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Fostering Client Connections with Alcoholics Anonymous: A Framework for Social Workers in Various Practice Settings

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ABSTRACT. Alcohol abuse is common among clients in human service agencies, but most never seek help for their drinking problems, either in professional treatment or self-help (mutual aid) groups such as Alcoholics Anonymous (A.A.). A.A. is a widely-available resource, but it is not always introduced to clients in a manner that fosters acceptance of A.A. Social workers in various practice settings can facilitate A.A. affiliation by working collaboratively with clients, seeking a goodness-of-fit between client needs and the resources available within A.A. This article offers a pragmatic approach to initial A.A. involvement, intended to help professionals utilize barriers to affiliation as opportunities for furthering both counseling goals and the connection to A.A. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com]*

KEYWORDS. Alcoholics Anonymous, alcohol, dropout, social workers, human services

INTRODUCTION

Alcohol problems are common among clients in most human services settings, e.g., 30% of general hospital patients (Johnson, Phelps, & McCuen, 1990) and 44% of mental health clients (Weisner & Schmidt,

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1993), but fewer than one-fourth of problem drinkers ever seek help in alcohol treatment settings or Alcoholics Anonymous (Weisner, Greenfield & Room, 1995). As Marlatt, Tucker, Donovan, and Vuchinich (1997) note, ''most substance abusers do not enter substance-focused treatments or self-help groups . . . [but do] . . . utilize other medical and mental services with higher frequency'' (p. 44). Therefore, there is a need to give greater attention to drinking problems ''within community agencies that provide general services to various populations'' (Institute of Medicine, 1990, p. 211). Because social workers are employed in a range of health, mental health, child welfare and other human service agencies, they are in a position to contribute to the Institute of Medicine's (1990) goal of ''broadening the base of treatment for alcohol problems'' within the community settings in which they are employed. This article provides social workers and other helping professionals with a more expansive and pragmatic understanding of Alcoholics Anonymous (A.A.), the most widely-available adjunct to professional treatment, and seeks to improve the ability of professionals in non-treatment settings to link clients successfully with A.A.

Although A.A. is not appropriate for all clients, the program provides a readily-accessible and no-cost support for individuals seeking recovery from alcohol abuse and dependence. Unfortunately, among individuals who initially attend A.A., 50% drop out by the fourth month and 75% within one year (Alcoholics Anonymous, as cited in Emrick, Tonigan, Montgomery, & Little, 1993, p. 59). Some individuals certainly drop out because they simply are not ready to stop drinking, but others may be leaving because they are unable to embrace or utilize important aspects of the A.A. program. This inability to connect with A.A. may be related in part to the approach taken by professionals when introducing A.A. to clients. For example, practitioners may contribute to dropout if they speak negatively about the program or if they fail to provide ''minimal understanding or preparation'' (Johnson & Chappel, 1994). Conversely, professionals may alienate alcohol-abusing clients from A.A. by attempting to rigidly impose the program on them without consideration for their individual needs and inclinations. The result of either undervaluing or ''hard-selling'' A.A. is that individuals may avoid the fellowship altogether, or may drop out early because they do not see how A.A. might be useful to them.

Straussner and Spiegel (1996), in their creative discussion of A.A.'s

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contribution to healthy ego development, assert that A.A. is essentially an ''undemanding and totally supportive'' approach that provides opportunities to ''utilize the program differentially during the various phases of the recovery process'' (p. 304). Several other writers also advocate that A.A. be employed flexibly with clients, and oppose rigid or coercive approaches. Nowinski (1996) states that mandated attendance is ''not consistent with the spirit of the fellowship,'' and recommends a ''low-key approach'' that emphasizes ''positive reinforcement'' and engaging clients in ''constructive collaboration'' rather than confrontation (pp. 40-41). Emrick et al. (1993) state that, ''quasi-coercive or coercive A.A. involvement is simply inappropriate, if not unethical or even illegal,'' and suggest identifying ''the ingredients in the A.A. experience that are most helpful for whom, and at what time in the course of recovery'' (pp. 59, 62). Gorski (1989) also opposes requiring A.A. attendance or providing only limited contact information about A.A. meetings, asserting that clients are more likely to go to A.A. if they are informed about the nature of A.A. meetings and practices and given choice regarding their participation. This view is supported empirically by Sanchez-Craig (1990), who found that choice in the development of recovery goals is associated with better outcomes in treatment for alcohol and other drug problems.

Others have also argued that a more viable connection to A.A. may result if professionals take a more collaborative, supportive approach that addresses individual client needs (Brasher, Campbell, & Moen, 1993; Montgomery, Miller, & Tonigan, 1993; Tonigan, Ashcroft, & Miller 1995). Sisson and Mallams (1981) found that ''systematic encouragement'' increased A.A. attendance in the short-term, and Anderson and Gilbert (1989) found that teaching communication skills improved subjects' ability to work the steps. Project MATCH (1997) findings suggest that when professionals ''facilitate'' A.A. affiliation in positive, non-coercive ways that individuals are more likely to embrace the A.A. approach. Thompson and Thompson (1993) believe that discussion of ''sponsorship, spirituality, and working the steps'' within the counseling setting will increase the likelihood that treatment and A.A. are ''working in concert'' (p. 59).

This article is based upon the assumption that A.A. is ''a rich and heterogeneous collection of group and individual experiences'' (Montgomery et al., 1993, p. 502) that can be more effectively utilized when professionals collaborate with clients to find a goodness-of-fit

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between client needs and preferences and the tools and supports available within A.A. However, to work collaboratively with clients, social workers must be more knowledgeable about the aspects of A.A. that are most appropriate during the initial months of recovery, and need to consider A.A. in more expansive and positive ways. Davis and Jansen (1998) suggest that social workers need to find ''common ground'' between social work and A.A. by coming to understand that both social work and A.A. ''embrace empowerment, connectedness, and interdependence and, most important, the principle that people can change, regardless of how oppressed they find themselves by their circumstances'' (p. 180). With greater insight into the meaning that A.A. can have to individuals struggling with alcohol problems, and better understanding of the ''nuts and bolts'' of how A.A. works, social workers in any setting can develop a more balanced, pragmatic approach to A.A. with clients. Such work might include exploring areas where clients may be having difficulty with A.A., and using barriers to affiliation as opportunities for furthering both A.A. involvement and the goals of the service setting that is involved, e.g., improvements related to health, mental health, child welfare, or employment. Furthermore, operating from a strengths-based approach, social workers can also seek to understand the areas where clients feel comfortable with A.A. or have interests and inclinations that can be mobilized to promote the A.A. connection. The result may be better engagement and retention of clients in treatment and A.A., and better outcomes with respect to agency service goals.

Overview

Alcoholics Anonymous describes itself, in the introduction to all of its literature, as ''a fellowship of men and women who share their experience, strength and hope with each other.'' In addition, A.A. is perhaps best-known for its widely-adopted Twelve Step ''program of recovery'' (Alcoholics Anonymous, 1952). Other writers have affirmed that A.A. is comprised of both the *fellowship* of sharing and support and the 12-Step *program* for achieving not only abstinence but ''good sobriety,'' i.e., mental and spiritual well-being (Tonigan et al., 1995; Anderson & Gilbert, 1989; Maxwell, 1984; Kurtz, 1982). Newcomers to A.A. are given various recommendations for becoming involved in both the program and fellowship aspects of A.A., and numerous writings indicate some agreement regarding guidelines for

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initial A.A. involvement (Emrick, 1989; Robertson, 1988; Alibrandi, 1985; A.A., 1975). These guidelines are embodied in a simple prescription for sobriety, sometimes referred to within A.A. as the ''A.A. six-pack'': *don't drink, go to meetings, ask for help, get a sponsor, join a group, get active*. For the newcomer to A.A., as well as those who have prior experience but have relapsed, these recommendations provide a basic roadmap for early-recovery affiliation. A flexible, expansive and collaborative approach in discussing and interpreting these guidelines may enable individuals who might otherwise leave A.A. to find a personally meaningful connection.

Don't Drink

''Don't drink'' embodies A.A.'s first and basic goal of abstinence, and also refers to ''the only requirement for membership'' in A.A., ''a desire to stop drinking'' (printed in the introduction to all A.A. literature). Many writers in the field of alcohol studies and most treatment professionals believe that until problem drinkers accept the need for abstinence, they are unlikely to make meaningful progress toward recovery (Maxwell, 1984; Kurtz, 1982; Alcoholics Anonymous, 1952). However, as Miller and Rollnick (1991) explain, *ambivalence* about the desire to stop drinking is a normal part of the process of making change in one's life and should not be taken as a sign that A.A. is not appropriate. When an individual's ambivalence about abstinence is acknowledged and explored by professionals in an accepting manner, the individual is more likely to consider a change in their drinking behavior (Bell & Rollnick, 1996). DiClemente (1993) suggests that individuals *contemplating* changing their drinking behavior may be agreeable to attending A.A. when they perceive the focus to be ''only on drinking behavior,'' but may resist efforts to address other issues too soon, e.g., the moral inventory (Step 4), harm to others (Step 8), and an ongoing review of personal transgressions (Step 10) (p. 91). Straussner and Spiegel (1996) view the appropriate and necessary function of the A.A. group in early recovery as ''a protective holding environment,'' and emphasize that A.A. ''is exemplified by the minimal demands'' required to ''join'' (pp. 304-305). Thus, contrary to the view that A.A. has rigid requirements, A.A. itself can be utilized as a ''low-threshold'' adjunct to treatment. Social workers can take this more positive and facilitative position, and perhaps serve to mediate

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the less flexible approach taken by some treatment programs regarding A.A. participation of clients.

The goal of abstinence also involves the first of the 12 Steps, the acceptance that one is ''powerless'' over alcohol, a controversial issue for many social workers who embrace empowerment as the hallmark of the social work profession. Davis and Jansen (1998) acknowledge that the concept of powerlessness is both the ''foundation of recovery'' within A.A. and ''a stumbling block for many professionals concerned that A.A. pushes 'powerlessness' on people who are already powerless in the dominant culture'' (p. 174). But they explain that, within the context of shared stories about the reality of the power of alcohol in people's lives, powerlessness becomes ''a metaphor of connectedness, not isolation,'' and they encourage social workers to seek to understand how accepting powerlessness can be empowering (p. 175). Kurtz (1982) further illuminates such an interpretation of powerlessness, i.e., a change in personal orientation from ''the prohibition, 'I cannot drink,' to . . . the joyous affirmation, 'I *can* not drink.' '' (p. 53). Similarly, Weinstein (1992) describes the ''surrender'' to powerlessness as a paradoxical effect in the tradition of Milton Erickson, resulting in ''a creative leap for the problem drinker who had been rigidly engaged in controlling the bottle'' (p. 35). Thus, Step One is the logical beginning, a focus on the struggle with alcohol within a fellowship of others engaged in the same struggle.

It is important to understand, however, that a key aspect of the early-affiliation acceptance of powerlessness is the concurrent need to seek a power greater than oneself as an alternative to the relationship with alcohol, and as an alternative to failed willpower over alcohol. The very real feelings of powerlessness that individuals experience with respect to their use of alcohol and other drugs may be felt more generally as total personal powerlessness, a very threatening feeling in the absence of some outside assistance that is more powerful than oneself. Straussner and Spiegel (1996) discuss the intense anxiety many individuals feel when first becoming abstinent, and view ''the group as the 'good mother' who understands and protects the individual'' (p. 306). A.A. has always suggested that the group itself can serve as the initial higher power as individuals explore their inclinations in that realm, but A.A. ''does not demand that you believe anything,'' stating that ''A.A.'s tread innumerable paths in their quest

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for faith,'' and ''all you really need is a truly open mind'' (Alcoholics Anonymous, 1952, pp. 26-27).

The A.A. fellowship also provides the opportunity to *give to* others as well as receive support. Yalom (1985) identifies concern for others (''altruism'') as a therapeutic factor that commonly occurs within groups, and Gartner and Riessman (1977) describe helping others as personally beneficial (''helper therapy''), i.e., when individuals help others they increase their own sense of ''being valued'' and in ''control'' of their lives (pp. 99-100). Within A.A., individuals are supported and given understanding and concern, and are also encouraged to offer the same to others. In the giving and receiving within a caring community, new meaning in life and an understanding of a power beyond oneself can develop.

However, even with the freedom to define one's higher power in terms of a personal understanding of ''God'' (A.A.'s Step 3), some individuals reject the need for addressing God as a requisite for sobriety (Trimpey, 1992), others object to the paternalistic view of a traditional male God (Kasl, 1992), and yet others simply feel confused or even hopeless about gaining an understanding of a personal higher power (Caldwell, 1994). But, as Wallace (1996) notes ''the addict's problem is not to find a higher power, because he/she already has one [alcohol or other drugs]. The trick is for the addict to switch from a destructive higher power to a constructive and beneficial one'' (p. 27). Wallace suggests that ''nondeistic'' principles such as ''love, knowledge, creativity and justice'' might serve the purpose, emphasizing that the person struggling with substance dependence must ''overcome extreme self-centeredness'' that characterizes the ''addict lifestyle'' (pp. 27-28). Davis and Jansen (1998) emphasize that Higher Power may be viewed as a force within or outside of the individual, but that it essentially involves ''an acceptance of the idea of human limitations,'' a ''letting go'' of the ''small self'' that is controlled by alcohol, and ''cooperating with'' the part of the one's being that ''carries wisdom and truth'' and fosters ''harmony and balance'' (p. 178). They add that, for social workers, the challenge may be to understand that ''letting go'' of ''things we cannot change'' is *not* the same as ''passive dependence.''

In summary, when the acceptance of powerlessness, the requirement for abstinence, and a view of higher power in terms of ''God'' are forced on clients before they are ready to commit to it, they may

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become alienated and avoid A.A. On the other hand, professionals may miss opportunities to link clients to A.A. when they don't realize that ambivalence about quitting drinking is normal, and that ambivalent clients can perhaps see A.A. as a place where they can consider their interest in stopping drinking as well as explore a personal understanding of what it means to focus on something beyond themselves.

Go to Meetings

An ''adequate'' level of meeting attendance is difficult to determine from the major writings of A.A. or in studies on affiliation. A common recommendation at discharge from treatment is the ''90-in-90'' plan, i.e. attendance at 90 meetings during the first 90 days after discharge, which ''squares well with research on relapse, [as] the majority of relapses occur within 90 days of initial sobriety'' (Nowinski, 1996, p. 43). In one study, treatment staff emphasized the need for at least five meetings per week, with strong encouragement for daily A.A. meetings in early recovery, and one A.A. advocate stated that individuals in early recovery should be ''in A.A. more [days] than they're out'' (Caldwell, 1994). At this stage individuals often need support in the absence of the structured treatment program from which they were recently discharged. Also, they must begin to develop relationships within A.A. in order to begin to see the nature of their alcohol problem and recovery from it in more positive ways, e.g., that they are not responsible for the disease of alcoholism, but are ''responsible for recovery'' (Beckman, 1980), and that they share this problem with decent, caring people, many of whom are establishing healthy lives without alcohol.

Some critics of A.A. characterize frequent meeting attendance in negative terms, e.g., ''substitute dependence,'' but individual circumstances such as unemployment or lack of social support may indicate the need for daily meetings. Similarly, individual circumstances may warrant lower levels of attendance, and stable patterns of 2-3 meetings weekly have been observed for some individuals in early recovery (Caldwell & Cutter, 1998). A.A. does recommend that frequent meeting attendance be balanced with ''activity not related to A.A.'' such as exercise, hobbies, or volunteer work (1975, pp. 15-18). In general, from a social work perspective, the level of meeting attendance should be discussed collaboratively with clients, considering individual

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needs, but should also include educating clients about the benefits of frequent attendance in the first few months.

The types of meetings attended is perhaps more relevant to initial engagement with A.A. than number of meetings. Tonigan et al. (1995) ''caution against regarding A.A. as a homogenous entity,'' and suggest that ''matching of individuals'' to different types of groups may facilitate connection (p. 616). For example, ''Speaker'' meetings tend to be larger and less personal, but provide individuals with opportunities to simply listen to stories and feel less conspicuous. ''Discussion'' meetings allow members to share their own story or listen to others, typically in a smaller, more intimate group experience. And when members attend ''Step,'' ''Big Book,'' and other ''special interest groups'' (for example, groups for men, women, gays, lesbians, and individuals with dual diagnosis), they can experience more specific and intensive interpretation of the program and closer relationships with other members (Kus & Latkovich, 1995; Kurtz et al., 1995; Maxwell, 1984). A.A. meetings also vary in terms of ''group processes and atmosphere,'' i.e., meetings tend to have individual ways of doing things and distinct personalities, and when newcomers attend a variety of groups there is a greater likelihood of finding a group that will ''foster affiliation'' (Montgomery et al., 1993).

There is an important reason for encouraging clients to attend a variety of meetings: As clients begin to understand the diversity of A.A. as well as to meet different people, they are more likely to experience ''identification.'' Newcomers are advised: ''Don't compare, identify,'' i.e., don't compare your situation to the speaker's story, but rather listen for ''fears, excitements, worries and joys which you can empathize with'' (A.A., 1975, p. 80). Maxwell (1984) notes that in identifying with speakers at A.A. meetings a newcomer ''comes to feel he is among others like himself–that he is where he belongs'' (p. 47). Bill Wilson called ''identification at depth'' a ''cardinal A.A. principle'' (Alcoholics Anonymous, 1988, p. 7), and Geller states that ''if you can't see yourself in others, you're in trouble'' (in Robertson, 1988, p. 111). However, professionals should be sensitive to the shame that may be felt when identifying with other problem drinkers (''alcoholics''), and ''normalize and empathize with the patient's initial reticence to identify'' (Nowinski, 1996, p. 46).

In summary, meeting attendance should include consideration of an attendance level that meets a given individual's needs, and exposure to

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the variety that A.A. has to offer in order to promote opportunities for identification. Professionals can assist individuals in finding appropriate meetings by being knowledgeable about the meeting types available in their geographic area. And professionals can minimize the possibility that clients will leave A.A. because they do not initially find a meeting that ''fits'' them by discussing the variety in A.A. and the need to ''shop around.''

Ask for Help and Get a Sponsor

Meeting attendance alone is not considered adequate to provide the support and sustain the commitment that long-term affiliation and sobriety require. Therefore, newcomers are encouraged to ask for help from other members, e.g., to obtain the telephone numbers of veteran members and call for support (''dime therapy'') when they fear that they might drink (Robertson, 1988; Alibrandi, 1985; Madsen, 1979; A.A., 1975). Members also often get together for discussion and mutual support in what has been called ''the meeting before the meeting'' and the ''meeting after the meeting.'' Thus A.A. affiliation provides opportunity for more private, unstructured exchanges outside of the structure of the formal meetings. Maxwell suggests that ''the most intimate and potent social dynamics'' occur ''before, after and particularly between meetings'' (p. 109). Sheeren (1988) identified ''reaching out'' to other A.A. members as one of the most important factors in the recovery process (p. 106).

Another dimension of the helping process within A.A. involves the practice of ''Twelve-stepping,'' i.e., helping others to maintain sobriety (Robertson, 1988; Maxwell, 1984; A.A., 1952). A.A.'s ''Big Book'' states that ''helping others is the foundation stone of your recovery'' (Alcoholics Anonymous, 1976, p. 97). And, although the term suggests that this practice is the last step in the A.A. program, members learn from the beginning that reaching out to others is critical to recovery–reaching out to give as well as receive support. As noted earlier (Gartner & Riessman, 1977), ''helper therapy'' benefits both the giver and receiver of help.

Thus, members' prospects for affiliation are, in part, based upon the capacity for and interest in seeking help from and providing help to others in the A.A. fellowship. The capacity to reach out for and accept help within A.A. is an issue that is also relevant to the overall well being of clients, and may be a focus of work with clients within the

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professional relationship, when appropriate. Discussing the reluctance or discomfort clients may experience regarding the personal encounters that occur in mutual aid groups such as A.A. may minimize obstacles to engagement with A.A. as well as foster healthier relationships outside of A.A.

The primary relationship newcomers have within A.A. is often their *sponsor*, a ''friendly guide'' or mentor who offers help on ''how to stay sober'' based upon ''personal experience, not scientific wisdom'' (Alcoholics Anonymous, 1975, p. 27). Having a sponsor is assumed to be part of early affiliation by most writers who address the topic (Kassel & Wagner, 1993; Emrick, 1989; Alibrandi, 1985; Maxwell, 1984). Sheeren (1988) found that having a sponsor was the most important factor in her study of the relationship between involvement in A.A. and relapse. Robertson (1988) states that a sponsor is ''under the best of circumstances . . . your closest friend and advisor'' (p. 223). Maxwell sees the sponsor relationship as the first opportunity for generating ''closeness'' within A.A. Straussner and Spiegel (1996) describe the sponsor as ''a parental or authority figure'' with whom ''difficulties in object relations may be manifested and acted out,'' forming the basis for establishing healthy ''new relationships on the road to object constancy'' (pp. 303-304, 308). And Madsen (1979) claims that ''if identification is made with A.A. and a sponsor, the newcomer is on the program, and his chances for a sober life are excellent'' (p. 183). Therefore, because this relationship is so critical, Alibrandi suggests that sponsors and their ''proteges'' be ''matched'' to increase the likelihood that the sponsor-protege relationship will succeed (p. 179).

Finding a suitable sponsor is not well-explained within A.A., as ''it is left up to the newcomer to pick someone as his or her sponsor, if one is wanted'' (Alcoholics Anonymous, 1975, p. 26). However, many treatment programs attempt to link patients with a ''temporary sponsor'' before discharge, and may introduce them to volunteers from A.A. who are willing to serve in this capacity. A.A.'s ''Bridging the Gap'' program (Alcoholics Anonymous, 1991) also seeks to strengthen the linkage to prospective sponsors. And professionals working with individuals in early recovery can assist clients to identify the type of sponsor they want, normalize the discomfort of entering into a relationship with a mentor, and role play how they might ask someone to serve in this role. Finding a sponsor is important within the A.A.

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view of recovery, but it should not be forced or pursued before the individual is ready. Less formal connections with other A.A. members should be promoted first with individuals who are uncomfortable with intimacy or who are initially concerned about others becoming overly-involved in their lives.

Join a Group and Get Active

Another factor that appears to be important in early affiliation is to join a group, what many refer to as a ''home group.'' A.A. recommends ''getting into the habit of regularly attending the meetings of at least one group'' (1975, p. 82), and Maxwell (1984) notes that ''a strong home-group life is important'' and requires ''more commitment and involvement'' (p. 105). Robertson (1988) states that a home group ''is a useful anchor for any member,'' and without one ''it is harder to form close relationships'' (p. 108). Obviously, belonging to a group is a way to get to know people in A.A. more intimately and to heed the guideline for ''asking for help.''

Additionally, regular participation in the same group may increase the likelihood that individuals will benefit from group processes. Johnson and Chappel (1994) suggest that, because of the power of group dynamics, A.A. should be called a ''group-help'' rather than a ''self-help'' movement. Several writers have commented on the ways in which Yalom's (1985) group curative or therapeutic factors operate within A.A. groups (Kassel & Wagner, 1993; Maxwell, 1984). Emrick et al. (as cited in Kassel & Wagner, 1993) ''reported that altruism, group cohesiveness, identification, and instillation of hope were factors cited most often in the A.A. literature.'' Caldwell (1994) found that individuals in early recovery who valued opportunities for sharing feelings (catharsis) and experienced a sense of belonging (group cohesiveness) were more involved in A.A. than individuals who did not report these factors as important aspects of their A.A. experience. Professional facilitation of A.A. affiliation might include helping clients to identify the ways in which they are and are not experiencing the curative dimensions of group participation. In this way, client strengths and inclinations can be mobilized and obstacles to effective group participation can be addressed. It is also important to recognize that A.A. groups constitute ''communities'' of individuals with common goals, and that connection with community reinforces the human need for interdependence, a need that is especially strong among indi-

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viduals who have often become isolated from others through their heavy drinking. Davis and Jansen (1998) suggest that, contrary to the view that A.A. is a ''substitute addiction,'' ''connecting with others through the fellowship of meetings, sponsors, and A.A.-sponsored events are ways to strengthen one's identity, not shrink it'' (p. 176). These authors (citing Van Den Bergh, 1991) further characterize A.A.'s emphasis on empowerment within the context of ''community affiliation'' and ''connectedness'' as essentially a feminist position, an ''antidote'' to the ''isolation and anomie'' that characterizes ''patriarchy'' (p. 176).

The last of the guidelines for early-recovery affiliation is the suggestion that individuals *get active* in the A.A. program and fellowship. A.A. provides examples of getting active through ''commitment'' in the performance of ''simple, menial chores'' such as setting up chairs, bringing and preparing refreshments, making coffee, cleaning up after meetings, and greeting newcomers (1975, pp. 14-15). Brown (1985) notes that these ''tasks'' allow newcomers with ''intense dependency conflicts. . . [to] . . . participate and be dependent while remaining interpersonally isolated for as long as necessary'' (p. 35). In other words, A.A. provides options for participation for individuals who may be initially unable to share in the interpersonal intimacy of A.A. Research indicates that ''role-taking within the group . . . may also be instrumental in initiating and maintaining change'' (Kassel & Wagner, 1993). Serving as secretary or treasurer for a group is also a way to get active, but A.A. suggests waiting until a member has 90 days of abstinence before taking on these roles (Alcoholics Anonymous, 1975). Several writers also refer to ''telling your story'' at meetings as an important way to become involved in A.A. (Emrick, 1989; Robertson, 1988), and Weinstein (1992) notes the value of metaphor in story telling in facilitating cognitive change, i.e., rethinking past drinking behavior and conceptualizing ''a non-drinking future'' (p. 37). Davis and Jansen (1998), in a compelling discussion of ''storytelling as metaphor,'' invite social workers to attend A.A. meetings and come to understand A.A. ''as a narrative community where identity transformation takes place through the telling of stories and the identification of personal meanings of metaphors'' (pp. 179-180).

''Trying the Twelve Steps'' and ''reading the A.A. message'' (Alcoholics Anonymous, 1975) are also fundamental aspects of A.A. in-

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volvement. ''Working the Steps'' is frequently discussed by writers who have analyzed A.A., but as noted above, Step work in early recovery focuses on powerlessness, Higher Power, and perhaps on the ''moral inventory'' process (Steps 4 and 5). ''Reading the A.A. message,'' i.e., the numerous writings published by A.A. itself, includes not only the ''Big Book'' (the A.A. ''bible''), but the *Twelve Steps and Twelve Traditions*, *Living Sober*, writings by A.A.'s founders, numerous pamphlets on various aspects of A.A., and in recent years a proliferation of related ''recovery'' texts based upon A.A. principles. Several of the writers mentioned earlier also identified reading of the A.A. literature as an important dimension of affiliation (Robertson, 1988; Sheeren, 1988; Alibrandi, 1985).

And finally, Alibrandi identifies widely-recognized ''tools'' that are offered to newcomers in early recovery, including the Serenity Prayer and well-known A.A. slogans such as ''One day at a time,'' ''Keep it simple,'' ''Easy does it,'' ''First things first,'' and ''Let go and let God'' (pp. 173-175). Other writers have also identified the use of the slogans (also referred to as sayings or aphorisms) as a dimension of program participation (Robertson, 1988; Maxwell, 1984; A.A., 1975). These writers, as well as veteran members of A.A., have suggested that as individuals become active in A.A. and committed to their recovery, the sayings become increasingly meaningful. It is therefore reasonable to view newcomers' acceptance of these sayings as one measure of their level of activity in A.A., and perhaps as an indicator of their inclination to affiliate.

CONCLUSION

This article is based on the premise that many problem drinkers who have an interest in stopping their drinking, and who might be able to benefit from A.A., are not making their way into the program. Although some individuals may not be appropriate for A.A. because they cannot tolerate either group interaction or the focus on spiritual issues, many others simply are not properly approached or assisted in making the A.A. connection. A.A.-oriented treatment professionals may be too heavy-handed and paternalistic, e.g., rigidly prescribing specific guidelines that ignore individual client needs and inclinations. On the other hand, social workers and other helping professionals in various human services settings may not adequately understand the

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richness and variety within A.A. and may "sell it short," or may fail to link clients to A.A. because they do not understand client ambivalence about A.A. as a normal part of the process of moving toward recovery. A.A. is a widely-available and free resource for individuals who are trying to overcome drinking problems, and its potential should be maximized, even as alternatives to A.A. are being developed and made available to problem drinkers.

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REFERENCES

Alcoholics Anonymous (1952). *Twelve Steps and Twelve Traditions*. New York: Alcoholics Anonymous World Services.

Alcoholics Anonymous (1975). *Living Sober*. New York: Alcoholics Anonymous World Services.

Alcoholics Anonymous. (1976). *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism* (3rd Ed.). New York: Alcoholics Anonymous World Services.

Alcoholics Anonymous (1988). Three talks to medical societies by Bill W., co-founder of Alcoholics Anonymous. New York: Alcoholics Anonymous World Services.

Alcoholics Anonymous (1991). *Bridging the Gap Between Treatment and A.A. Through Temporary Contact Programs*. New York: Alcoholics Anonymous World Services, Inc.

Alibrandi, L.A. (1985). The folk psychotherapy of Alcoholics Anonymous. In S. Zimberg, J. Wallace & S. Blume, (Eds.), *Practical Approaches to Alcoholism Psychotherapy* (2nd edition) (pp. 163-180). New York: Plenum Press.

Anderson, J.G. & Gilbert, F.S. (1989). Communication skills training with alcoholics for improving performance of two of the Alcoholics Anonymous recovery steps. *Journal of Studies on Alcohol*, *50*(4), 361-367.

Beckman, L.J. (1980). An attributional analysis of Alcoholics Anonymous. *Journal of Studies on Alcohol*, *41*(7), 714-726.

Bell, A. & Rollnick, S. (1996). Motivational interviewing in practice: A structured approach. In: F. Rotgers, D.S. Keller & J. Morgenstern (Eds.) *Treating Substance Abuse: Theory and Technique* (pp. 266-285). New York: The Guilford Press.

Brasher, B., Campbell, T.C., & Moen, D. (1993). Solution oriented recovery. *Journal of Systemic Therapies*, *12* (3), 1-14.

Brown, S. (1985). *Treating the Alcoholic: A Developmental Model of Recovery*. New York: John Wiley & Sons.

Caldwell, P.E. (1994). *Early Post-Treatment Alcoholics Anonymous Affiliation*. Unpublished doctoral dissertation, Brandeis University, Waltham, Massachusetts.

Caldwell, P.E. & Cutter, H.S.G. (1998). Alcoholics Anonymous affiliation during early recovery. *Journal of Substance Abuse Treatment*, *15* (3), 221-228.

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Davis, D.R. & Jansen, G.G. (1998). Making meaning of Alcoholics Anonymous for social workers: Myths, metaphors and realities. *Social Work*, *43* (2), 169-182.

DiClemente, C.C. (1993). Alcoholics Anonymous and the structure of change. In B.S. McCrady & W.R. Miller (Eds.) *Research on Alcoholics Anonymous: Opportunities and Alternatives* (pp. 79-97). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Emrick, C.D. (1989). Alcoholics Anonymous: Membership characteristics and effectiveness as treatment. In M. Galanter (Ed.). *Recent Developments in Alcoholism: Volume 7: Treatment Research* (pp. 37-53). New York: Plenum Press.

Emrick, C.D., Tonigan, J.S., Montgomery, H., & Little, L. (1993). Alcoholics Anonymous: What is currently known? In B.S. McCrady & W.R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and Alternatives* (pp. 41-76). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Gartner, A. & Riessman, F. (1977). *Self-Help in the Human Services*. San Francisco: Jossey-Bass Publishers.

Gorski, T.T. (1989). *Understanding the Twelve Steps: A Guide for Counselors, Therapists, and Recovering People*. Independence, MO: Herald House.

Institute of Medicine. (1990). *Broadening the Base of Treatment for Alcohol Problems*. Washington, DC: National Academy Press.

Johnson, N.P. & Chappel, J.N. (1994). Using AA and other 12-step programs more effectively. *Journal of Substance Abuse Treatment*, *11* (2), 137-142.

Johnson, N.P., Phelps, G.L., & McCuen, S.K. (1990). Never try to carry a drunk by yourself: Effective use of self-help groups. *Journal–South Carolina Medical Association*, *86* (1), 27-31.

Kasl, C.D. (1992). *Many Roads, One Journey: Moving Beyond the 12 Steps*. New York: Harper Perennial.

Kassel, J.D. & Wagner, E.F. (1993). Processes of change in Alcoholics Anonymous: A review of possible mechanisms. *Psychotherapy*, *30* (2), 222-234.

Kurtz, E. (1982). Why A.A. works: The intellectual significance of Alcoholics Anonymous. *Journal of Studies on Alcohol*, *43*, (1), 38-80.

Kurtz, L.F., Garvin, C.D., Hill, E.M., Pollio, D., McPherson, S., & Powell, T.J. (1995). Involvement in Alcoholics Anonymous by persons with dual disorders. *Alcoholism Treatment Quarterly*, *12*, (4), 1-18.

Kus, R.J. & Latkovich, M.A. (1995). Special interest groups in Alcoholics Anonymous: A focus on gay men's groups. *Addiction and Recovery in Gay and Lesbian Persons* (pp. 67-82). Binghamton, NY: The Haworth Press.

Madsen, W. (1979). Alcoholics Anonymous as a crisis cult. In M. Marshall (Ed.), *Beliefs, Behaviors, and Alcoholic Beverages* (pp. 382-388). Ann Arbor: University of Michigan Press.

Marlatt, G.A., Tucker, J.A., Donovan, D.M., & Vuchinich, R.E. (1997). Help-seeking by substance abusers: The role of harm reduction and behavioral-economic approaches to facilitate treatment entry and retention by substance abusers. In L.S. Onken, J.D. Blaine & J.J. Boren (Eds.) *Beyond the Therapeutic Alliance: Keeping the Drug-Dependent Individual in Treatment*. National Institute on Drug Abuse Research Monograph 165 (NIH Publication No. 97-4142, pp. 44-83). Washington, DC: U.S. Department of Health and Human Services.

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Maxwell, M.A. (1984). *The A.A. Experience: A Close-up View for Professionals*. New York: McGraw Hill.

Miller, W.R. & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: The Guilford Press.

Montgomery, H.A., Miller, W.R. & Tonigan, J.S. (1993). Differences among A.A. groups: Implications for Research. *Journal of Studies on Alcohol*, *54*, 502-504.

Nowinski, J. (1996). Facilitating 12-step recovery from substance abuse and addiction. In F. Rotgers, D.S. Keller, & J. Morgenstern (Eds.) *Treating Substance Abuse: Theory and Technique* (pp. 37-67). New York: The Guilford Press.

Project MATCH Research Group (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29.

Robertson, N. (1988). *Getting Better: Inside Alcoholics Anonymous*. New York: Fawcett Crest.

Sanchez-Craig, M. (1990). Brief didactic treatment for alcohol and drug-related problems: an approach based on client choice. *British Journal of Addiction*, *85*, 169-177.

Sheeren, M. (1988). The relationship between relapse and involvement in Alcoholics Anonymous. *Journal of Studies on Alcohol*, *49*: 104-106.

Sisson, R.W. & Mallams, J.H. (1981). The use of systematic encouragement and community access procedures to increase attendance at Alcoholics Anonymous and Al-Anon meetings. *American Journal of Drug and Alcohol Abuse*, *8*, 371-376.

Straussner, S.L.A. & Spiegel, B.R. (1996). An analysis of 12-Step programs for substance abusers from a developmental perspective. *Clinical Social Work Journal*, *24* (3), 299-309.

Thompson, D.L. & Thompson, J.A. (1993). Working the 12 steps of Alcoholics Anonymous with a client: A counseling opportunity. *Alcoholism Treatment Quarterly*, *10*, (1/2), 49-61.

Tonigan, J.S., Ashcroft, F. & Miller, W.R. (1995). A.A. group dynamics and 12-step activity. *Journal of Studies on Alcohol*, *56*, 616-621.

Trimpey, J. (1992). *The Small Book: A Revolutionary Alternative for Overcoming Alcohol and Drug Dependence* (Revised). New York: Dell Publishing.

Van Den Bergh, N. (1991). *Feminist Perspectives on Addictions*. New York: Springer.

Wallace, J. (1996). Theory of 12-step oriented treatment. In F. Rotgers, D.S. Keller & J. Morgenstern (Eds.) *Treating Substance Abuse: Theory and Technique* (pp. 13-36). New York: The Guilford Press.

Weinstein, D.L. (1992). Alcoholics Anonymous as change agent: Effective Ericksonian psychotherapy. *Journal of Systemic Therapies*, *11* (1), 33-44.

Weisner, C., Greenfield, T. & Room, R. (1995). Trends in the treatment of alcohol problems in the US general population, 1979 through 1990. *American Journal of Public Health*, *85* (1), 55-60.

Weisner, C. & Schmidt, L. (1993). Alcohol and drug problems among diverse health and social service populations. *American Journal of Public Health*, *83* (6), 824-829.

Yalom, I.D. (1985). *The Theory and Practice of Group Psychotherapy*, 3rd Edition. New York: Basic Books.