cross-cultural practice, preparing students to work with recovering people has become one of the chief challenges in social work education in the last decade. The design of a comprehensive curriculum in alcoholism and other drugs represents an important step in this direction. But

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social workers preparing to work with this population face a dilemma that few other helping professionals encounter in their attempts to serve the public. They are likely to experience a direct challenge from some clients about their level of expertise. The challenge usually comes in the form of a question--how can you understand my problems if you have never had a problem with alcohol or drugs? If the helping professional happens to be in recovery, there is the added dilemma of whether to disclose his or her own status as a recovering person. Will this help or hurt the client? Will it facilitate or impede the treatment? What does it mean when the client issues such a direct challenge?

While some study participants raised this issue, still others expressed concern about the quality of preparation and continuing education of their physicians and therapists. Several, like Emily (23) and Dorothy (25), went further and acted as lay teachers to their doctors. Clearly, empathy and understanding, though important professional skills, did not constitute "cultural competency." The helping professional needs a more solid knowledge base upon which to build a practice. The following areas emerged as crucial in the preparation for work with recovering people (note the

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correspondence of these areas to the themes discussed in Chapter 7):

a) <u>Uncovering the Alcoholic's Past</u> (related to Theme 1)

Recovering alcoholics in A.A. learn the importance of "keeping it green," that is, remembering what it was like to use and abuse alcohol and what the consequences were for themselves and for their significant others. Once in A.A. they are cautioned to "look back at the past but not to stare at it." Often they are unsure of their own histories. Thus hearing someone else's story provides them with an opportunity to rediscover their own past and to put it in perspective. Many, though not all, come from alcoholic homes and may not have understood the impact of family alcoholism on their upbringing and how it may have shaped their development and influenced their own drinking. Learning to understand the past and accept responsibility for one's behaviors and actions is an important part of the process of becoming sober and maintaining one's sobriety. Preparation for work with recovering alcoholics should include acquiring knowledge about the biopsychosocial effects of the abuse of alcohol. It also needs to include an appreciation of the impact of family history and dynamics

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on the development of alcoholism. Professional helpers must demonstrate sensitivity to those still struggling to overcome the shame associated with a family history of drinking and their own alcoholism. They must also respect and support the decision of these individuals to seek help and to continue to do so over the years through an organization like A.A. and not view this long-term affiliation as a sign of pathological dependency.

b) Understanding A.A. (related to Theme 2)

As the interviews with the 30 study participants make clear, long-term recovering alcoholics who have gotten sober in A.A. do retain strong ties to the program. They attend meetings; perform service; interact with other program people--sponsors, sponsees, and peers; read A.A. literature; use program "tools"; work on the Steps; speak a special program language; and continue to participate in many of the rituals associated with A.A. membership (ex: they identify themselves as alcoholics, celebrate sober anniveraries, qualify and share at meetings). An understanding of A.A.--its principles and practices--that is free of bias and critical scrutiny is, therefore, an important starting point for anyone preparing to work with a recovering individual.

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c) <u>Understanding the Experience of Recovery</u> (related to Theme 3)

As much as long-term A.A. members are encouraged to communicate their early history of alcohol abuse prior to their entrance into the program ("what it was like before they got sober"), they are also encouraged to recall and transmit their experience of recovery ("what it was like to get sober"). As the 30 interviews demonstrated, just as there was no single pathway to A.A., there was no template for recovery. Qualifying at meetings, sharing from the floor, and listening to other people's stories helped the recovering alcoholic to develop a language for his or her own experience. Many described this experience as a "process" with its own properties and permutations. They compared it to the peeling of an onion, to use a metaphor often heard in A.A. rooms that is meant to convey the complexity of the recovery experience. Understanding this experience places unique demands on the professional to set aside pre-conceived theoretical frameworks and diagnostic categories that may distort what the recovering person is trying to communicate.

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d) Seeking Other Recovery Resources (related to Theme 4)

Recovering alcoholics in A.A. are taught that alcohol is only a symptom of deeper psychological and social distress. A.A. does not promote itself as a "panacea" or cure-all for the alcoholic's problems. But as its Preamble shrewdly states, neither does it "engage in any controversy," endorse or oppose any causes, or ally itself with any other organization or point of view. Individual A.A. members, however, rarely discourage their peers from seeking out other resources to help the individual maintain his or her sobriety. Such resources might include other self-help programs, counseling and therapy, physical examinations, even the taking of medication (as prescribed by medical and psychiatric professionals), educational and job training programs, and services that promote social health, personal welfare, and financial stability. Understanding the resource network available to the alcoholic and helping to facilitate access to these resources is a primary responsibility of the practicing professional.

e) Self and Personal Identity (related to Theme 5)

A.A. members sometimes call alcoholism a "disease of

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arrested development." Active alcoholics develop rigid defenses to protect their drinking and medicate themselves from the shame, humiliation, and stigma that accompanies abuse of the substance. As the stories of the 30 study participants so poignantly demonstrated, self-destructive drinking sabotaged personal growth and the ability to lead an examined life. Many study participants made a distinction between abstinence, the cessation of drinking, and sobriety, the beginning of a personal transformation and actualization of self that was still taking place well past their first decade. For some, personal growth meant added challenges--acceptance of aging and impairments in health, withstanding ethnic stereotypes (especially cited by Hispanic and Jewish interviewees), and coming to terms with one's sexual differentness in the face of overwhelming social stigma, another test of their ability to stay sober. Understanding the nature and dynamics of this transformation, while supporting the recovering individual in the process, requires a major commitment on the part of the helping professional.

f) <u>Work and Professional Life</u> (related to Theme 6)

Active alcoholism can have an adverse impact on one's

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working life. But the recovering alcoholic also faces challenges in the workplace where drinking is still an acceptable social lubricant. Moreover, as the interviews indicated, many study participants unexpectedly found themselves reevaluating their occupational goals over the course of their sobriety. Choices made in a haze of alcohol unraveled in sober time as self-perceptions changed. For some study participants, the change was gradual enough to plan for meaningful alternatives; for others it was so swift and unforgiving that it left the individual depressed and immobilized. Still others faced role strain and radical changes in work status because of illness, business reversals, retirement, and age discrimination. The helping professional must be prepared to support the recovering alcoholic through all these transitions and vicissitudes. He or she must understand the workplace challenges that await the sober individual and, if necessary, be equipped to provide information about alternative futures and assistance as needed in evaluating this information.

g) <u>Social Life and Environmental Context</u> (related to Theme 7)

Almost uniformly, study participants reported on the

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difficulties they encountered in building a social life without alcohol. Smith (1993) noted that the "social world" of A.A. played a significant role in facilitating the reintegration of the alcoholic, especially nonaffiliative types, into a social setting. The skills learned through exchanges with sponsors, sponsees, and A.A. peers, together with the service opportunities provided in the program, could be applied to interactions with family, friends, partners, and co-workers and in environmental contexts beyond that of A.A., though the alcoholic may not always meet with total success. The helping professional must be prepared to support the individual as he or she undertakes these challenges and attempts to find or resume a place in the larger society.

h) Spirituality (related to Theme 8)

While a controversial aspect of recovery, many study participants noted the importance of developing a spiritual life in sobriety and found much comfort in doing so. Some found their spiritual home in organized religion, others found it in individualized spiritual practices, while still others discovered it in an A.A. meeting room. Only a few seemed disinterested. A.A. itself is not a religious

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program, though newcomers are often troubled by references to a Higher Power and God in the A.A. literature and in meeting rooms. A.A's emphasis is more subtly spiritual. Though the Oxford Movement and the writings of William James are among its historic progenitors, a passage by Herbert Spencer quoted in Alcoholics Anonymous (1976) alerts the recovering alcoholic to A.A.'s real message:

> There is a principle which is a bar against all information, which is proof against all arguments and which cannot fail to keep a man in everlasting ignorance--that principle is contempt prior to investigation. (p. 570)

The helping professional, trained in the scientific method which emphasizes objectivity over superstition and metaphysics, should not underestimate the power of spirituality as a healing force. Thus the message to the alcoholic to keep an open mind and avoid "contempt prior to investigation" might well be applied to the intellectual arrogance of many practicing professionals who, under the influence of Freud, might view the recovering alcoholic's spiritual drive as irrelevant or even pathological. It should be noted that Freud's adversary, Carl Jung, is counted as one of the spiritual godfathers of A.A. When a friend of Bill Wilson appealed to Jung for help with his

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alcoholism, Jung replied that only a spiritual or religious conversion could help him (Alcoholics Anonymous, 1976, p. 27; see also Jung's letter to Bill Wilson dated January 30, 1961, in Adler & Jaffé, 1975, pp. 623-625). Thus, Jung gave A.A.'s spiritual orientation his professional imprimatur.

i) **Meaning and Values** (related to Theme 9)

While A.A. invites a search for spirituality, it also places great emphasis on living a life according to principles and values. The recovering person is encouraged to search for meaning, lead an examined life, take personal inventory, and make amends for the wreckage of the past and, when called for, any turmoil created in the present. In sharing and qualifications, the recovering alcoholic offers public testimony to a change in value system. The individual may recount conflicts which arise as he or she tries to navigate soberly in a culture that still values drinking. Under great strain or for no reason at all, he or she may face the prospect of relapse and place his or her accumulated sobriety at risk. While A.A. meetings, especially Beginner's meetings, offer much practical wisdom designed to forestall these events, the helping professional must be prepared to assist the recovering individual in

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understanding the urge to self-destruct, which is at the core of alcoholism, and how to counteract it.

III. Beyond the Bridge - Toward an Ecology of Sobriety

As the interviews with the 30 long-term study participants demonstrated, rebuilding one's life through A.A. was a work in progress many years in the making. But the "social world" of A.A., the venue where the symbolic reconstruction took place, was not the closed system or tightly bounded sphere depicted by Smith (1993). On the contrary, as noted in Chapter 3 and earlier in this chapter, A.A. members employed a different metaphor to describe their experience of the program--it was a "bridge back to life." Gregory (10), for example, used this metaphor in explaining how A.A. helped him to cope with changes in his HIV status before and after he began taking protease inhibitors:

> . . . I woke up that . . . morning and said . . . I'm here, I'm still alive . . . . [I had changed] my thinking . . . . I'm living with AIDS today . . . I'm not dying from AIDS. Back then I was dying from AIDS . . . . Today I happen to have AIDS . . . it's just part of me. You see, the program helped me to accept that . . . I just have AIDS. It's something I have to deal with. . . . I'm on medication. I'm doing the cocktail. . . . I'm being responsible for that. And it was the program who [sic] turned me around saying it's a bridge back to life. . . . I need to get a life. I need to get a good life.

Analogizing A.A. to a "bridge" calls attention to a way

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of conceptualizing the program often overlooked in the literature--it is an open interactional system. On the one hand, it is a unique total environment or gestalt, the ecological equivalent of a culture of sobriety, able to sustain itself and its members with "adequate provisions for its own change" (Balgopal & Vassil, 1983). On the other hand, it provides a pathway and linkage to a world ("life") beyond itself. The making of this culture of sobriety begins with A.A. and extends outward into new pathways of social construction beyond the bounds of the program. By their behaviors and activities, A.A. members, represented here by the 30 study participants, are carriers of this culture transmitting it as they establish (or reestablish) new relationships with different levels of the environment beyond A.A.

While researchers have attempted to map out "cultures of drinking" (Harford & Gaines, 1981; Fine, Akabas, & Bellinger, 1982), no such blueprint exists for a culture of sobriety which has yet to be explored. This is understandable since A.A.'s stated policy is one of "attraction rather than promotion" (Tradition 11). But the fact that A.A. has unwittingly attracted critics (see

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Riessman, 1990; Zimmerman, 1991; Blau, 1991; Gelman, 1991; Rieff, 1991; Ellis, 1992; Kaminer, 1992) in the past 10 years and has received unsolicited media attention[1] is perhaps evidence of its growing impact on the larger American culture.

Unlike scatter diagrams of "cultures of drinking" (see Harford and Gaines, 1981) which pinpoint venues like bars, social clubs, and other places where alcohol is served, mapping a "culture of sobriety" is a much more elusive undertaking and at best in its rudimentary stage. Sarbin's (1970) notion of "differentiated ecologies," however, offers a tentative, but useful framework within which to capture the transactions of the recovering alcoholic at all levels both inside and outside of A.A.

Sarbin attempts to provide a role-theoretical perspective for community psychologists as change agents by conceptualizing targets for change as the "conduct of persons in differentiated ecologies." In an effort to

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1 An interesting study could be made of the numerous references to A.A. or the "12 step" model over the past decade in the press, films, and television (see Blau, 1991).

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locate these targets for change in a "complicated and changing environment," he proposes conceptualizing the environment as a "set of *differentiated ecologies*--that is, differentiated aspects of the world of occurrences which intrude upon man at all times and in all places" (p. 90). An individual's survival as a "biosocial organism, as a valued person, as a conceptual entity, and as a member of society" depends on one's ability to "correctly locate [oneself] with reference to the world of occurrences" (p. 90). If an individual fails in this task, his or her behavior is likely to be regarded as dysfunctional or "inappropriate, improper, and/or ineffective" (p. 94). When the conduct strains the community's tolerance level, the individual is "removed" and an attempt is made to change his or her conduct. "Removal" usually begins with referrals to "specialists whose aim is to assess the probability of improving conduct through therapeutic intervention before removal from the community." These specialists might include, among others, community psychologists (Sarbin's audience), psychiatrists, social workers, and the clergy. Sarbin is mainly concerned with clarifying the intervention role of the community psychologist, as opposed to other

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therapeutically-oriented specialists, in what he calls the "social (or role) ecology."

The present discussion, however, borrows Sarbin's ecological framework and loosely adapts it, not to identify a target in need of change by a professional specialist, but to illustrate more positively what the long-term recovering alcoholic has made of the experience of self-help participation in A.A. and what remains to be accomplished. The four ecologies are:

1. **The Self-Maintenance Ecology** -

Sarbin (1970) defines this area as the ability to make "discriminations between potentially hostile objects or persons and benign objects or persons" (p. 91). It represents one's basic ability to survive as a "biosocial organism." A failure to orient oneself correctly in this ecology would result in such dysfunctional conduct as phobias, overgeneralization, hallucination, and cognitive distortions.

As the stories of the 30 study participants make clear (see Chapter 7, Theme 1), active alcoholism severely damaged the self-maintenance skills of many members of this sample group making it difficult for them to function successfully

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at this ecological level. Prolonged and excessive intake of alcohol (along with other drugs) had induced fear, cognitive distortion, aggression (or its opposite), defensiveness, obsessionality, overgeneralization, black and white thinking, compulsivity, even auditory and visual hallucinations. Individuals reported feeling anxious, empty, fractionated, numb, depressed, in despair, and sometimes suicidal. Unfortunately, for some, these symptoms, though recognized, were misdiagnosed and the individual was labeled mentally ill and referred to a hospital mental ward (known affectionately in A.A. as the "flight deck").

While the deterioration in study participants' self-maintenance, or what Sarbin calls "discriminative," skills was halted with the cessation of alcohol (and drug) intake, nearly all credited A.A. with helping them to begin to correct these distortions and find the emotional balance that so completely eluded them when they drank; hence the distinction many interviewees made between abstinence (cessation of drinking) and sobriety. While it was impossible to second-guess what would have happened if they had not entered A.A., many indicated that it was

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inconceivable that they could have gotten sober, much less ceased their drinking, without the interposition of A.A. When probed further on this point, a few indicated that they thought other people (and here they excluded themselves) might be able to do so without the assistance of A.A. No study participant, however, could identify anyone who had successfully done so and who they would have called "sober." In general, study participants did not regard abstinent self-changers as "sober" people. In fact, most seemed to adopt the commonly held view in A.A. that abstainers were "dry drunks," that is, while they no longer drank, their basic "alcoholic" behaviors remained unchanged.

As study participants' self-reports indicated (see Chapter 7, Theme 5), everyone described major changes in discriminative skills and emotional intelligence as well as greater acceptance of personal identity. Changes in discriminative skills included the ability to identify and evaluate consequences, recognize feelings, reality test, and see a "middle ground" in place of extremes. Emotional intelligence included greater ego awareness, enhanced self-reflection, increased empathy, and the ability to tolerate discomfort and regulate feelings. Personal

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identity changes included greater normalization of individual self (that is, a sense of feeling adult and age appropriate); emergence of a "real" as opposed to a "false" self; acceptance of one's sexual orientation; feeling more integrated, whole, and autonomous; an improvement in coping skills; and an enhanced sense of empowerment, self-efficacy, and self-esteem.

While self-maintenance reports were generally positive, study participants seemed to respond openly to questions about still unresolved issues of self-development and personal growth. For example, depression, envy, anger maintenance, and obsessive-compulsive behaviors (acting out with food, sex, or money) were mentioned as problem areas. Many had sought out professional help for these issues. Several were on medication for mania, depression, and compulsivity.

In general, the comments of James (10), the "ice man," summed up study participants' efforts to improve at the level of what Sarbin called a "self-maintenance ecology":

> . . . on a lot of levels I was never intimate with myself . . . that's one of the things I had to do in recovery . . . . I had to get a relationship with myself. . . . The environment of A.A. is about self-awareness . . . it's about change . . . . If we were OK the way we were, we wouldn't be there. And

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> once you start changing . . . they provide a positive avenue because there is such a thing as negative change also, but . .. there's no room . . . for negative change. There's no room in A.A. for [the] status quo. . . . 'Cause either you're working towards recovery or you're on your way to the next drink. I learned that the hard way.

2. <u>Social Ecology</u> -

Sarbin (1970) defines this area as the ability to locate oneself in the social structure. One must have knowledge of this structure as well as the ability not only to define one's role in it but to "[infer] the role of others." According to Sarbin, the "matrix of such answers, usually in role-related terms, defines one's social identity" (p. 92). The inability to orient oneself correctly in the social ecology means that one's "subsequent conduct may not meet the expectations of others who have made contrary locations" (p. 93).

While Sarbin's definition relies heavily on role-related behaviors, it may be more loosely interpreted to mean the ability to form and maintain social relationships, that is, as friend, colleague, worker, employer, peer, parent, sponsor, sponsee, partner, mentor, teacher, and learner.

Chapter 7, Theme 7, describes the efforts which study participants made to establish healthy social relationships

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within and beyond A.A. Many had entered the program with damaged familial ties. They also lacked healthy peer supports since entrance into the program often meant abandoning ties to friends who were still drinking and taking drugs. With A.A. serving as a social laboratory, study participants were encouraged to use the program to build a sober peer network by making phone calls, having coffee with A.A. members, and finding a sponsor. Often they discovered that the friends they thought they could count on outside of A.A. were, as Jose (20) had learned, "bottle" friends who disappeared when they entered A.A. For many, the true meaning of friendship remained to be discovered in an A.A. meeting room.

In general, formation of a social ecology began proximally in A.A. and moved distally beyond the program. Many study participants commented on this centrifugal pattern. Regina (12) described it as an "expansiveness" that she observed in herself and in others. Emily (23) noted how everything flowed from her connection to A.A. which then extended outward. And Dorothy (25) commented that "real honest to God relationships . . . were created and started in A.A. and if I couldn't work out my problems

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with people in A.A., I couldn't work them out with anyone else . . . either."

The development of close ties to A.A. sponsors and peers served many purposes. First, they functioned as models of healthy relationships. Dorothy (25) learned this early in her sobriety:

> I came into A.A. and I watched everybody. And I checked out those who seemed to be pretty comfortable and I did what they did. I think that's still the case. We always have a lot to learn from somebody.

Long after networks were established, the program still functioned as a laboratory and well-spring for old-timers like Dorothy within which to refine social skills and build new ties:

> . . . I don't think I would be as comfortable today as I am if I didn't continue the maintenance in the program, if I didn't continue to go, and observe and see and feel . . . and continue to build new relations, not just maintaining all my friends.

In addition, these A.A.-based networks provided support, feedback, advice, validation of selfhood (as in the case of several gay men), and a heavy dose of what A.A. members like to call "unconditional love" even in the face of much resistance and provocation, as the "ice man" reminded this researcher:

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> God works his miracles through the people he puts in my life. If it wasn't for the people in the rooms who hung in there when I kept telling them . . . 'get away from me, leave me alone, I'll hurt you' . . . and I meant these things.

For older individuals like Edmund and Harriet (68 and 72 years of age respectively; each had 23 years of sobriety) who were estranged from their loved ones, A.A. friends served as surrogate families providing an intimacy that was missing from their real families. Moreover, where relationships in blood families had been competitive, social relations in A.A. were perceived as collaborative. Edmund commented:

> . . . all of us had in common one wish, that we collectively and individually would be sober and stay sober. [A] secondary residue was that they were not competitive with each other. [These] relationships . . . were profoundly more influential to me than anything that was blood . . . . We had a concern and love and compassion and a willingness to extend ourselves without . . . even a notion of a reward . . . not even a thank you. . . . It still even to this day exists more within the A.A. structure for my life than it does . . . elsewhere.

The formation of social ties in A.A. also produced secondary gains for study participants like the lessening of a preoccupation with self as Janice (16) was to discover when she tried to support a close A.A. friend who was dying of AIDS:

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> . . . being there through it all . . . learning a lot about myself, finding out that I wasn't going to run away, that I would stand there with somebody and be whoever they needed me to be and put myself aside for it and realize that what they needed was more important than my own feelings at that time . . . .

Study participants learned how to express their anger appropriately without fear of losing the other as object. They learned to assert themselves. They learned how to listen and not try to fix others or take away their pain. They also learned how to "read" feelings in other people.

Once having established social relations in the program, A.A. members were expected to practice this principle, among others, in all their affairs (Step 12) or as the "ice man" succinctly put it, "you have to take your program with you." They were encouraged to make amends to those they had harmed (Steps 8 and 9) and to try to repair ties to family, friends, and other associates outside of A.A. For the most part, many succeeded and seemed surprised by the results. They reported expanded social ties beyond A.A. which they worked hard to cultivate and maintain.

Not all study participants, however, were successful at the social ecological level. Some regretted exploiting A.A. relationships for their own ego satisfaction. Others struggled to maintain a balance between their tendency to

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isolate and a need to maintain social ties. Several intimate partnerships with A.A. members broke down--a marriage ended in a bitter divorce when one partner relapsed, another marriage foundered, while a third couple ended a long-term relationship, which had produced a child. Finally, family problems mounted for some study participants whose children were caught committing anti-social acts and showing signs of addiction.

3. **Normative Ecology** -

Sarbin (1970) defined a "normative ecology" as the "systems of norms and values that guide cultural participation and, to a large extent, supersede specific roles" (p. 93). At this level, the individual locates himself or herself in this ecology by asking, "how well am I meeting the standards" or "how well am I participating in my culture" (p. 93)? While this level is not fully developed by Sarbin, he seems to have in mind a wider sphere of public engagement--the larger culture. For the purposes of the present discussion, therefore, a "normative ecology" will be defined as participation at the broader community level. Given this definition, Sarbin's questions become appropriate to ask of the 30 study participants. How well have they

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participated at the broader community level? How well have they met standards?

With the exception of one study participant who no longer attended A.A., all others continued to do service by their very presence at meetings. Many chose to take on specific tasks and roles in and out of meetings serving as sponsors, speakers, officers (known in A.A. as "trusted servants"), doing telephone work for New York Intergroup, attending A.A. regional conferences, and helping to operate hotlines at the community level. As with the social ecological level, many took this service ethic with them into the wider social world. Emily (23) explained this widening service commitment, which had begun in A.A., as a "freeing up of the shackles of self." Self-maintenance had now been taken to a higher level of human endeavor:

> . . . the principles of A.A. and the sort of foundation of it for me in my life has been, I learned that early on . . . . I learned early on those basic principles [that] you can't keep it unless you give it away . . . wanting to live in service . . . that has just gone deeper into me as time passes. . . . I don't even get it, although it's certainly supported, in church. I don't get it in the same way that I get it in A.A.

From A.A., to family, to a profession, to being active in her church, to helping a community of elderly nuns, her commitments seemed to expand exponentially:

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> I notice the world around me. I'm interested in what's going on and I read about things and I talk about things and I take actions. When I think it's appropriate I write letters or call . . . my councilperson.

Two decades of experience in A.A. had transformed a fractionated and dispirited self ("Everything was in little pieces and I could never pursue anything I was interested in") into a mature, integrated, goal-directed, purposeful human being with "long-term commitments and a sense of rootedness in the world":

> I have a world, I have a community . . . I have my routines, things I love and things I do and people I have long association with now . . . , many of them outside the program.

Many other study participants described experiences similar to that of Emily's but in different language. Dorothy's (25) path had taken her from welfare dependency ("I was a direct detriment on society") to being a "citizen of the world." Note her choice of metaphor to illustrate how she perceived herself at the level of normative ecology:

> I think the program talks about being a citizen, being a friend of a friend, and a worker among workers, and a citizen of the world. So the principles of trying to be a good citizen, it's not baloney, it's real.

Edmund (23) used a similar elevated vocabulary to describe what it meant for him to live "within [a] community of sober people":

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> People's lives become more meaningful to them and society. They have a care . . . [a] way of behaving and directing themselves, that's related to, not their family, not to religion, but to a set of maxims, principles . . . collectively drawn together from a variety of areas. It's not mystical . . . .

While Edmund still struggled at the self-maintenance level to keep in check his inner demons ("I know that inside of me there is a reptile at work"), he strove to "live a virtuous, worthwhile life." He proudly enumerated his various commitments at the community level--a respected career in the health field as a policy maker, service on several non-profit boards that influenced health policy, invitations to join prestigious professional organizations as a layman because of his extensive policy experience--and attributed this widening service ethic to the moral education in citizenship he had received in A.A.:

> A.A. gave me a focus for behavior which had as its end goodness and righteousness and a morality and ethics and a measurement of my behavior . . . as a citizen on the planet.

Like Edmund, many other study participants reported being engaged in projects at the community level--volunteering for church-related service, mentoring the homeless in shelters, working with the terminally ill in hospitals, promoting HIV prevention education in schools, establishing political advocacy networks. Others demonstrated their concern more

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indirectly through charitable contributions to organizations promoting social justice.

To be sure, not all study participants were able to function securely at this ecological level. Some struggled with more mundane self-maintenance and social ecological problems associated with job loss, business failure, retirement, broken relationships, and ill health. But even those beset with serious personal problems seemed to strive towards living a purposeful life according to a set of principles acquired in A.A. If they could not function as a "citizen of the world," by their commitment to sobriety and to meeting attendance they could at least act out their roles as good citizens in A.A.

4. <u>The Transcendental Ecology</u> -

Sarbin's (1970) fourth ecology is situated at the more abstract level of what he calls "transcendental objects." Here the individual must locate himself or herself in relation to such abstractions as "God, the universe, mankind, justice, [and] departed ancestors" and search for satisfactory answers to the question, "What am I in relation to transcendental objects"? According to Sarbin, failure to resolve this question "may lead to chronic doubt, obsessive

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thought, and to other forms of conduct that interfere with individual adjustment and life" (p. 94).

A.A., in its own way, invites the individual to make a similar search at this transcendental level. Steps 3 and 11 are steeped in the language of transcendence, while Step 12 makes explicit that Step work is designed to lead to a "spiritual awakening." While this subject remains controversial among some in A.A., it is clear from the responses of a majority of the 30 study participants that spirituality and the search for transcendence remained central to the maintenance of their sobriety. Why this should be so has confounded researchers who have sought to demystify the program in an effort to understand its hold on its adherents. A.A. shrewdly answers its critics with Herbert Spencer's cautionary note to avoid "contempt prior to investigation" (Alcoholics Anonymous, 1976, p. 570).

Often the most eloquent and moving moments of the interviews occurred when study participants shared private thoughts about their transcendental experiences. That they did so is significant given the fact that a few expressed residual anger towards professional helpers who had rejected their attempts to share this dimension of their lives. As

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Janice (16) commented:

> I've never really had the sense that any of the therapists I've gone to have fully understood or accepted the spiritual aspects of recovery. . . . I've somehow felt at times that I've almost defended that to therapists in a way.

Study participants' narratives contained numerous allusions to a transcendental experience of a Higher Power as individuals sought to make sense of their alcoholism and subsequent recovery. But examined more closely, these references also provided a window on the complex ecology that constituted the recovery experience. In ecological terms, Alice's (26) explanation linked the self-maintenance ecology with the more transcendental ecology:

> What I really believe my alcoholism did to me is that it alienated me from God and the better part of myself. When I stopped drinking I was better able to nurture myself and to seek things that enhanced my ability to stay sober.

Regina's (12) insights revealed a matrix of interconnecting self-maintenance, social, and transcendental levels:

> . . . a major part of my recovery . . . is the 11th Step . . . to be aware of God's will in whatever way it comes through to me . . . . It's allowed me to feel comfort . . . to go that extra step of really caring about others in some real way. And where that has brought me today is that my mother who was my abuser . . . has Alzheimer's and that has allowed me to take care of her who never took care of me . . . in this openhearted and compassionate way . . . . I then am . . . certainly healed by . . . being able to feel

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> her love when . . . she couldn't give it before . . . and certainly I couldn't have been present for it anyway.

Fred's (13) narrative depicted a triangulation of three ecological levels--self-maintenance, normative, and transcendental:

> What has happened to me is . . . unbeknownst to me I lost my humanity to alcoholism and I lost my connection to myself and to the world and . . . having not known what I had lost . . . I didn't even know to look for, or to try to get it back, but . . . in some inexplicable way found it, on a deeper level found my humanity and found my sense of myself and God and the world through A.A.

Complex ecologies, like the ones embedded in these excerpts, are everywhere to be found in the stories told by the 30 study participants. They are the scaffolding of a remarkable but elusive culture of sobriety for which the present study has attempted to supply a blueprint.

SUMMARY

This chapter offered a detailed analysis of the outcomes of interviews in terms of the theoretical framework proposed in Chapter 3. The chapter was divided into three sections. Section I, "Building the Bridge - The Narrative as Metaphor," applied narrative theory to a discussion of the interviews. Section II, "Crossing the Bridge - The Recovering Alcoholic as Cultural Guide," utilized a cultural

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competency perspective to analyze outcomes. Sections I and II then served as a conceptual bridge to Section III, "Toward an Ecology of Sobriety," which reframed the material and incorporated it into a more fully elaborated ecological model of sobriety.

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CHAPTER 9

SUMMING UP

INTRODUCTION

This chapter presents the conclusions derived from the interviews with the 30 study participants and offers recommendations for future research efforts. It also contains a discussion of the implications of the study's findings for contemporary social work practice and for the formulation of new policy directions within the field.

CONCLUSIONS AND RECOMMENDATIONS FOR FURTHER RESEARCH

The literature survey presented in Chapter 2 noted the paucity of qualitative studies in social science and in social work on long-term recovering alcoholics, especially those with 10 or more years of uninterrupted sobriety. There is, however, a curious irony here. If this were a target population of long-term survivors of cancer or AIDS, undoubtedly there would be considerable research interest in these individuals. But long-term survivors of alcoholism have not drawn the attention of the research community in the same way. One can only speculate as to why this is so.

Barber (1994) notes the "air of pessimism" that hangs over the addiction field given the relapse-prone nature of

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the disease. Although there are documented treatment successes, he argues, there is still considerable confusion over such methodological issues as how to define success, how to measure it, and how to validate these outcomes.

Moreover, as we have seen, A.A as a lay organization (with 65 years of experience welcoming the alcoholic) still represents a significant challenge to the hegemony of medical, health, and social work professionals whose expertise is undermined by the self-defeating behaviors of the active alcoholic. Finally, as many researchers have noted (see, for example, Goldstein, 1990; Saleebey, 1992 and 1996), the professions are still dominated by a diagnostic lexicon that emphasizes pathology over strengths. Active alcoholics provide enough "case example" fodder to justify their being regarded as some of the most difficult, intractable, and unglamorous clients to work with. Sober alcoholics, especially those in so-called "early" (Stage I) or "middle" (Stage II) recovery, seem to be the focus of research and popular self-help books perhaps because of their greater accessibility (see, for example, Larsen, 1985). But the long-term recovering alcoholic with 10 or more years of sobriety appears to have receded from the

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researcher's view.

The present study was undertaken to overcome the pervasive pessimism noted by Barber and to give voice to a population long since reintegrated into the social and economic mainstream and, therefore, now largely silent. Long-term survivorship in A.A. is not an anomaly. It is a genuine phenomenon in need of further study. Whether accompanied by treatment or other forms of therapeutic intervention, many more A.A. stories remain to be uncovered, examined, and legitimized as the kinds of examples of resilience and successful adaptation over time discussed in the strengths-based perspective literature (see Masten, 1994; Saleebey, 1996). Qualitative research, with its focus on narrative, not numerics, seems best suited as the vehicle with which to undertake this work (see also Lowery, 1999).

Many conclusions can be drawn from the present exploratory study. They may open new pathways for further investigation:

1. Long-term recovery of 10 or more years may represent a new developmental stage (Stage III) in the recovery cycle. However, long-term recovery is not necessarily progressive. Nor is there any single path to protracted sobriety or any

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single method that assures maintenance of that sobriety. The characteristics of this advanced stage remain to be elucidated.

2. Personal development is an open and fluid process that is unique to the individual. It can be re-invigorated at any point in the life cycle of the person who chooses recovery over active alcoholism. Long-term recovery narratives challenge the fixed model of psychosocial development offered by Erik Erikson and others.

3. The development of a secure personal identity is a remarkable feature of recovery. Recovery in A.A. plays a significant role in the consolidation of this identity for both males and females, whether heterosexual or homosexual. The components of this process need to be identified and better understood.

4. A.A. has contributed to a paradigm shift from a culture of drinking to a culture of sobriety. An undue and somewhat cynical emphasis in the last decade on the trendiness of the recovery movement has inhibited a fuller discussion of the attitudinal changes occurring in American culture towards drinking. The topographical features of a culture of sobriety remain to be mapped out. A secondary research task

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is determining the extent to which A.A. has interpenetrated the culture in terms of language, imagery, metaphor, and general philosophy of life.

5. A.A. has played an important role in helping recovering individuals cope with life-threatening illnesses like AIDS. The scope and depth of its impact as a care-giving resource network and its ability to help in the management of catastrophic illness has yet to be told.[1]

6. Spirituality, as A.A. literature suggests, is an important source of strength, inspiration, meaning, and healing. The mechanisms of this vague and undervalued process need to be identified and a comparison made between those long-term recovering individuals who have chosen a spiritual path and those who have not. What differences, if any, exist between the two populations in the consolidation and maintenance of their sobriety?

7. A.A. is a natural helping community that provides essential lessons in civic and moral development. Many study participants successfully transferred their

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1 See, for example, the story told by P. [Peter] S. (1991). For a different view of how some individuals have chosen to cope with HIV illness and alcoholism, see Gorski (1993).

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experiences as citizens in A.A. to larger ecologies beyond the program. What are these lessons and what is their relevance to American culture? Moreover, an urban A.A. increasingly reflects the diversity and egalitarianism of contemporary society. While the present study revealed few differences in the experiences of a representative sample of urban Americans, more attention needs to be directed to the narratives of so-called minorities in A.A.--women, African-Americans, Hispanics, Native Americans, Asian-Americans, and gay men and lesbians.

8. A.A. continues to offer personal meaning and fellowship to long-term recovering alcoholics, single or partnered, regardless of age, gender, sexual orientation, religion, or race/ethnicity. In general, the commitment to their sobriety that study participants demonstrated was matched by the degree to which they remained affiliated with the A.A. program and adhered to its principles and practices. Only one individual in the sample was discovered to have ceased her attendance in the program; however, she still remained sober and retained strong ties to other still affiliated long-term A.A. members. We know little about what happens to those with long-term sobriety who no longer attend

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meetings. To what extent do they remain sober? Do they retain strong ties to other attendees? What lasting impact, if any, has A.A. had in their lives? Nor do we know much about those who have achieved long-term sobriety through alternative natural helping networks like Rational Recovery or similar programs. How do these populations compare with long-term sober A.A. attendees?

9. Long-term recovering alcoholics in A.A. offer continuity, a stable presence, experience, inspiration, and wisdom to others in the program. Their seniority, in chronological years and length of sobriety (more than half had remained sober from first onset in A.A., itself a remarkable achievement given the relapse-prone nature of the disease), is especially symbolic. More than half of the study participants in the sample were over the age of 50 at the time of the interviews; one-third of the total sample was 60 years of age or older and four were over 70. Three of these individuals had entered A.A. over the age of 50. Despite the fact that the average age of A.A. attendees was found to be 45 (A.A. World Services, 1998 A.A. Membership Survey), A.A. manages to retain older individuals. This is significant given the fact that alcoholism is still a

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largely invisible problem among older adults (see Haberman, 2000). Their commitment to the program and attendance at meetings is worthy of note and further study.

10. Couples in A.A. have a mixed history of success in sustaining their partnerships. What is the impact of the program on these relationships when one or both partners are in the program?

11. A.A. narratives provide a powerful testimony of healing and personal transformation. As self-reports, they have been largely unchallenged by investigators. A study of key informants--the significant others of recovering individuals--could provide further validation of these self-reports.

12. Individuals who have sought recovery in A.A. credit the program with helping them to maintain their sobriety. Many did not see themselves as self-changers, that is, they attributed their ability to maintain their sobriety to their experience of being in the program. More work needs to be done on identifying a population of long-term, secure self-changers, that is, people who never attended Alcoholics Anonymous but who nevertheless stopped drinking without any self-help or therapeutic intervention. What are the

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characteristics of *these* self-changers? How do they manage to maintain their abstinence? What do they report about their experiences? How do they compare to their counterparts in A.A.?

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The Curriculum Modules on Alcohol and Other Drug Problems for Schools of Social Work (1995), produced by the Curriculum Enhancement Task Force in collaboration with major social work professional organizations, represent a significant contribution by the profession to the education and training of social workers seeking to work with active and recovering alcoholics. Much attention in these modules is devoted to an understanding of the nature and complexity of the illness (the Curriculum reviews the various conceptualizations of alcoholism, including the "disease" model), its impact on families and significant others, the array of self-help, pharmacological, and other treatment modalities available, the status of social work research, and the policies that govern the profession's public response to addiction. But this modular outline, detailed and thorough as it is, represents the perspective of the professional. Therefore, it provides only a partial picture

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of what is needed. Missing are the contributions of the seasoned "cultural guide"--the long-term recovering alcoholic.

The present exploratory project is an attempt to rectify this omission and complete the picture with contributions from 30 experienced cultural guides. What emerges is the fact that there are still gaps in the education and training of social workers that need to be addressed. Chapter 8 noted some of these general areas--improved understanding of the biopsychosocial effects of alcoholism; knowledge of the impact of alcoholism on families; greater familiarity with self-help groups like A.A.; increased respect for and support of the alcoholic still struggling to overcome active addiction; understanding of sobriety as a process as well as an outcome; knowledge of the resources available to the alcoholic and how to facilitate access to them; awareness of the nature and dynamics of personal change; and support for the recovering individual as he or she enters or returns to the workplace, reestablishes connections to significant others, and develops a spiritual life. The following recommendations supplement those already discussed in Chapter 8.

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As we have seen, much of social work literature on alcoholism, following a medical model, is too focused on pathology. A strengths perspective needs to be applied to a study of active and recovering alcoholics. Practitioners must examine their beliefs and attitudes about alcoholism and be careful not to contribute to the continuing denigration and stigmatization of sufferers from this disease. A strengths perspective would challenge social workers to rethink and reframe their approach in working with alcoholics.

Social workers who treat alcoholics in agency settings or in private practice need to become more familiar with A.A. and other self-help entities which appeal to and serve this population. But the familiarity must go beyond textbook knowledge. They should attend Open meetings of A.A. with some regularity, read A.A. literature, and make an effort to meet and talk with recovering people at all stages of sobriety (see Lee, 1960; King et al. 1979; Grutchfield, 1986; and Davis & Jansen, 1998). Twelve-step and other self-help organizations do not exist to compete with professionals; nor should they be viewed as a threat to professional practice. Instead, social workers should look

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for ways to collaborate more effectively with these groups and view them as potential allies in helping alcoholics to stay sober and to begin to function more effectively in the key arenas of their life--work and relationships.

Social workers would do well to support and encourage those recovering alcoholics who choose to develop their spiritual lives. They should abandon the intellectual arrogance that often accompanies professional training which may have suggested that spiritual development and religious affiliation are either irrelevant or pathological. They need to recognize the powerful healing provided in a spiritual and religious context.

Social workers must understand the underlying complexity of alcoholism as an illness. There is no "cure" for this disease. In A.A., the recovering alcoholic learns to maintain constant vigilance against the reoccurrence of the disease in its many manifestations. As we have seen from the interviews with study participants, recovery does not guarantee, however, that the individual will be free of self-defeating behaviors. Social workers need to be knowledgeable as well about other co-addictions like bulemia, gambling, excessive spending, and sexual

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compulsivity with which the long-term recovering person still may be struggling; and with how and where to access the resources available for help with these baleful co-existing conditions.

Social workers must respect and be sensitive to the concerns of the recovering alcoholic about medications to combat depression. Many recovering individuals in A.A. differ in their attitudes toward the use of prescription drugs for depression. Those in recovery who are averse to taking these medications are likely to use the A.A. program to try to alleviate their distress. Social workers should be supportive of clients who choose to maintain drug-free lives.

Social workers must be attentive to their own addictive patterns of behavior and assume responsibilty for seeking help as needed. Some may be in recovery from alcoholism and the kinds of co-addictions described in the narratives of study participants. As professional helpers, however, they must be clear about whether or not to disclose this personal information to clients.

The social work curriculum needs to include more personal narratives of individuals who have achieved

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long-term sobriety. As we have seen, cultural competency also includes the willingness to assume the role of "learner" to individuals who have first-hand knowledge of their own cultures. These "cultural guides" are in a unique position to provide vivid testimony of the impact of the disease and the dynamics of recovery. A.A. maintains a Speaker's Bureau of individuals who are willing to recount their stories in a public setting. Social work educators should take advantage of this important A.A. service to the professional and lay communities and view it as a pedagogical opportunity.

Finally, armed with this cultural competency perspective, social workers can play a significant role as they collaborate with other professionals (physicians, nurses, psychologists, clergy) who work with active and recovering alcoholic clients. In particular, they can provide a much needed "linkage" to these professionals by representing the concerns of this much stigmatized client population. Such advocacy will help to overcome the negativity, misinformation, and stereotyping that still exists and contributes to the denigration of the recovering alcoholic.

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IMPLICATIONS FOR SOCIAL WORK POLICY DEVELOPMENT

As noted in Chapter 2, the NASW Delegate Assembly approved a new policy statement on alcohol and other drugs in 1996. The statement covered four major areas--1) social policy; 2) professional issues; 3) prevention, intervention, and service delivery; and 4) research. While the statement is comprehensive, this study yielded the following additional recommendations for future social work policy consideration:

1) Social Policy -

The social work profession should:

a. Assume a more active role in promoting public awareness that alcohol and drug abuse is a serious national health problem despite government statistics that show a decline in alcohol and drug dependency.

b. Provide more active advocacy at national, state, and local levels for funding for the expansion of treatment and service delivery systems.

c. Assume a leadership role in the struggle for a universal health care that includes coverage for alcohol (and drug) problems.

d. Sponsor the first national social work conference on

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alcohol and drug abuse.

d. Endorse more positive, abstinence-based approaches to alcoholism and speak out against "moderation management" strategies which mislead the public into believing that an alcoholic can return safely to moderate drinking (see Verhovek, 2000).

e. Support abstinence-based organizations like A.A. and collaborate with other advocacy groups like Mothers Against Drunk Driving (MADD) and Students Against Drunk Driving (SADD) in urging more effective legislation to curb drunk driving and to create a uniform national blood alcohol level standard.

f. Solicit the participation and involvement of long-term recovering alcoholics in the formulation of policies and treatment protocols benefitting the active and recovering alcoholic.

2) **Professional Issues** -

The social work profession should:

a. Foster greater collaboration with other professionals (ex: psychologists, physicians, clergy) regarding alcohol and drug problems without sacrificing a primary role in the education and training of social work practitioners

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specializing in the treatment of alcohol and drug dependent clients.

b. Strengthen attempts to identify and provide services for social work colleagues who need help with alcohol and drug problems.

c. Establish a credentialing and recredentialing process within the profession for social workers who plan to work with alcohol and drug clients.

d. Offer courses, workshops, and other professional development activities in alcohol and drug education, treatment, and research for credentialing and continuing education credit through the Internet.

e. Encourage practitioners to attend Open meetings of A.A. and related self-help organizations as a form of self-education.

3) <u>Prevention, Intervention, and Service Delivery</u> -

The social work profession should:

a. Assume a more active role in the design and implementation of effective treatment strategies and service delivery systems.

b. Be knowledgeable about what works and what does not work, and be able to adapt treatment to different client

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groups--women, the elderly, ethnic minorities, gays and lesbians.

c. Enthusiastically support and encourage client attendance in self-help organizations like A.A.

d. Understand the needs of the long-term recovering individual and utilize a strengths perspective in working with clients with past histories of alcohol abuse.

4) Research -

The social work profession should:

a. Understand the history and evolution of the role of social work in the identification, care, and treatment of alcoholics.

b. Take a more proactive role in the conduct of research on alcohol and drug problems and treatment and service delivery policies and practices.

c. Contribute to a new research category herein called "sobriety or recovery studies" by conducting more quantitative and qualitative longitudinal research on those who succeed in maintaining sobriety and sober living.

d. Undertake the creation, design, and development of a new social work journal with a focus on social policy; professional issues; prevention, treatment and service

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delivery; and research in alcohol and drug abuse.

SUMMARY

This chapter presented the conclusions which emerged from interviews with the 30 study participants and offered recommendations for future social work research efforts. It also provided a discussion of the implications of the study's findings for contemporary social work practice and for the formulation of new policy, research, and educational initiatives within the profession.

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APPENDIX A.

THE TWELVE STEPS

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

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THE TWELVE TRADITIONS

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority--a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose--to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

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APPENDIX B.

INTERVIEW GUIDE

INTRODUCTION: I am conducting a study about recovery through Alcoholics Anonymous. I am particularly interested in speaking with you because you have ten or more years of continuous sobriety. Since there has been very little written about people with long-term recovery, I think your experience with the program would be very important to document in an effort to help people understand the nature of recovery and the role that A.A. has played in it. The information you provide will help to improve research and education in the field of alcoholism.

The questions I will ask you pertain to the process of recovery as you have experienced it in A.A., to the past and current problems, issues, and obstacles you have encountered and may still be encountering in maintaining your sobriety, and to the strategies and solutions you have devised to overcome these obstacles. In addition, I will ask you questions about your family, your friends and associations, your personal development, your occupational history and plans, and your spiritual outlook. Everything you say to me in this interview will be kept strictly confidential and your identity will be known only to me. Thank you very much for your time, patience, and assistance.

1. Describe your personal development in A.A.

a. Describe the course of this development. What was the process like? Was it easy? Difficult?
b. What changes, if any, have you experienced in yourself in your sobriety?
c. Can you identify stages in your personal development in A.A.?
d. How has your later recovery differed from your early or middle recovery?
e. What difficulties did you encounter in your personal development?
f. What helped you to overcome these difficulties?
g. What relationship do these changes have to the maintenance of your sobriety?

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2. What were the most important milestones or critical events of your recovery?

a. Describe these milestones or critical events.
b. What helped you to achieve these milestones?
c. Who were the most important influences on your recovery?
d. What were the most important influences on your recovery?

3. What has helped you to maintain your sobriety on such a long-term basis?

a. Have you ever been close to relapse while in A.A.? Give examples of times you felt at risk. How did you cope? What helped you to stay sober?
b. What keeps you from drinking today? Why haven't you relapsed?
c. What do you do today to maintain your sobriety?
d. How do you feel about being a long-term sober person?

4. What role does A.A. play in helping to maintain your sobriety today?

a. Do you attend meetings? How often? What kind?
b. Do you have a sponsor? Do you sponsor others?
c. Do you still maintain contacts with other A.A. members? With whom? How often?
d. What is your experience of A.A. as a long-term sober person?
e. What obstacles or difficulties do you encounter in A.A. as a long-term sober member? What steps, if any, have you taken to resolve these obstacles or difficulties?
f. Are you active in A.A. today? In what capacity? (speak at meetings, make 12 step calls, volunteer/service work, run meetings, group representative)
g. What are your needs as a long-term sober member? Does A.A. address your needs as a long-term sober member? If not, what should A.A. do to address your needs?

5. Since joining A.A., have you sought outside help for any problems, issues, or conflicts in your life?

a. What efforts did you make to get help?
b. From whom did you seek help? Social worker? Psychologist? Psychiatrist? Medical doctor? Counselor?

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Spiritual or pastoral advisor? Other?
c. Did you disclose your membership in A.A. to this person? What was his/her attitude toward A.A.? Was he/she knowledgeable about A.A.? Knowledgeable about alcoholism? Knowledgeable about recovery?
d. Was the help compatible with your recovery?
e. Are you still receiving outside help?
f. What is the relationship between the help sought and the maintenance of your sobriety?

6. What changes have occurred in your occupational or professional status since becoming sober?

a. Describe your work history in sobriety.
b. Have your professional or occupational goals changed in sobriety? If yes, how have they changed?
c. Is there any connection between the changes in your professional or occupational goals and the maintenance of your sobriety?

7. What kind of support system do you have today?

a. Describe the people in your support network (ex: household, extended family, A.A. friends, non-A.A. friends, A.A. sponsor, sponsees, work colleagues, school friends, neighbors, professional helpers, co-religionists). To your knowledge, how many of these people are in recovery themselves?
b. How many of these people know that you are in recovery? How do you feel about them knowing this?
c. Which relationships are the most meaningful to you? Why?
d. Is your support network different from or similar to the support system you had prior to recovery? If different, describe how it has changed.
e. Do members of your network provide emotional support, concrete assistance, information or advice, spiritual or moral guidance?
f. Which members of your support network are you closest to? Least close to? Sort of close to?
g. How long have you known the people in your network?
h. How often do you see the people in your network?
i. What role does your support network play in the maintenance of your sobriety?

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8. How would you describe the quality of your life today as a long-term sober person?

a. How does it differ from the time when you were drinking?
b. What are your goals today? How are they different from the time when you were drinking? From early sobriety?
c. What activities do you participate in today? Personal? Professional? How are they different from the activities you were involved in when you were drinking?
d. What organizations or associations do you belong to today? Are they different from the groups you belonged to when drinking? From early sobriety?
e. Do you socialize with people who drink? How do you handle these situations? Do you go to bars? Do you keep alcohol at home?
f. Are you involved in any activities that promote sobriety or the goals of A.A.? Have you personally initiated any of these activities?
g. What obstacles to your sobriety do you encounter in your environment? How do you overcome these obstacles?

9. How has your spiritual life changed, if at all, since coming to A.A.? If there have been changes, then answer the following:

a. Describe your spiritual life prior to your entrance into A.A.
b. What changes have you made in your spiritual beliefs or practices since coming to A.A.?
c. Since entering A.A., what experiences have influenced the development of your spiritual life?
d. Who has influenced you the most in the development of your spiritual life since coming into A.A.?
e. What have you done to maintain your spiritual life since coming to A.A.? What do you currently do to maintain your spiritual life?
f. What connection does your spiritual life have to the maintenance of your sobriety?

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APPENDIX C.

BACKGROUND SURVEY

Date of interview: How contacted:

Sex: M F Age:

Racial/Ethnic Background:

African-American Native American
Hispanic Asian/Pacific Islander
Caucasian Other:

Occupation:

Marital Status: Single, never married Divorced
Married Widowed
Separated Partnered
Is spouse/partner in AA? Y N
If YES, how long?

Children: # Ages:

Family of Origin:

Mother: Living or deceased? Is mother your biological parent? Y N If not, who raised you?
Father: Living or deceased? Is father your biological parent? Y N If not, who raised you?
Children of Alcoholic(s)? Y N
(circle either or both) Mother Father
If YES, is or was mother in AA? Y N How long?
If YES, is or was father in AA? Y N How long?
Number of siblings: M ( ) F ( )
Siblings who are alcoholic:
Male - How many? In AA? Y N How long?
Female - How many? In AA? Y N How long?

Date of entry into AA:

Years of continuous sobriety in AA:

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APPENDIX D.

INFORMED CONSENT AGREEMENT

Please read the following statement:

I am conducting a study about recovery through Alcoholics Anonymous. I am particularly interested in speaking with you because you have ten or more years of continuous sobriety. Since there has been very little written about people with long-term recovery, I think your experience with the program would be very important to document in an effort to help people understand the nature of recovery and the role that A.A. has played in it. The information you provide will help to improve research and education in the field of alcoholism.

The questions I will ask you pertain to the process of recovery as you have experienced it in A.A., to the past and current problems, issues, and obstacles you have encountered and may still be encountering in maintaining your sobriety, and to the strategies and solutions you have devised to overcome these obstacles. In addition, I will ask you questions about your family, your friends and associations, your personal development, your occupational history and plans, and your spiritual outlook. Everything you say to me in this interview will be kept strictly confidential and your identity will be known only to me as the researcher.

The interview will be tape recorded and will be used for research purposes only. At the same time, as the researcher I will also be taking notes. You have the right to refuse to answer questions and to request that the tape recorder be turned off at any point in the interview. If at any time this interview is particularly difficult, you can stop it and voluntarily withdraw from the study without penalty. Please feel free to ask any additional questions regarding the purpose or procedures of this study.

Thank you very much for your time, patience, and assistance.

I understand these instructions and the information provided and do agree to participate in the research described.

_____ _____

Signature Date

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