

How does AA's 12 Steps and membership of the *Fellowship* of Alcoholics Anonymous work for addressing drinking problems?

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Contents

Contents.....	1
Abstract.....	6
Declaration.....	7
Copyright Statement.....	7
Acknowledgments.....	8
Figures.....	9
Chapter 1: Introduction	10
1.1 Setting the Context	10
1.2 A Brief History of AA	12
1.2.1 AA, Alcoholism, Disease and Diagnosis.....	14
1.2.2 The 12 Steps and Twelve Traditions	16
1.3 AA and Criminal Desistence	20
1.4 The Aims of the Study	21
1.5 Thesis Structure	22
Chapter 2: Literature Review: Perspectives on Alcoholics Anonymous and Other Mutual Aid Groups.....	26
2.1 AA's Stated Theory of Change.....	27
2.1.1 AA Meetings.....	28
2.1.2 AA Meetings: Functionality	29
2.1.3 'Turns of Talk': Therapeutic Practice	31
2.1.4 Sponsorship and Helping Others in AA	32
2.1.5 Working the Twelve Steps	35
2.1.6 AA's 'Practical' Steps: 4, 5, 8 and 9	36
2.1.7 The 'Middle Steps', 6 and 7: Towards Reflexive Growth	39
2.1.8 Maintaining a Spiritual Growth and Sobriety: Steps 10, 11 and 12.....	40
2.1.9 Social Networks and the AA <i>Fellowship</i>	42
Summary	44
2.2 The Nature of Alcoholics Anonymous and Other Mutual-Help Groups	45
2.2.1 Categorisation	46
2.2.2 AA's Shared Characteristics with other Mutual-help Groups.....	48
2.2.3 Experiential Knowledge	51
2.2.4 Reciprocal Help	52
2.2.5 Differences amongst Mutual-help Organisations and Alcoholics Anonymous	53

2.2.6 Philosophy; Spiritual/Non-Spiritual	54
2.2.7 Membership, Meetings and Governance	55
2.2.8 Political Stance	57
Summary	58
2.3 Effectiveness of Alcoholics Anonymous.....	61
2.3.1 Conceptual and Methodological Considerations in Judging Effectiveness.....	62
2.3.2 Alcoholics Anonymous Studies across Three Eras	67
2.3.3 AA's Claimed Success and Studies Using AA Survey Data.....	72
2.3.4 Meta Analytic and Systematic Reviews of AA's Effectiveness	73
2.3.5 AA Affiliation, Individual and Cultural Characteristics	76
Summary	78
Chapter 3: AA's Mediated Behavioural Change Model: A Conceptual Analysis.....	81
3.1 Introduction	84
3.2 Motivation.....	84
3.2.1 External/Formal Pressures.....	85
3.2.2 External-Informal Pressures.....	87
3.3 Structured Social Engagement.....	95
3.3.1 Social Capital	96
3.3.2 Access to Resources: 'Stocks' of Social Capital in AA.....	98
3.3.3 Recovery Capital	99
3.3.4 Transferring Social Capital and Supportive Network characteristics.....	101
3.3.5 Collective Efficacy	106
3.4 Personal Agency.....	107
3.4.1 Story Telling in AA: The Narrative Account.....	108
3.4.2 From Condemnation to Redemption	109
3.4.3 Re-Biographing.....	110
3.4.4 Scripts and the Frameworks for Identity Change in AA	112
3.4.5 Connecting Personal Agency, AA and Structure	117
3.4.6 Knifing off 'Old Playmates and Playgrounds'	121
Summary	122
Chapter 4: Methods	128
4.1 Introduction	128
4.2 The Aims of the Study	129
4.3 Methodological Approach	133

4.3.1 Basic Approach in Relation to Overall Research Strategy.....	133
4.3.2 Research Design	135
4.3.3 Access and Sampling.....	136
4.3.4 Methods and the process of analysis.....	141
4.4 Ethics and Practical Consideration.....	148
4.4.1 Informed Consent	150
4.4.2 Confidentiality and Anonymity	151
Conclusion.....	152
Chapter 5. The model: From a Vicious Cycle of Decline to a Virtuous Circle of Change	155
5.1 Motivation: An Awareness of the Pressures to Stop	157
5.1.2 Informal Social Pressure: Family and Friends	158
5.2 Internal Pressure.....	161
5.2.1 The ‘Revolving Door’	162
5.2.2 Psychological Pressure	163
5.3 The Transition from External to Internal Pressure	164
5.3.1 ‘Blame’ and Responsibility	164
5.3.2 Decisional Balance: Ready to Listen.....	165
5.4. Structured Social Engagement.....	166
5.4.1 AA Meetings.....	167
5.4.2 Dynamics of Relationship Formation in AA	168
5.4.3 Sponsorship and Working the Twelve Steps.....	170
5.4.4 Benefits of Membership to AA’s Wider Social Network.....	172
5.5 Personal Agency.....	179
5.5.1 Self-Efficacy: Avoiding Relapse	179
5.5.2 Enhanced Self-Efficacy Beliefs.....	181
Summary	184
Chapter 6: Threats to Sustaining Positive Change: ‘Spinning off the Helix’	186
6.1 Structuring Coping Mechanisms through Experiential Knowledge and Language	188
6.2 Managing Distal Threats	191
6.2.1 Chronic Health Problems	192
6.1.2 Coping with Bereavement and Loss.....	194
6.3 Proximal Threats From Within AA	199
6.3.1 Dealing with Perceived and Actual Aggression.....	199
6.3.2 Preserving Ideological Purity and Program Fidelity	204

6.3.3 The Limitations of Sponsorship.....	209
Summary	218
Chapter 7: Pre-Requisites for Sustained Behavioural Change: The Reorientation towards Self-Control	220
7.1 Framing the ‘Recovery Script’ in AA.....	223
7.1.1 Accepting the ‘Condemnation Script’	226
7.1.2 Developing a Reflexive Capacity through Dissonance	228
7.2 Spirituality and Control	230
7.3 Behavioural Change: From Condemnation to Stable, Long-Term Sobriety	238
7.3.1 ‘Altered Attitudes’ to Alcohol	239
7.3.2 Self-Regulation through AA Discourse: The Use of ‘Linguistic Echoes’	240
7.3.3 Structuring Agency through Cognitive Self-Regulatory Mechanisms.	243
7.3.4 Attitudes to Criminality and Moral Transgressions	246
Summary	254
Chapter 8: Discussion.....	257
8.1 Introduction	257
8.1.1 Assessing the acute ‘ideal-typical’ model	259
8.2 Threats to Disengagement.....	262
8.2.1 Managing Distal Threats	263
8.2.2 Managing Proximal Threats	265
8.3 New Perspectives and New Knowledge.....	268
8.3.2 Accepting the ‘condemnation script’	270
8.3.3 Developing a Capacity for Self-Reflection.....	272
8.3.4 Developing Control: Prerequisites for Behavioural Change	273
8.3.5 The Use of ‘Linguistic Echoes’: Phrases Used in the ‘Recovery Script’	275
8.4 Implications: Alcohol-Drug Treatment Policy, Recovery and the Criminal Justice System	276
8.4.1 Recovery: a sprawling agenda and contested goals	277
8.4.2 AA, Alcohol and Offending	279
8.5 The Limitations of the Thesis and the Future Research Agenda	281
8.5.1 The Limitations of the Data.....	282
8.5.2 AA: Un-Monitored and Un-Regulated.....	285
8.5.4 Further Empirical Questions	286
8.5 Conclusion.....	288

Bibliography	291
Appendices.....	320
Appendix A.....	320
Appendix B: Interview Topic Guide Membership to Alcoholics Anonymous	321
Appendix C.....	322

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Abstract of Thesis Submitted by James Graeme Irving for the Degree of Doctor of Philosophy entitled:

How does AA's 12 Steps and Membership of the *Fellowship* of Alcoholics Anonymous Work for Addressing Drinking Problems?

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Abstract

Alcoholics Anonymous (AA) is the world's largest and most recognisable recovery 'program', and central to its philosophy is the 12 Step Program. AA is a global organisation of 2.2 million members worldwide (AAWS, 2001), with a reported 3,600 weekly meetings in the United Kingdom (AAWS, 2011). AA has made many claims in their literature about the program's effectiveness (AAWS, 2001: 84). Alcoholism is associated with a number of very serious health and social problems, including involvement in crime (Finney 2004; Fitzpatrick, 2010; Alcohol Reduction Strategy 2003). As fiscal pressure mounts, groups such as AA will be of interest to policy makers. Through an analysis of interviews with twenty long-term abstinent members of Alcoholics Anonymous, the thesis seeks to explain the effects of participation in AA's therapeutic practices.

Evidence from the literature on AA, revealed three concepts key to understanding participation in AA: Motivation to Engage (MtE), Structured Social Engagement (SSE), and Personal Agency (PA). A hypothetical model of AA-mediated behavioural change, constituted by these elements, was constructed and the findings supported this putative model. Further analysis revealed the coping strategies members of AA employed that ensured engagement with AA during stressful life events that threatened abstinence. The model was adapted to incorporate the temporal effects of long-term engagement with AA. Elements of Maruna's (2001: 73) *Condemnation Script* resonated in the narratives of AA members. Contra Maruna's analysis, AA members accepted 'condemnation script', but these were not negative, limiting beliefs. AA's therapeutic practices structure, a coherent sense of self, one that supports cessation from negative patterns of drinking. The data exposed the sustained usage of AA's discourse in the narrative accounts given. This finding extends Borkman's (1976) *Experiential Knowledge* thesis, a language of 'truth' based on personal experience. The 'linguistic echoes' embedded in each narrative, suggests that a person uses AA's discourse to 'scaffold' their recovery. This thesis provides an explanation of AA's therapeutic practices of how adherence to AA's principles, cognitively restructures the individual towards mastering self-control. AA's philosophy and the following empirical evidence asserts abstinence as pre-requisite for recovery from alcohol dependence.

Declaration

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Figures

Figure 1 Comparisons of Mutual-Help Groups Across Four Domains	59
Figure 2 AA's Circular Process of Recovery	81
Figure 3 Hypothetical Model of AA Mediated Behavioural Change: Basic Components	126
Figure 4 Hypothetical Model of AA Mediated Behavioural Change: Basic Components	131
Figure 5 Hypothetical Model of AA-Mediated Behavioural Change: Temporal Components	132
Figure 6 Cohort Descriptors	140/141
Figure 7 Hypothetical Model of AA Mediated Behavioural Change: Basic Components	156
Figure 8 Hypothetical Model of AA-Mediated Behavioural Change: Temporal Components	187
Figure 9 Hypothetical Model of AA-Mediated Behavioural Change: Temporal Components	221
Figure 10 Assessing the Acute 'Ideal-Typical' Model	259
Figure 11 Hypothetical Model of AA-Mediated Behavioural Change: Temporal Components	262
Figure 12 Changes to the Model: AA's Mediated Effects.....	269

Chapter 1: Introduction

1.1 Setting the Context

According to the 2011/12 CSEW, there were 917,000 violent incidents where the victim believed the offender(s) to be under the influence of alcohol, accounting for 47% of violent offences committed that year. This represents a rise of 3 percentage points on the previous year [2010/11].

...the World Health Organisation (WHO), the harmful use of alcohol results in 2.5 million deaths each year globally. Alcohol [...] is ranked by the WHO as the third leading cause of death and disability in the developed world (WHO, 2010).

The problems associated with excessive alcohol consumption remain stubbornly acute, cutting across nations, socio-economic categories, whilst remaining the second (caffeine being the first) most regularly consumed substance. Set against these stark statements of the negative effects alcohol brings to large numbers of people, Alcoholics Anonymous (AA), and its members, claim to have helped many people recovery from alcohol dependence (Alcoholics Anonymous Worldwide Services [AAWS], 2001).

The overall aim of this study is to uncover and explain how 20 members of Alcoholics Anonymous (AA) have successfully abstained from negative drinking patterns and have also desisted from criminal behaviour. The outcome of this study was an intriguing set of overlapping, yet also divergent narratives of change. These were people's stories, embracing the gamut of human experience. Taken together these stories make a profound statement about what it is to be first, a drinking alcoholic, second, a recovering alcoholic in AA and third, demonstrate the lasting changes individuals have undergone which have helped maintain abstinence. The realities of the respondents'

lives are explored and examined throughout this thesis. There are moments of dark humour, a perhaps incomprehensible commitment to continued drinking in the face of debt, chronic ill-health and the removal of children into the care of social services. There are accounts of deep sadness, the suicide of a sponsee and the loss of intimates.

This thesis captures the ‘dis-ease’ (Denzin, 1987) of alcoholism and the mechanisms used by AA members to regain control of their lives, seeking a truer, more authentic sense of self while relinquishing the negative effects of guilt and patterns of distorted cognition (Sachs, 2003). This thesis argues and evidences pre-requisites for sustaining abstinence, for example, acceptance of AA’s ‘recovery script’. AA provides the context and framework for these pre-requisites to be attained and developed, and we here detail participants’ stories of their recovery ‘journey’.

Before setting out a short overview of the contents of this thesis, it is necessary to sketch a brief history of AA, and its therapeutic practices. Alcoholics Anonymous, the organisation has endured much criticism (Peele, 1998; Buffe, 1991) and received much support (Kurtz, 1979; Denzin, 1986, 1987; Makela, 1996; Smith, 2007) while others such as Miller and Kurtz (1994) have attempted to delineate and describe popular myths and misconceptions which have become associated with AA. AA has had a profound effect on the development of treatment systems, since its creation in 1939 (Kurtz, 1979). Focussing on key developments, one can see how this ‘history of ideas’ has become embedded in current government policy, particularly the concept of ‘recovery’ (United Kingdom Drug Policy Commission, 2008), and how AA’s beliefs on alcoholism has become firmly rooted in the narratives of the AA members studied here. An account of

how these discourses of recovery have helped structure identity and behaviour are at the heart of this study.

1.2 A Brief History of AA

‘...quite simply the most successful self-help organisation ever established’ (Davidson, 2002: 4).

Since its inception, Alcoholics Anonymous has become a yardstick by which all other mutual-help organisations are measured against (Kutz and White, 2003). There were and are, other recovery groups and organisations pre-dating AA, such as the *Washingtonians* (1840), *Fraternal Temperance Societies* (1842) and Native American recovery ‘circles’ (1737) (Blocker et al, 2003). White and Kurtz (2009) note the unique and of distinctive features that have helped AA surpass the achievements of every other recovery group. Amongst these are AA’s growth and geographical spread with more than 2 million members across 150 countries, its influence on the treatment of drug addiction and upon the treatment ‘industry’ generally (White, 1998), and its lasting influence on popular culture (Room, 1989).

The inception of Alcoholics Anonymous dates to the 10th of June 1935, in the United States of America, Akron, Ohio (Borkman, 2006). This is the day when Dr Bob Smith had his last drink. Together with Bill Wilson, who had been abstinent for five months at that time, they co-founded AA (Kurtz, 1979). The pair were originally a part of the Oxford Group, a Christian organisation combining social activities with religion. The Oxford Group’s teachings were religious in nature, and some of the core beliefs are

reflected in AA's tone and practices (Davidson, 2002). The Oxford Group practised public and one-to-one confessions, group discussion characterised by honesty, unselfishness and repentance for past wrong-doing by making amends to injured parties (ibid). As a derivative practice of the Oxford Group, AA also aimed for personal change, not just the goal of abstinence. Believing that the Oxford Group's focus upon God would be problematic for most alcoholics, Smith and Wilson began to focus solely on helping other alcoholics achieve sobriety. The pioneering AA members continued to meet as affiliates of the Oxford Group. However, divergent goals emerged from the alcoholic and the non-alcoholic populations of the group. Thus, after four years, in 1939, AA was established in its own right rather than as a sub/splinter organisation of the Oxford Group (Valverde, 1998).

White and Kurtz (2008) trace a core element of AA's therapeutic practices - the 'helper principle' - a term originally coined by Reissman (1965), to a chain of events and relationships involving Bill Wilson and another early AA member who had been treated by and Carl Jung. Jung had suggested that recovery from alcoholism had, in a relatively small number of cases, been affected by a profound spiritual experience, augmented by a commitment to supporting others in a similar predicament. This suggestion from an eminent psychiatrist helped AA to cast the medical and psychiatric professionals into a supporting role, rather than allowing these discourses to potentially co-opt and subordinate AA (Valverde, 1998). Kurtz (1979) argues that while the medical profession provided some useful insights and treatments, such as Antabuse, overall the profession had performed inadequately. Establishing the validity of experience as an orienting concept that sets the shared meaning of experience above medical/psychological knowledge, AA and its founding members began attract to

further members. One of AA central beliefs is that a person for whom alcoholism has been experienced and stable recovery has been achieved, has a greater capacity to gain the confidence of another, fellow alcoholic. This shared knowledge of a common problem, later became termed ‘experiential knowledge’ (Borkman, 1976), as a cannon of wisdom, set aside from expert and common knowledge, occupying a middle-ground. In terms of AA’s therapeutic practices, the sharing of experience is characterised by honesty and is an uninterrupted series of monologue group context. The sponsor/sponsee, dyad, involves the sharing of deeply personal and sometime humiliating, with another member of AA familiar with the 12 Step Program and is a necessary pre-requisite for building trust (AAWS, 1952; Smith, 2007). These practices were carried forth by Wilson, Smith and other early members of AA, and helped shape its distinctive dynamics of communication.

1.2.1 AA, Alcoholism, Disease and Diagnosis

AA conceptualises alcoholism as a pervasive problem that encompasses a range of behaviours related but not limited to excessive drinking and that may manifest themselves without the consumption of alcohol. AA states that, ‘Our liquor was but a symptom’ (AAWS, 2001: 64). AA describes the problem of the alcoholic existence in various ways, avoiding the singular term ‘disease’ wherever possible and substituting this for less controversial terms such as ‘malady’ or ‘illness’ (AAWS, 2001; 1952). Further, conceptualising the alcohol problem as a chronic state that affected the mind, body and spirit enabled AA to apply and adapt a holistic recovery philosophy (AAWS, 2001; Miller and Kurtz, 1992).

AA, despite its holistic philosophy, has long been associated with a version of a 'traditional' medical disease model. AA's Key text, *Alcoholics Anonymous* (1944/2001) became the main vehicle through which AA's ideas became diffused amongst AA members and groups. The chapter, "The Doctor's opinion" evades the word 'disease', but because metaphors such as an 'allergy' and 'bodies sickened' are used, these were intuitively associated with the disease concept of alcoholism (Kurtz, 2002). Kurtz (1981) traces the association of AA and the 'disease' model/understanding of alcoholism to the 1940s. In the United States, because of AA's early associations with the medical professional, coupled with the newly formed The National Council on Alcoholism (NCA), in the early 1940s, understood the problem of alcoholism, along similar descriptive lines which Silkworth outlined in 1939. In summary, '...the body of the alcoholic is quite as abnormal as his mind' (AAWS, 2001: xxvi). It is to the mind and spirit, which AA directs and focuses the greater part of their rehabilitative efforts. AA distinguishes those alcoholics who are merely not drinking as dry and those who are, actively engaged in AA therapeutic practices, attending meetings, working through the steps with the aid of a sponsor, for example, as being sober (Denzin, 1987; Smith, 2007). Sober alcoholics in AA, are persons living free from resentment and selfishness which are the chief cognitive distortions or defects of character that threaten to undermine the alcoholic's recovery (AAWS, 2001, 1952). Both these terms feature as a diagnostic criteria and as selfishness and resentment diminish, these are understood in AA to indicate recovery.

1.2.2 The 12 Steps and Twelve Traditions

A new member is encouraged to abstinent, “one day at a time”, sobriety is initiated, and thereafter, maintained, by “working the Program” (Strobbe, 2009). The Twelve Steps, are AA’s Program of recovery.

The Twelve Steps of Alcoholics Anonymous:

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 (AAWS, 2001: 59-60, emphasis in original).

Strobbe (2009: 10) asserts that ‘working the program’ is a colloquial expression, used by AA members that describes attending AA meetings, and, with the aid of a sponsor, engaging with the Twelve Steps, with the overall effect of finding a spiritual purpose and pathway to successful recovery. The Twelve Steps emerged as a ‘suggested program of recovery’ (AAWS, 1939-2001: 71). New members are encouraged to conceptualise not-drinking ‘one day at a time’. As a framework or model of personal recovery, each of the Steps is designed to lead the individual from a chronic-hopeless state of alcohol addiction to a fully recovered(ing) functioning member of society, characterised by a ‘new freedom and a new happiness’ (AAWS, 2001: 84). Asserting the primacy of spirituality over religiosity allowed AA to break free from the religious confines of the Oxford Group, while paving the way for future AA members to emerge from what would have been, competing and conflicting faiths (Miller and Kurtz, 1995).

AA engineers unity amongst each recovering alcoholic, individual groups and the organisation as a whole via the Twelve Traditions (AAWS, 1952). The Twelve Traditions of Alcoholics Anonymous (The Short Form)

1. Our common welfare should come first; personal recovery depends on 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 the 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 nonprofessional, 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 (AAWS, 2001: 562).

Krentzman et al (2011) suggest that the Twelve Traditions may be AA's lasting contribution to the recovery from alcoholism, rather than the Twelve Steps. This prediction is based on the commitment that AA members make to keep within the organisational goals that the Twelve Traditions define for its governance. Krentzman et al (2011) suggest that compliance with AA's Twelve Traditions has exerted a protective influence. As a set of policies, the Twelve Traditions have prevented the organisation falling into internecine and external conflicts which have been the downfall of other mutual self-help groups. AA's inclusive membership criteria are one such example (Tradition Three, AAWS, 1952). The onus is placed on the individual to declare oneself a member, rather than having to fulfil any financial or other potentially divisive criterion for membership. AA's financial independence is achieved by first 'owning no property' and second relying solely on members' donations, thus AA remains, 'fully self-supporting' (Tradition Seven, 1952: 160). Third, taken together, the Twelve Traditions make explicit the responsibility for individual recovery is dependent on the unity of the AA Fellowship, (AAWS, 2001: 574) and that AA groups and individual members are reminded of its singularity of purpose, 'to carry the its message [recovery via AA] to the alcoholic who still suffers' (ibid: 150). No member may direct AA, individual entrepreneurship and opinion is subordinated to the collective, the 'group conscience' (Tradition Two, ibid). Without entering into external debates concerning politics or religion, 'endorsing nor opposing any causes' (Tradition Six & Ten, AAWS, 1952: 155; 176), AA has remained autonomous and largely unaffected by the passing of almost eight decades and continues to thrive (Gross, 2010).

1.3 AA and Criminal Desistence

The criminological literature on desistence has paid little attention to the effects of AA. This paucity of empirical knowledge forms the rationale for this study, particularly the literature suggests, AA's process of initiating abstinence and the process of achieving desistence, share many, complimentary and analogous dimensions. Shadd Maruna's seminal (2001: 26) *Making Good*, describes and analyses the desistence process as one characterised by a 'maintenance of crime-free behaviour'. In a similar vein, this study uncovers the mechanisms by which AA's therapeutic practices help maintain a drink-free existence. Maruna uncovers key elements in the identity narrative that helps attribute a coherent, meaningful and ultimately enabling sense of self for the successful desisters. For Maruna, many of the 'plot devices' emerging from the desisters' narratives follow the same trajectory as those told by individuals in AA meetings. Here Maruna establishes the purpose and value of AA's narrative device, but any analysis of the transformative effects that AA has (may have) upon the criminal, recovering individual ceases. Similarly, Sampson and Laub's (2006) cumulative work re-traced and re-interviewed men from the Glueck's (1950) longitudinal study with the aim of explaining the progress of these men from childhood, adulthood and late-adulthood, in terms of desistence, amongst other things. Making explicit reference to AA, Sampson and Laub, (2006: 142) report that a number of the desisted cohort had sought the help for drinking from AA, 'Norman changed with the help of AA, and what motivated him in large part was the fear of losing his wife and family', another individual had not drunk with the help of AA since 1968, (ibid: 239), thus describing AA as the 'turning point' in his life while another asserted the only sense of 'joy' he had ever experienced was his time in AA. Despite the empirical support found in Sampson and Laub's work,

in terms of behaviour change and as their interview with Patrick revealed a pervasive concern for the problem of alcohol-related crime (ibid: 240), AA's ability to help rehabilitate and facilitate desistence has remained largely un-explored by criminologists.

1.4 The Aims of the Study

This thesis aims to uncover AA's mechanisms of change. Based on the interviews conducted with the respondents, this study illuminates how engagement with AA has shaped abstinence. In addition, as a secondary set of interests, the effects that engagement with AA may have on criminality will be assessed. It therefore aims to do the following:

- a) To examine and explain the experience of long-term abstinent members of AA.
- b) To assess critically these narratives of change using the putative theoretical model developed from the literature review.
- c) To identify how the respondents have used AA's therapeutic practices to maintain engagement with AA and sustained abstinence.
- d) To develop a model of behaviour change, that will inform a clearer understanding of AA and draw out the positive effects of membership to AA.

In an effort to maintain a coherent structure through the thesis, the model of behaviour change developed and described, guides the analytic chapters, helps to articulate the main arguments and informs the discussion.

1.5 Thesis Structure

Chapter Two assesses the literature on AA and is organised into three separate sections. First, this chapter explores the nature of AA. This is achieved by assessing AA's chief organisational features as they relate to other self-help/mutual-help organisations with the same goal, that is, recovery from alcohol addiction. Second, the mechanisms of change are evaluated using AA's key literatures (AAWS, 2001 & 1952), alongside academic perspectives. Third is the controversial issue pertaining to AA's efficacy as a 'treatment'. The overall effectiveness of AA is considered. A critical engagement with the strengths and weaknesses of existing research designs lays the foundation for this study's methodology while also highlighting under-investigated elements of the AA recovery experience. Studying AA's literature and academic perspectives provided an insight into AA's recovery process. Put simply, first one requires the motivation to change and engage with AA, second engagement with AA's salient therapeutic practices. Third, following engagement with AA's, changes in self-efficacy, supported abstinence, the fourth, 'expected' outcome.

Chapter Three presents an original theoretical framework, an 'ideal model' that links the knowledge gaps exposed in the Chapter Two and supports the methodological rationale argued for in Chapter Four. From the literature review, three overarching concepts are derived to form a putative model of the experience of recovery in AA. These are: motivation to engage (MtE); structured social engagement (SSE); and personal agency (PA). The fourth component, the effects on abstinence, are the subject of the analysis. This model constitutes what I will term the 'virtuous cycle' of change - an 'ideal' model- and I employ the constituent concepts as an overarching analytical framework.

This framework informs deductive qualitative data analysis while the maintenance of a more generally ‘grounded’ approach allows new concepts to emerge inductively. Importantly, the model/framework was developed further. As all the respondents were abstinent for a number of years, it became apparent that this ideal model needed to be conceptualised to represent recovery over time.

Chapter Four sets out and describes the methodological approach undertaken in this study. The chapter begins with a description of models development. This functions by showing a 'hypothesised change process' which is then revisited in the discussion Chapter Eight, alongside an 'empirically-derived change process', model. Details of data collection, participant criteria/selection, use of a gate-keeper, and the tools used for data analysis are described. Importantly, ethical considerations are explored with regard to researching an ‘anonymous’ group of people, and the limitations of the data derived from using a small sample.

Chapters Five, Six and Seven are the key findings chapters that are framed and structured in relation to the ‘ideal model’. Drawing on the experiences of long-term members of AA, the findings chapters demonstrate the conditions and changes that individuals undergo and experience in order to achieve lasting sobriety. Through a process of deductive analysis, using the theoretical framework, findings emerged that demonstrate how AA’s therapeutic practices impacts upon criminal desistence and a de-escalation of personally troubling behaviours, such as sexual promiscuity. Importantly, some of the difficulties encountered in maintaining abstinence and achieving personal development goals are assessed here.

Chapter Five in particular demonstrates the ideal model of change. Literature taken from social capital studies, for example Coleman, (1988), are used to help shed light on AA's (mostly) beneficial effects. Chapter Five also details the motivations which precipitated joining AA, AA's therapeutic activities and some of the more immediate changes in behaviour experienced in early-to-mid-recovery. Breaking new ground, Chapter Six assesses the moderators of the change process, including the under-acknowledged negative effects of AA membership. Problems associated with sponsorship are assessed in relation to Bandura and Locke (2003) notion of self-efficacy in order to offer an explanation of how individuals remain abstinent. The effects that threats to disengagement from AA and the ways in which members of the study cohort manage them form the core findings of this chapter.

Chapter Seven explores the change experienced by long-term abstinent members of AA. Crucially, this final chapter summarises the cognitive and behavioural responses that have produced these effects. The individual undergoes a process of cognitive restructuring, accepting AA's basic tenets and practices which develop habits of moral reflection and self-control.

Finally chapter Eight summarises and synthesises the implications of study findings. The chapter discusses findings in relation to the original 'ideal model' of behavioural change, and how, in light of the findings, this model developed. I discuss the limitations of the study, together with and outline a related agenda for future research in the area. Such future lines of inquiry include the possibility of investigating the apparent higher than average suicide rate amongst alcohol recovering populations and the 'career

structure' that AA offers, such as opportunities to work (voluntarily) in many positions in AA. AA Service Officers operate at many (internal) levels: intergroup, region and conference. The effects of such 'deep' membership are as yet unknown.

As Maruna (2001) points out, criminology has a certain times been pre-occupied with the persistent, perhaps un-repentant criminal; those unwilling to forego such behaviour are society's 'nut, sluts and perverts' (Sumner, 1995). The participants in this study have all demonstrated behaviour that at one time or other could be categorised in this way, and this is their story.

Chapter 2: Literature Review: Perspectives on Alcoholics Anonymous and Other Mutual Aid Groups

This chapter explores three separable but interrelated aspects of Alcoholics Anonymous (AA) as an organisation. First, the *mechanisms* underlying an ‘active theory of change’ will be considered. This provides a ‘thick’ description of the phenomena under investigation: AA. In AA identification is achieved with other alcoholic sufferers at AA meetings and supported by peer interaction. Alcohol dependency is directly addressed using the Twelve Step Program and a Sponsor. This is a person with substantial length of continuous sobriety and been through the Twelve Steps already. AA’s active theory of change is also claimed to rest on the development of a spiritual dimension to be nurtured and incorporated into an individual’s life.

The second part will address the *nature* of the organisation, using both academic accounts and Alcoholics Anonymous’ own documents (AAWS, 1952 & 2001). Understanding the nature of Alcoholics Anonymous (AA) is fundamental to understanding how it works. Alcoholics Anonymous is distinct from other self-help groups and mutual aid groups. Comparing AA to some of these other groups will help to clarify and highlight the distinctiveness of the AA *Fellowship*. This process will be aided by examining texts such as AA’s *Preamble* (1947), AA’s basic text *Alcoholics Anonymous* (2001) and *The Twelve Steps and Twelve Traditions* (AAWS, 1952).

Third, the claimed and empirically demonstrated effects or *impact* of participation on the sufferer will be assessed. Alcoholics Anonymous has made strong claims to the benefits of the Twelve Step Program (AAWS, 2001:58). Empirical evidence on the effects of AA has focused on several aspects of AA. AA has been assessed on clinical outcomes measuring abstinence using longitudinal research designs (Project MATCH, 1993& 1996). In addition, AA's objective to invoke a strong affiliation amongst its members has been studied in terms of assessing AA's effectiveness (Caldwell and Cutter, 1998; Cloud et al, 2004; Emerick, 1987; Klein et al, 2011). Affiliation has been constructed using four criteria: regular participation at AA meetings (Arminen, 1996, 1998, 2001); the use of a Sponsor (Crape et al, 2002; Whelan et al, 2009); implementing the Twelve Step Program (Ayless et al, 2008; Swora, 2001, Eaton, 2007; Hart and Hignett, 2005); and the development of a spiritual dimension into the individual's life (Connors et al, 2009; Davis et al 2007, Galanter, 1999; Green et al, 1998; Horstman and Tonigan, 2000; Murray et al, 2003; Oakes et al, 2000; Petreet, 1996, Spalding and Metz, 1997; Tonigan, 2007; and Zenmore, 2009). Social network analysis has also been used to examine the importance of the frequency and quality of AA member's social ties with each other (Groh, 2008; Kaskutas, 2002; Kelly et al, 2011; Witbrodt and Kaskutas, 2005). This develops the idea that there is another aspect to recovery in AA: the therapeutic effects of socialising with other recovering AA members both within and outside of the formal confines of the AA meeting (Borkman, 2009; Kelly et al, 2011).

2.1 AA's Stated Theory of Change

Members of Alcoholics Anonymous (AA) claim to experience a change in behaviour towards alcohol that goes beyond the usual clinical outcome measures, such as reduced

alcohol intake and medical comorbidities. Humphreys (2004) argues that the analytic ‘lens’ used to assess self-help groups’ efficacy, in terms of clinical treatment evaluation, is insufficient to understand the mechanisms of change that occur in these settings. This is because the changes occurring amongst the members of the self-help groups go further than those usually associated with health care and psychological interventions.

The mechanism(s) of change, in AA need to be understood in their constituent parts. Each of these parts is related and overlaps, but the starting point in this process is the attendance at an AA meeting. As AA is a complex entity, no single mechanism can account for change (Kurtz, 1979; Smith, 2007). As Kelly and McCrady (2009) argue, it is likely that there are simultaneous mechanisms that occur in an individual, which are both psychologically- and socially-activated, they are psycho-social. The focus of this section is on the claimed mechanisms of change that occurs in AA. As an individual experiences change, this can be understood as the ‘pull’ deeper into the AA Fellowship, as the individual attends AA meetings, acquires a sponsor, applies the Twelve Step Program, and participates in the supportive network of recovering alcoholics.

2.1.1 AA Meetings

Type and Format of AA Meetings

The formal arena and first point of contact for those seeking help from AA is the meeting. The basic purpose is that AA members may ‘share our experience strength and hope with one another’ (AAWS, 1952 preamble). There are two basic types of AA

meetings are either ‘open’ or ‘closed’. Closed meetings are for members and potential members only, those with a ‘desire to stop drinking’, (AAWS, 1952:143). The ‘open’ meetings are accessible to the public, however, members of the public would not be allowed to participate in any of the rituals and practices of the meetings (Borkman, 2009). Donovan (1984) describes common rituals observed in AA meetings, reading the AA *Preamble* (1947) followed by a moment of reflective silence, the meeting then ‘opens’ for ‘sharing’. Closing the meeting, the secretary or Chair asks the group to observe the principle of anonymity, as prescribed in the ‘yellow card’, which states that ‘who you see here, what you hear here, when you leave here, let it stay here’, then members collectively recite the Serenity Prayer.

Meetings are termed ‘speaker/discussion’ meetings (Smith, 2007; Arminen, 1996 & 2001; Kelly and McCrady, 2009), AA members are invited to open the meeting by speaking on a chosen topic. These topics can be derived from either the basic text, *Alcoholics Anonymous* (2001), *As Bill Sees It* (1967), or *The Twelve Traditions and Twelve Steps* (1952). The speaker narrates or ‘shares’ their own experience on the chosen topic, reflecting and quoting the tenor of AA literature. This will be their own experiential monologue and interpretation of a particular Step(s) or principles of AA.

2.1.2 AA Meetings: Functionality

Individual and group cohesion is predicated on AA’s belief that where health care professionals, family and friends have failed, ‘*the ex-problem drinker [...] can generally win the entire confidence of another alcoholic in a few hours*’ (AAWS,

2001:18 my italics). According to AA, this dialogue of open vulnerability is crucial in establishing trust and a common identity amongst new members. At the AA meetings the new member is exposed to Borkman's (1979) 'experiential knowledge'; they begin to hear the language of AA and how other members stay sober (Sommer, 1997; Robertson, 1998; Smith, 2007). New members are encouraged to listen for the 'similarities, not the differences', it is hoped that the new member begins to connect their own experience to that of other members. Kurtz (1979: 61) notes that the narrator offers a 'profound honesty of personal weakness', one that demands no reciprocity, but demonstrates the necessity of honesty a pre-requisite for 'getting the Program' and maintaining recovery. Attendance at an AA meeting helps bring an end to the loneliness that most alcoholics feel (Allen et al, 1981). In other words, attendance conceptually transforms the 'I' of the singular, isolated individual into a 'We' – a group of like-minded alcoholics. This establishes a common identity, a common set of reasons for drinking, and a common set of strategies for recovery (Donovan, 1984: 411).

Vaillant (2003 & 2006) and Gossop et al (2003) found that men, who had attended AA on a weekly basis (or more frequently) spent less days intoxicated and were likely to achieve stable abstinence. Ogborne and Bornet (1982; & Jin et al, 1998) maintain that relapses are an inevitable part of recovery in AA, particularly amongst newcomers. AA conceptualises relapses or 'slips', in AA parlance, as a failure to maintain participation in the AA program (AAWS, 2001). Smith (2007; see also Kurtz, 1979; Rudy, 1980 & Sheeren, 1998) argues that the abstinent AA member becomes vulnerable to existing psychological vulnerabilities, which are held in abeyance by participation in the AA program. Smith indicates the potential for relapse in AA is the gradual withdrawal from AA meetings: 'I got so complacent about meetings. I didn't need them anymore. But as

it says in the Book, the disease is powerful. And all we have to fight it with is this program' (Smith, 2007:47). This statement reasserts the primacy given to attending AA meetings, and also affirms that the fault was *not* with the AA program but rather *with* the individual. AA offers the following caveat: 'Rarely have we seen a person fail who has thoroughly followed our path' (AAWS, 2001:58). Following a relapse, AA meetings function to re-integrate the member. The discussion at the meeting focuses on the circumstances which led to a return to drinking. Once the member has admitted the nature of the violations of normative AA practice, the boundaries to normative behaviour are reaffirmed and strengthened (Rudy, 1980).

2.1.3 'Turns of Talk': Therapeutic Practice

Arminen (1996, 1998 & 2001) provides a detailed and useful analysis on the dynamics of 'sharing': simply, how therapy is achieved by talking in AA meetings. The normative process of conversational interaction is suspended in an AA meeting; typically members take turns in delivering short uninterrupted monologues (Denzin, 1986; Smith, 2007), direct exchanges between members are proscribed (Chappel, 1991:100). The opening 'turns' (Arminen's phrase) start with a declaration of status ("I am XXXX and I'm an alcoholic"), followed by reference to either the previous speaker's 'share' or topic under discussion. This 'co-construction' process arranges the speaker's themes to be reciprocally relevant to the listeners, so that they may identify with the speaker's experience and thus create *therapeutic* relevance for the audience (Arminen, 1998). As an AA member speaks, they are subtly reiterating one of AA's central functions: "*Our stories disclose in a general way what we were, what happened, and what we are now*" (AAWS, 2001:67 my italics).

AA members close their monologues demonstrating ‘the rhetoric of gratitude’. These closing utterances are orientated towards acknowledging the direct and positive effect AA has had on the member’s life (Arminen, 2001). Arminen’s (2001) analysis needs further explanation of the reasons *why* the rhetoric of gratitude is observed and practiced by each member of AA. Kurtz (1979:24) maintains the recovering alcoholic is still capable of ‘childishness, immature grandiosity and infantile defiance’. Tiebout (1944) suggests that to combat these habitual ‘inadequacies’, AA members need to develop a degree of humility, expressed in Arminen’s (2001) closing turns of gratitude.

2.1.4 Sponsorship and Helping Others in AA

Sponsorship is not a mandatory practice, but strongly encouraged. Wheelan et al (2009) observes that AA sponsors sometimes have more than one sponsee, and it is also considered ‘good’ AA practice if sponsors are sponsored themselves (Strobbe, 2009). The pamphlet *Questions and Answers on Sponsorship* (Alcoholics Anonymous, 2005) guides both the potential sponsor and sponsee on all issues relating to sponsorship. The sponsor serves to guide the less experienced AA member through the Twelve Steps. The salient points regarding sponsorship are summarised as follows:

- A sponsor does everything possible, within the limits of personal experience and knowledge, to help the newcomer get sober and stay sober through the AA programme.
- They field any questions the new member may have about AA.
- Sponsorship gives the newcomer an understanding, sympathetic friend when one is needed most — it assures them that at least one person cares

There are similarities between the AA sponsor and a mentor: both require the person to have a better understanding of the functions and requirements of the mentee/sponsee needs in order to fulfil their prospective role. Smith (2007; cf; Wheelan, 2009; Zenmore, 2009) points out that sponsors and sponsees are recommended in AA to be of the same sex: sponsoring a person of the opposite sex is a proscribed behaviour, as AA 'wisdom' teaches that the vulnerable newcomer in early sobriety may confuse help with romantic notions. As such, this proscribed behaviour is referred to as 'Thirteenth Stepping' (Smith, 2007: 34). There are exceptions to this same sex 'rule': homosexual members of AA often acquire a sponsor of the opposite sex, essentially re-enforcing the same logic. AA's Traditions (AAWS, 1952:188) attempt to guard against such behaviour, asserting that 'principles before personalities' ought to be observed, thus preserving the egalitarian nature (Valverde, 1998; Valverde and White-Mair, 1999). Acquiring a sponsor is the only formalised relationship in AA, and is this normatively prescribed for working through the Twelve Steps (AAWS, 1952:59; Chappel, 1991). Sponsoring others in AA is putatively understood to strengthen one's own recovery while simultaneously helping the newcomer (Zenmore et al, 2002; Zenmore, 2007). The book *Alcoholics Anonymous* captures the this principle: 'nothing will so much insure immunity from drinking as intensive work with other alcoholics' (AAWS, 2001: 89). Pagano et al (2004) found that, in terms of relapse prevention, sponsorship was itself a protective factor amongst those who sponsor AA members. Whelan et al (2009) explains this protective factor demonstrates fidelity to AA, such as encouragement to complete the Twelve Steps and attending meetings regularly.

Findings from Project MATCH (1993 &1997) support AA's central tenets that helping others through sponsorship were significantly more likely to maintain sobriety over

longer periods (Pagano et al, 2004:767). Using Project MATCH data, Pagano et al (2009) conducted a second investigation amongst individuals sponsoring alcoholics, finding commitment to abstinence was strengthened and length of sobriety was partially attributed to sponsorship. Crape et al (2002) claim similar results however, over and above descriptive and theoretical suppositions made regarding the benefits of sponsorship, the temporal ordering of events in an AA member's recovery process is not clear. For instance, does a sponsor have to have been through the entire Twelve Step programme before one becomes a sponsor? Zenmore (2007: 448) refers to this phenomenon as 'reverse causation'. This can occur whereby successful recovery precedes sponsorship and completion of Step Twelve.

Young (2012) studied the categories and characteristics of sponsors. The author found that majority of sponsors were older than those they were sponsoring, tended to be parents and acknowledged the spiritual necessity of the AA program. Young (2012) determined that, despite AA's doctrine that one 'needs' a sponsor, sponsee/sponsor relationships 'age out', but individuals do not necessarily return to drinking. Importantly, there exists a cohort of AA members who do not have a sponsor but appear to maintain substantial lengths of sobriety. Young's study highlights the dynamic and multidimensional aspect of the role which sponsors play in recovery from alcoholism in AA. In early recovery, Witbodt and Kaskutas (2005) report having an available sponsor to be more important than any other activity for alcohol-dependent individuals. Whelan, et al (2009: 419) suggest that successful sponsor/sponsee relationships, after a number of years, perhaps 'flatten out' rather than 'age out', as the need for intense support lessens after initial recovery.

2.1.5 Working the Twelve Steps

AA's behavioural model of an alcoholic is of loss of control once drinking has commenced. AA holds that the merely abstinent, the 'dry drunk', still carries the artefacts of character displayed by the drinking alcoholic: grandiosity, infantile defiance and so forth (Denzin, 1987). Having worked the Twelve Step Program, the 'sober' AA individual lives free from these psychological and behavioural defects of character (Kurtz, 1979). Without the Twelve Step Program, and the 'tools' to manage these problems, AA doctrine teaches that the 'the person I was drank' if sufficient change does not occur: 'the person I am will drink again' (Borkman, 2009).

Surrender and Reconceptualising Reliance: Steps One, Two and Three

The book *Alcoholics Anonymous* (AAWS, 2001) and the Twelve Steps and Twelve Traditions (AAWS, 1957) explain exactly how to carry out each of the Twelve Steps. The objective regarding Step One is that the individual should 'surrender', focusing particularly on the inability to control one's alcoholism. Step One achieves this by moving past experiences from the unconscious to the conscious mind, through engagement with the literature and identifying with other's similar experiences. Tiebout (1944:5) describes this process of surrender as 'the unconscious forces of defiance and grandiosity actually ceases to function effectively', and the individual accepts their alcoholism.

Morgernstern et al (1997) notes that AA's method of targeting the psychologically maladapted characteristics of the alcoholic, such as grandiosity, are unique. AA makes

explicit the link between this dysfunction and continuing alcohol abuse. Step One suggests that through defeat one finds liberation and strength (AAWS, 1952). Thus AA offers an alternative of reliance, based on a ‘willingness’ to believe in a Higher Power rather than self-determination: ‘with hardly an exception, [a person] will be *absolutely unable to stop drinking on the basis of self-knowledge*’ (AAWS, 2001:39; italics in original my parentheses). Step Two encourages that a ‘Power greater than ourselves could restore us to sanity’. The primary method for this process to occur requires substitution: ‘you can if you wish make AA itself your ‘higher power’ (AAWS, 1952: 27). The underpinning logic here is that here is a group of people who have found a ‘solution’, while your own efforts have amounted to failure; in this sense the group is a power greater than yourself. Step Three advocates that a person ‘turn our will and our lives over to the care of God as we understood Him’. The key to understanding this step, is a willingness to believe that one’s own efforts to control alcohol consumption should be left to the AA program.

2.1.6 AA’s ‘Practical’ Steps: 4, 5, 8 and 9

AA’s ‘practical’ steps requires the individual to make a list of persons, talk to their sponsor or make amends to someone. The objective is the amelioration of other dysfunctional areas of an individual’s life, such as sex, debt, anger and criminality (AAWS, 2001: 69 & 78). These specific, problematic areas are addressed in the AA literature using vignettes, for example, illustrating entanglement in extra-marital relations and committing fraudulent acts through work-based opportunities. AA locates these behavioural and emotional problems within the individual. Contorted emotions,

desires and unrealistic expectations are a result of 'false' pride exacerbated by an inflated ego (Tiebout, 1944; Kurtz, 1979).

The often quoted AA axiom 'Four and Five to stay alive' is believed to be crucial in maintaining sobriety. Step Four suggests 'Make a fearless moral inventory of ourselves'; and Step Five proposes to, 'Admit...the exact nature of our wrongs' (AAWS, 1952: 43 & 56). In practice, Step Four advises the individual to draw up a table, listing the nature of the resentment, to whom the resentment is directed and what area of the individual's life they perceive to be affected (AAWS, 2001: 65 & Swora, 2004). AA doctrine asserts that the alcoholic 'leads a double life', and that negative experiences occur during excessive drinking, resulting in acute moral failing and an increasing sense of self-loathing. These events cause great distress, keeping the alcoholic in a state of 'constant fear and tension-that leads to more drinking' (AAWS, 2001:73). The consequences for incomplete practice of Step Four and Five is unambiguous: 'Some people are unable to stay sober at all, others relapse periodically', or individuals will suffer 'irritability, anxiety, remorse and depression' (AAWS, 1952:57).

Step Four teaches that an individual must relinquish the 'tormenting ghosts of yesterday', and in a practical sense to do this Step Five states that one must 'talk to somebody about them' (AAWS, 1952: 56). After the 'survey of the human wreckage left in his wake', these actions have the claimed therapeutic effect of forgiveness for the individual and forgiving those that had actually harmed the individual: 'As the pain subsides, a healing tranquillity takes its place' (ibid: 63).

Step Eight ‘Made a list of all persons we had harmed...’ and Step Nine, ‘Made direct amends to such people...’ (AAWS, 1952:43, 79, & 85). These are practical exercises and follow on from Step Four. The objective of Step Eight: to make a formal list of persons to whom amends must be made. Step Nine can be understood as therapy in action; making direct amends to those persons harmed is the given objective. There are caveats for instance, divulging the details of extra marital affairs ‘upon the shoulders of an unsuspecting wife or husband’ (ibid: 88). AA encourages the individual to establish the ‘willingness’ to make amends where possible (Borkman, 2009).

Donovan (1984) provides a thorough description of Steps Four through to Ten, analysing these in terms of ‘mortification’, understood as the act of investment of self in the collectivity of AA, and detachment from the former self. The objective is to exchange a former identity for one prescribed by the collective experience of working through the Twelve Step Program. Thus, once practised and understood, the principles of the Twelve Steps become integral to one’s understanding of, and are consonant with, one’s conception of self. According to Donovan (1984), in Step Four, the act of disclosing one’s innermost fears and negative behaviours, gives the pre-appointed sponsor access to the internal state of the individual. The private sphere of one’s inner world thus becomes public, as members may choose to ‘share’ elements of their Step Four and Five experience in meetings, thus fulfilling AA’s tenet to ‘Share experience strength and hope’. Experiences are re-framed into a positive allegorical narrative, confirming the absence of guilt and shame. Anderson and Gilbert (1989) reported that individuals felt Steps Four and Five were the most difficult parts of the AA Program, but that the self-disclosure skills learned while practicing these steps aided the recovery process. Swora (2001) assessed the nature of the ‘healing effects’ which AA confers on

its members. The re-living of past and painful memories, serves to function as a protective factor by reminding members of the negative consequences of drinking.

2.1.7 The ‘Middle Steps’, 6 and 7: Towards Reflexive Growth

Steps Six and Seven, the ‘middle steps’, are perhaps the most abstract in nature. Steps Four and Five, give the individual a retrospective ‘map’ of harms done, potential ‘triggers’, and ‘defects’ which if not managed, will again result in negative behaviour or drinking. Thus, satiating such ‘warped’ desires, ‘enjoying’ various forms of malign behaviour, ‘lust’, ‘self-righteous anger’, ‘gluttony’ and ‘slothfulness’ has led to imperfections of character. Step Six asks that the individual is ‘entirely ready to have God remove all these defects of character’ (AAWS, 1952:64). The alcoholic’s behaviour, according to AA theory, is one of incompatible and unsustainable demands for satisfactions of basic desires. Step Six requires a measure of ‘character building’; that is a call to practice a greater degree of moral action, framed as an internal narrative. This narrative informs and develops one’s sense and capacity for reflexivity, further suggesting that the individual to strive towards avoiding indulgent behaviours.

Step Seven directs a person to ‘Humbly ask Him to remove our shortcomings’ (AAWS, 1952: 76). This level of abstract spiritual practice is guided by the theory that, as drinking alcoholics, spiritual values were placed second to material and emotional satisfactions, thus blocking spiritual growth (Swora, 2010). Step Seven is characterised by individuals either praying, as it is suggested in AA’s main text (AAWS, 2001:76), or

being mindful of certain traits or behaviours that need changing, with the help of one's Higher Power.

2.1.8 Maintaining a Spiritual Growth and Sobriety: Steps 10, 11 and 12

Steps Ten, Eleven and Twelve are sometimes referred to as the 'maintenance steps' (Borkman, 2009:21). Practicing Steps Ten, Eleven and Twelve should negate the possibility of having to repeat the 'moral inventory' and making 'direct amends' by maintaining a 'fit spiritual condition' (AAWS, 2001: 85). Step Ten is the capacity to act in a reflexive manner. Correcting mistakes by taking a 'personal inventory', AA doctrine reminds members that they are not 'cured of alcoholism', but in this regard 'We are not fighting it, neither are we avoiding temptation. We feel as though we have been placed in a position of neutrality, safe and protected' (ibid). Step Eleven is the practice of further self-reflection: 'we constructively review our day. Were we resentful, selfish, dishonest....we ask God's forgiveness and inquire what corrective measures should be taken' (ibid: 86). Step Twelve's central theme is to carry the message of AA's Twelve Step model of recovery to other alcoholics (AAWS, 2001).

In AA's literature, recovery culminates in Step Twelve: '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' (AAWS, 1952: 109; my emphasis). In AA, spirituality is regarded as its 'core' principle, generating feelings of kinship with oneself, a Higher Power and other members of AA. Tonigan (2007) suggests that AA attendance, length of sobriety and practicing Steps Eleven and Twelve results in an increase in spirituality. As Davis et al (2007) argue, alcohol counsellors have come to accept that clients' needs should be treated holistically; spirituality being a part of this

approach. Winzelberg and Humphreys (1999) reported that atheists and agnostics were less likely to be referred to AA by clinicians, and that some alcohol abusers consciously rejected AA's spiritual philosophy and sought other treatment modalities. Winzelberg and Humphreys (1999) found that, regardless of 'God belief', AA attendance could not be predicted 12 months after treatment; and in spite of AA's doctrine that the 'disease' of alcoholism necessitates a spiritual approach, studies have drawn no conclusive evidence that a spiritual dimension is, per se, a clearly definable mechanism of change.

Project MATCH (1993& 1997) depicted that individuals displaying higher levels of religiosity did not benefit to any greater degree from Twelve Step Facilitation (TSF) intervention, which encouraged individuals to attend AA. Tonigan et al (2002) argue that measures constructed did not include an absolute zero, which would demonstrate no 'God' belief. The measures were therefore based on the assumption that all participants had some level or capacity for spirituality. The authors found that, atheists and non-believers were less involved in AA. Smith and Tonigan (2009: 357) refers to the spiritual dimension of AA as 'the lightning rod of conflict', dividing professional and laypersons alike. However, AA's belief that it is partly a 'spiritual' disease which necessitates a 'spiritual cure' finds some support (Carroll, 1993; Kurtz, 1979 & 1982). The AA literature offers the terms 'God' 'Higher Power' and 'spirituality' are interchangeable and have an overall convergence of meaning. These terms become subsumed in AA's operational vernacular, as each AA member attaches their subjective meaning to these terms as they interpret the Twelve Step Program.

Murray et al (2003) assert that those members of AA with higher levels of reported beliefs in a God/Higher Power did *not*, contrary to AA's doctrine on recovery, have better life satisfaction or greater lengths of sobriety. Murray's discussion on the AA literature relating to 'God' was limited and made no reference to the panoply of explanations and techniques used by AA to develop a notion of a Higher Power. AA's central text, (AAWS, 2001), suggests reframing the concept as 'a Power greater than ourselves', and the assurance that 'When, therefore, we speak to you of God, we mean your own conception of God. Galanter (1999) establishes the difficulties in measuring a 'standard dose' with regard to developing spiritually in AA. This is because, geographically, AA groups may differ in their approach to discussions and commitment to spiritual practices. AA's broad approach to spirituality provides an AA member with a 'space' to exist cognitively in, but this may be too elusive to accurately measure the positive effects on alcoholism (Bogenshutz, 2009).

2.1.9 Social Networks and the AA *Fellowship*

AA considers the concept of the *Fellowship* as an all-encompassing community of recovering alcoholics which exists with the broad remit to support members of AA. Kurtz conceptualises AA as a form of community and, as with Room and Greenfield (1993) (see also Barrows, 1998; Bloomfield, 1994 and Smith, 2007), AA is a social movement. This captures what, according to Kutz (1997) – previous studies which focussed on a singular aspect of AA have missed, that is the *Fellowship* of AA, is the reality of Alcoholics Anonymous.

The notion of *Fellowship* has been reframed in socio-scientific studies of AA as a social network (Kelly, et al, 2009). Participation in low-risk therapeutic activities, which promote pro-abstinent friendship networks, is freely available to members of Alcoholics Anonymous. Krentzman et al (2011: 24) notes the response from a woman when asked what had been the most helpful aspect of AA membership when dealing with alcohol problems: 'Going to AA and getting involved with people because I'm a very social person so I do like people around me'. Kelly et al (2009 & 2011) note that other recovery modalities cannot compare to AA's availability. Membership of AA's broader Fellowship, in terms of a social network, gives flexible, 'on demand' access to sober peers, through periods of high risk, for example during Christmas where access to other treatments would be limited.

Upon entering AA members often undergo a radical re-ordering and restructuring of existing relationships (Donovan, 1984). Hoffman (2006: 677) describes how members are encouraged to, 'abandon old playgrounds and playmates': a euphemism for staying out of drinking establishments and mixing with non-abstinent friends. Longabaugh et al (1998) re-iterates these sentiments: AA support networks serve to 'buffer' an individual from networks *supportive* of drinking.

Individuals in early sobriety often suffer physical and emotional discomfort (Allen, et al, 1981). Having more experienced members available to talk to 'pulls' the newcomer into the *Fellowship* of AA further and faster. These interactions with other members often occur outside the formal relationships, such as the sponsor/sponsee dyad, and involve social gatherings that revolve around going out for coffee and eating out (Rynes

and Tonigan, 2012). Smith (2007) asserts that such practices often serve to integrate less 'sociable' types who are uncomfortable with participation at the formal level of the AA meeting. These less formal gatherings provide an opportunity to build interpersonal relationships, where difficulties with understanding the concepts proposed by AA, and other problematic areas of an individual's life, can be aired in relative privacy (ibid). Groh (2008) identifies that this particular type of *functional* informal support is generally dyadic in nature, however, *structural networks* consist of groups of AA members whose are engaged in other social activities. Reflecting allegiances to AA, (for instance motorcycling) the 'Easy does it riders' take their name from one of the AA slogans (Valverde and White-Mair, 1999) ('easy does it'), and is linked to the film of the late 1960s.

Summary

AA's claimed theory of change operates through stages of participation. The AA member experiences the 'pull' into AA by first attending AA meetings, learning the process of 'sharing' with its concomitant 'rules' for therapeutic practice (Arminen, 1996,2001). Here the new member is encouraged to listen for the similarities of the lived experience of alcoholism, based on AA's theory that 'unchecked self-centeredness' and an 'unbridled ego' drives destructive alcoholic drinking patterns (AAWS, 2001; AAWS, 1952; Smith and Tonigan, 2009). This process helps end the alienation and loneliness felt by the isolated alcoholic (Allen, et al, 1981; Giannetti, 1981). The individual begins to understand their problem as one that can be 'solved', through sharing a common strategy for recovery with the help of a Higher Power (Donnovan, 1984). Abstinence is insufficient: in AA parlance being a 'dry drunk'

(Denzin, 1986; Smith, 2007), is still displaying the same negative behavioural deficiencies as the alcoholic who is still drinking, and will inevitably lead back to destructive drinking.

The Twelve Steps provide a framework for developing a reflective capacity, based on full disclosure of past misdemeanours, followed by a restorative process for harms done and further self-examination in terms of behaviour towards other people. This process is aided with the guidance of an AA Sponsor (Young, 2012; Wheelan et al, 2009). This develops humility and positive, authentic relationships with others. The prescribed Twelve Step Program emphasises the necessity of close relationships, regular attendance at AA meetings, communion with one's Higher Power and engagement in wider AA social gatherings and practices. As a corollary of these actions, AA provides a pro-abstinent low-risk supportive network of relationships through the *Fellowship* of AA (Kelly et al, 2011).

2.2 The Nature of Alcoholics Anonymous and Other Mutual-Help Groups

Keith Humphreys (2004) provides a clear and helpful descriptive typology of some of the common and optional features that characterise mutual-help groups. These are the groups' approaches to, philosophy, mutual problems, goals, politics and leadership. Following Humphreys' typology, this section explores areas of commonality and difference in relation to AA, and identifies some of the gaps in his and other authors' understanding (Kelly, 2009; and Borkman, 2009). The other mutual-help groups to be contrasted to AA are Women for Sobriety (WFS), Free Life (Vie Libre), Moderation Management (MM) and SMART Recovery. These groups were selected because they all offer help to the individual with alcohol problems in a group setting. Importantly,

though, there are significant differences amongst these groups, such as women-only members (WFS), a rejection of the ‘necessity’ to develop a personalised spiritual dimension (SMART Recovery and Free Life), and controlled drinking (MM) rather than abstinence based recovery goals. These respective differences in philosophical and program technologies will be drawn out to help better understand the AA *Fellowship*.

2.2.1 Categorisation

Room and Greenfield (1993:167) proposes that ‘AA [...] does not neatly fit the usual descriptive categories of social science. This is of course more of a problem for social science than for AA’. As a starting point, it is perhaps therefore wise to use AA’s own description of the organisation, as a *Fellowship*, rather than attempt the ‘Procrustean’ feat of neat categorisation.

There are conflicting accounts of what Alcoholics Anonymous (AA) is, it has been variously perceived as a treatment, an intervention, and a self-help group. At times, even within the same article, AA is defined as a Twelve Step mutual-help organisation, and then as a mutual-help fellowship (Kelly and McCrady, 2009: 321, 322). Makela et al (1996: 8) use the term ‘mutual-help movement - a specific kind of social movement’. As a social movement, one of the key characteristics of AA is that it is a group of ‘conscience’, with a lifestyle associated with its membership that is not wholly based on escaping from or just coping with the aftermath of either single or multiple catastrophic life events.

Humphreys (2004:12) asserts that the term 'self-help group' is something of a misnomer. Practically, self-help conjures Victorian ideals of betterment, of men 'pulling themselves up by their boot straps'. Humphreys argues that the notion of 'self-help' has been linked with a plethora of self-help books available, but this connotation of self-help is not what is available in self-help/mutual-help groups. These groups are fundamentally a collective endeavour to solve a common problem, based on a collective experience of mutual/reciprocal help.

The term 'mutual-help' organisation arguably better defines the AA organisation. This implies a number of key features observable in AA and other groups with a therapeutic goal. These are a reliance on reciprocal emotional and practical support, being non-professionally-led, and having a recovery program or ideology that values experiential knowledge over scientific or academically generated knowledge. One exception is SMART (Self-Management and Recovery Training) recovery, which does ground its recovery concepts in evidence-based cognitive and behavioural methods, but members also use experiential knowledge in the group setting (Hovarth, 2000).

John Kelly et al (2009: 238) define Alcoholics Anonymous (AA) as the following, 'AA is a non-professional, community based fellowship that provides help through a network of informal gatherings, convened at rented venues, such as churches and hospitals'. This describes some of the main facets of AA, but Kelly's 'informal gatherings' are viewed by AA as 'formal'. These formal gatherings consist of AA meetings listed publicly, and are to be found in a variety of media and other professional organisations, such as the internet and GP's surgeries. It is the *informal* gatherings that AA members engage in –

parties, walks in the countryside, and social gatherings, to celebrate birthdays and Christmas for instance – that also constitute the notion of the *Fellowship*.

Borkman (2009: 28) has identified the AA Fellowship's defining characteristics as: 'the network of relationships among AA members, families, and friends'. The nature of these relationships is egalitarian and based on mutual trust. This level of trust comes from sharing experience in a non-hierarchical way, not just in the formal setting in the AA meeting, but in friendship networks outside of the meetings. One key point has been missed in Borkman's analysis (2009). The primary reason that such relationships flourish is because they are based on sobriety. Most members of AA have not previously encountered one another. Therefore, as a new member joins AA, other members can view this person objectively, as it is unlikely that the new member has had any negative impact on other members' lives during their drinking. Essentially, all new relationships start with a 'clean slate'. Past wrongdoing is judged as a 'natural' consequence of alcoholism, the new and shared common goal of achieving and maintaining sobriety forming the bedrock of these new relationships.

2.2.2 AA's Shared Characteristics with other Mutual-help Groups

Mutual Problems and Shared Goals

Common to all mutual-help groups is the belief that the shared problem of alcoholism can be overcome more effectively as a group rather than individually. Each person who seeks help for their alcohol problem does so because they have begun to suffer levels of distress that have warranted seeking specialised help. The type of help received may differ in theoretical terms (for example where one locates the root cause of alcoholism),

but each mutual-help group possesses a highly developed program of change, grounded in a developed form of 'experiential knowledge' that members freely share, primarily in a group setting, and then on a one to one basis (Borkman, 1976).

Perhaps the most obvious shared goal amongst mutual-help organisations is that of personal change towards alcohol consumption. There is a continuum to be observed in terms of abstinence. Alcoholics Anonymous (AA) maintains that abstinence is the first requirement to begin the process of change. This is evident in AA's Step One (AAWS, 1952:21), as does Women For Sobriety (Kastukas, 1994& 1996) and Free Life (Fainzang, 1994). SMART Recovery incorporates the notion of moderation, but clearly states the goal to be worked towards is abstinence (Hovarth, 2000; Eric et al, 2000), while Moderation Management explicitly aims to return members to controlled drinking (Klaw et al, 2003).

Moderation Management's (MM) principles of recovery are self-management, balance, moderation and personal responsibility. MM members share strategies to help moderate drinking patterns, using daily drinking diaries. Once a balance has been achieved, the overall plan for future drinking is to limit alcohol consumption to 3-4 days a week (Kelly and Yeterian, 2008). Moderation Management (MM) rejects the disease notion of alcoholism and the goal of long-term abstinence (Klaw, et al, 2003). In addition, MM eschews spirituality as a requisite dimension for recovery, preferring instead to expand a person's ability to understand their drinking habits and address these negative patterns of drinking using cognitive and behavioural principles (Klaw, 2003). Moderation Management has developed a nine step plan focusing on self-esteem and self-

management. The nine step plan is guided by a professional, and from the outset it is suggested that a person is abstinent for 30 days. If this period of abstinence is not achieved, the health care professional may deduce that the individual is incapable of moderation and should therefore be referred to a program of abstinence (Kishline, 1994).

Women for Sobriety (WFS) (Kastukas, 1994 & 1996) is markedly different to AA with the emphasis being on personal empowerment rather than surrendering to a 'higher power'. According to Kirkpatrick (1977), the founder of WFS, surrender may work for 'grandiose', 'arrogant' and 'self-absorbed men', but women suffer from low self-worth/esteem and lack confidence. Thus, the WFS program for recovery revolves around a thirteen-point, positive affirmation plan, based on four themes: no drinking, positive thinking, believing in one's own competency, and growing spiritually and emotionally. Having sponsors and lifelong membership are discouraged in WFS, as they encourage dependence and suppress the person's ability to take full control of their lives and (Kirkpatrick, 2000).

Free Life (Vie Libre) defines itself as a movement of cured drinkers and rejects the notion of anonymity on the grounds that Free Life members are not ashamed of their status (Fainzang, 1994: 338). Questions and themes are proposed for discussion at the group meetings. Topics range from the negative effects of drinking and the acquisition of pink or green cards. The partners of Free Life's members are strongly encouraged to join, and once a new member has progressed past the probationary period of six months of total abstinence they are issued with a pink card. This is the same for both the now

ex-alcoholic and their spouse, who has also committed themselves to abstinence. The green card is held by the spouse/partner, who is a sympathiser to the goals of Free Life but still drinks. Recovery is maintained and pivoted around tight solidarity amongst members, partly engendered by the card system. Practically, recovery is supported and maintained through efforts to recruit new members and promote better health care/alcohol treatment policies in the public sphere.

SMART (Self-Management and Recovery Training) Recovery's fundamental document is its Purposes and Methods statement, which contains its central philosophy and beliefs. The 'four point program' aims to 1) build motivation to change 2) cope with urges and craving 3) manage problems, negative cognitions and actions 4) balance short-term and long-term satisfactions (Hovarth, 2000:185). The program represents an effort to condense and synthesise a large body of empirical findings from cognitive and behavioural research. This body of scientific knowledge underpins the program, but the language used in meetings is not scientific/technocratic; it is grounded in experience. The four-point program is used by the facilitator to unpick 'faulty' beliefs which have led to negative actions and behaviour (Eric et al, 2000).

2.2.3 Experiential Knowledge

The role experiential knowledge has played in validating mutual-help groups, as a legitimate means by which one may recover from alcoholism, is key to understanding the attraction and retention of their members. Borkman (1979, 1990 and 1999) has argued that experiential knowledge is distinct from lay/common and expert/professional

forms. Common sense ideas are derived from pervasive cultural influences, and as such are inherently prone to swift changes. Professional forms of knowledge are theoretically derived and scientifically tested, and are less prone to be influenced by shifting cultural beliefs (Humphreys, 2004: 15). Experiential knowledge is therefore a form of ‘truth’ learned from individual experience (Borkman, 1979: 446). There are, according to Borkman, two prerequisites for this truth to become established and embedded within the mutual-help framework, the type of information and the attitude towards it. The type of information is gained from a person’s experience of alcoholism, and is usually replete with situational and emotional content. The attitude towards this knowledge is built on the shared experience of alcoholism. Some commonalities which reflect the overall experience of alcoholism are thus credited with a high degree of validity. Attitudes towards this knowledge are shaped because of the ubiquity of the common negative experience of alcoholism.

2.2.4 Reciprocal Help

All mutual-help groups adhere to some form of help-giving as a common function that aids recovery. In AA this is set out in Tradition Five: each group’s primary purpose is to help other alcoholics (1952: 154). In most situations concerning the need for help, the dynamics of the relationship are one way, with the counsellor having expert knowledge over the help-seeker. Mutual-help groups have been successful in reducing this hierarchy of relationships. The establishment of the ‘helper principle’ as a key component of recovery amongst alcoholic sufferers has ensured this principle is embedded within recovery discourse (Pegano et al, 2011). Riessman (1965, 1990) suggests the power of the ‘helper therapy principle’ is simple: when the helper commits

to helping a new member, and they share the same problem, the helper's commitment to the program is strengthened and help-seeker access the necessary help. A mutually shared problem helps to 'flatten' the relationship between the two. This is particularly useful in re-establishing a sense of value to an individual, one who has previously been socially and psychologically marginalised in this sense by the damaging effects of alcoholism (Laudet, 2007).

2.2.5 Differences amongst Mutual-help Organisations and Alcoholics Anonymous

Leadership roles within AA may differ to those within some of the other mutual-help groups. AA, through its Traditions Eight and Two, maintains that individuals must rotate from roles of relative leadership after set periods of time: one year for a group secretary sometimes known also as the 'Chair' (AAWS, 1952 & 2003). In addition to this, an AA group secretary does not lead the discussion or actively order the sequence of speakers who contribute to the meeting (Arminen, 1998). In contrast, groups such as SMART Recovery (Hovarth, 2000; Eric et al, 2000) and Women for Sobriety (Kirkpatrick, 2000; Kaskutas, 1994 & 1996) use designated or trained facilitators who guide topics of discussion and invite people to speakers who have particular areas of experience. In addition to this, Hovarth (2000: 182) states that occasionally in SMART recovery, facilitators may be health care professionals; although under what circumstances professionals lead groups, and for how long, remains uncertain. Typically, a moderator in the Women for Sobriety group will have two years' continuous sobriety, while also needing to demonstrate a level of understanding of their program and pass a test on WFS philosophy (Kaskutas, 1996:264).

The terms ‘peer-led’ and ‘self-directed leadership’ are often used to denote the lack of professionalisation in mutual-help groups. Common to AA and mutual-help groups of alcohol sufferers is the notion that peer leadership helps remove dynamics of power that might hinder recovery. Self-help and mutual-help groups in various fields have often evolved either explicitly or implicitly in response to the perceived iatrogenic effects of professional intervention (Crossley, 1998), because of the embedded cultural prejudices within the health care system (Humphreys, 2004). Humphreys (2004) asserts that, in addition to the positive effects of peer leadership, mutual-help groups create roles, assigning tasks which bind people tighter to the organisation and further consolidates recovery.

2.2.6 Philosophy; Spiritual/Non-Spiritual

Central to AA’s approach is a reliance on a ‘higher power’. This has proved to be the most controversial and easily definable difference between AA and other groups dealing with alcohol problems (Laudet, 2009). Other Twelve Step groups have used AA’s Twelve Steps, and the notion of a ‘Higher Power’, but have modified the wording slightly to take into consideration other problematic behaviours. Groups which have the word ‘*Anonymous*’ in their title, such as Cocaine Anonymous, Gamblers Anonymous, Nicotine Anonymous, Narcotics Anonymous and family groups, Alanon, and Ala Teen, all use the notion of a ‘Higher Power’ and regard anonymity as spiritual principle to be developed (Denzin, 1987; Smith, 2007; White and Kurtz, 2009).

Women for Sobriety also encourage spirituality as a desirable component to recovery; but the need for this is less explicit and recovery is not ‘jeopardised’ if a spiritual dimension into one’s life is not developed. Notions of spiritual growth for members of WFS are regarded as the ‘fundamental object of life’, and have likely evolved from the distinctive support that is accessed and given by women for women (Kaskutas, 1996: 260).

SMART recovery does not advocate spiritual development, rejects the notion of alcoholism as a disease, and that a person has to acknowledge powerlessness over alcohol. Ellis and Schoenfeld (1990), argue that perpetuating the notion of ‘powerlessness’ towards alcohol, creates dependency on external supports, rather than teaching self-reliance. This approach is broadly reflected across other mutual-help groups discussed. Free Life and Moderation Management direct recovery towards correcting maladaptive thinking, adopting psycho-social practices that are commensurate with behaviourist theory, which situates a person’s locus of control internally rather than externally. This is in direct contrast to how AA members are explicitly encouraged to, rely on a ‘Higher Power’ in Step Three (see, AAWS, 192; 35; Fainzang, 1994; Eric et al, 2000; and Hovarth, 2000).

2.2.7 Membership, Meetings and Governance

The nature of Alcoholics Anonymous (AA) membership has been notoriously hard to define (Macintire, 2000). Estimates reported by AA (AAWS, 2001: xxiii) are in the region of 2 million people from 150 different countries. Membership requirements

defined in Tradition Three state that a person needs only have a 'desire to stop drinking' in order to join, ensuring an open membership policy. This also means that procedures for exclusion from AA have no precedents or procedures to follow (Makela et al, 1996: 42). Sub-groups of AA have proliferated. Gay, Lesbian (Hall, 1994) and Black African American groups (Brisbane and Womble, 1985) exist; but, if such groups are adhering to the Traditions, others who wish to attend should not be excluded from participation as per Tradition Three (AAWS, 1952:143). AA claims to have attracted 'Catholics, Protestants, Jews, Hindus and sprinklings of Moslems and Buddhists', but exact numbers remain unknown (AAWS, 2001: xxiii). Alcoholics Anonymous (AA) is the only organisation to state that recovery is also dependent on its members' ability to follow its methods of governance. Tradition One clearly states this: 'Our common welfare should come first; *personal recovery depends* on A.A. unity' (AAWS, 1952:133, my italics).

Membership to Women for Sobriety is restricted to women only, and, to date, the number of WFS groups is estimated at 150-300, with 1000 to 2000 members. Kaskutas (1992 & 1994) has provided the most recent and detailed analysis of membership. Kaskutas reports that 98% were white, 'well-educated', and approximately 30% attended AA as well. Access is strictly 'by appointment only', requiring an individual to make contact via the internet. Humphreys (2004: 90) encapsulates the problem of understanding WFS membership and governance:

"Why the only alcohol related self-help organisation founded by a sociologist adopted cumbersome procedures and growth –impeding organisational structures remains a mystery."

SMART recovery has formed partnerships in the UK, with over 250 other organisations in the third sector, criminal justice agencies, and commissioners for treatment and care providers (Smart, 2011, para 2). The proliferation of Smart recovery across the treatment sector and its methods of promotion lie in stark contrast to AA's strategy for growth. AA's Preamble and Twelve Traditions reflect AA's political neutrality; 'A.A. is not allied with any sect, denomination, politics, organization or institution' (AAWS, 1947; page1, para, 1).

2.2.8 Political Stance

Alcoholics Anonymous' stance on political (religious and social) causes is also distinctive. Its' position of neutrality is expressly stated in the Preamble and codified in Tradition Ten (AAWS, 1952:175). AA members are permitted to affiliate to any political party they so desire, but do so as a member of wider society, not as a member of AA. Other self-help groups do have a political dimension in either an overt sense (that is the organisation was born from political struggles), or through being underpinned by a political philosophy.

The French mutual-help group Free Life (Vie Libre) situates problematic drinking within the structural conditions of the working class (Humphreys, 2004:64), and declares that it is 'society that makes us drink' (Fainzang, 1994:338). Free Life urge members to take up political activities, such as advocating for better alcoholism treatment through increased government spending, thus disclosing one's status as a recovering alcoholic publicly. Free Life believes that the problem of alcoholism in the

working classes is a result of political and economic marginalisation. There are distinct Marxist overtones to the organisation, as Fainzang (1994) describes Free Life's attitude towards its members and recommendations for action; 'Alcoholics are likened to slaves chained to the ground; this means that recovery amounts to rising, fighting against advertisements, social pressure, and alienation, and breaking out of one's chains to obtain freedom' (Ibid: 339).

Women for Sobriety, although not having any overt political agenda, traces its provenance back to a broadly feminist framework of action. Kaskutas (1994:186) reports that women have different reasons for drinking, associated with issues pertaining to sexuality and gender roles for instance, or have suffered physically, sexually or psychologically at the hands of men. For these reasons, the personal experience of alcoholism for members of WFS can be understood to be politically defined in relation to a woman's inability to recover in an 'overtly' male-oriented and dominated mutual-help group (Kirkpatrick, 1977).

Summary

Laudet (2009) documents the impact AA has had on other self-help and mutual-help groups, noting that the focus on abstinence in the US, and UK treatment policy initiatives have made AA and other Twelve Step Fellowships ideally placed to treat individuals with alcohol and other problems (UK Drug Policy Commission, 2008). Those groups, such as Narcotics Anonymous, Ala-Teen and Gamblers Anonymous, have adopted the AA's Twelve Step Program of recovery and the Twelve Traditions in

their entirety. Other mutual-help groups have deliberately set themselves against AA's philosophy or organisational practices. For example, Women for Sobriety only accept female members and focus on developing an internal locus of control. Free Life members publicly criticise government policy and believe anonymity encourages shamefulness. SMART recovery meetings are led by trained facilitators and adhere to scientifically-derived principles based on cognitive and behavioural treatments. Of the common characteristics that AA and other mutual-help groups share perhaps the most significant is an adherence to Borkman's (1976) notion of *experiential knowledge* as the primary discourse for conveying a shared experience and recovery techniques. Also, the practice of *reciprocal help*, features strongly as a shared characteristic across mutual-help groups.

Figure 1 - Comparisons of Mutual-Help Groups across Four Domains

	Philosophy: Spiritual/Non- Spiritual	Mutual Problems And Shared Goals: Abstinence Based	Political Stance	Facilitator- Led: Trained/Un- Trained
Alcoholics Anonymous	Yes, Strong	Yes, Strong	None	Untrained
Women For Sobriety	Yes, Moderate	Yes, Strong	Moderate	Trained
Smart Recovery	Yes, Moderate	Yes, Moderate	None	Trained
Moderation Management	None	No	None	Trained
Free Life	None	Yes, Strong	Strong	Untrained

Figure 1 provides an illustrative guide to some of the key comparative characteristics. Despite the controversy attached to AA and its focus on spirituality (Bufe and Peele, 1998), the ubiquity of the ‘spiritual’ domain, demonstrates that other groups have incorporated this concept into their recovery programs, such as WFS (Kastukas, 1996). SMART Recovery claims many of its members have rejected the ‘overtly religious’ content of AA (Eric et al, 2000) in favour of a more secular and cognitively focused approach. However, Orr (1996) reports that SMART Recovery quietly acknowledges the positive role spirituality plays in recovery.

The distinctive nature of the *AA Fellowship* is the complex relationship between AA’s members, their recovery and the organisational structure codified in the Twelve Steps and Twelve Traditions (AAWS, 1952). Each of the similarities and differences that have been examined and explained above can be traced back to one or a set of intertwined principles laid down in the Twelve Traditions. AA’s self-funding capabilities and relationship to outside causes and agencies have kept it free from any influence, political or otherwise. AA has co-opted an individual’s recovery as dependent on the success of the organisation, as set out in Tradition One (ibid). This is perhaps one of the least understood differences examined and demonstrates the complexity of the relationship between the individual, and how the organisation survives.

What emerges in the *AA Fellowship* is a sense of camaraderie felt amongst its members (AAWS, 2001:17). This is achieved by working the Twelve Step Program, doing service in AA, and adherence to the Twelve Traditions: AA’s operating principles. Thus the *Fellowship* is predicated on sobriety facilitated by the Twelve Steps, which have to

be operationalised through membership of AA - the success of which is dependent on their members staying sober and helping others (Step Twelve and Tradition Four). This relationship is cyclical and has functioned with undeniable success in terms of longevity (75 years); its geographical spread across 150 countries, and a membership count approximating 2 million (Gross, 2010).

2.3 Effectiveness of Alcoholics Anonymous

This subsection is organised into three broad areas of analysis. The first gives a brief description of the three eras of outcome research on AA, and includes important information on how key elements of AA's practices have been conceptualised and operationalised. There then follows an overview of review studies, including meta-analyses (Tonigan et al, 1996: Kownacki and Shaddish, 1999: Ferri et al, 2009). The last section provides an account of individual and cultural characteristics of demographic groups that may affiliate more or less strongly with AA (Kaskutas et al, 1999: Galaif and Sussman, 1995).

Findings from AA effectiveness studies are extraordinarily hard to decipher. For example, Groh (2008: 44) states, 'Overall, the AA literature is characterized by inconsistent findings, with researchers continuing to debate the role of AA in promoting abstinence (Emrick et al., 1993; Humphreys, 2004; Kownacki & Shadish, 1999; McCrady & Miller, 1993; Tonigan et al., 1996)'. Kelly et al (2009: 237) add to the debate, notably using almost the exact same references, 'Rigorously conducted empirical reviews of AA-focused research indicate that AA participation is helpful for many different types of individuals in their recovery from alcohol dependence (Emrick

et al. 1993; Tonigan et al. 1996; Kownacki and Shadish, 1999; Kelly 2003; Humphreys 2004; Ferri et al. 2006; Kelly and Yeterian 2008)’. The former quote from Groh et al (2008) suggests that claims of AA effectiveness are ambiguous whereas the latter, from Kelly, seems to suggest a consensus of positive opinion regarding effectiveness.

While the limitations of these studies are critically assessed, the results emanating from these studies on effectiveness are stated. Importantly this section identifies salient mediator practices, such as engaging with an AA sponsor and attending meetings. The effect mediates changes in a person’s identity and notions of self-efficacy. Therefore, here components of a hypothesised model of change emerge and will be discussed in detail in Chapter Four.

2.3.1 Conceptual and Methodological Considerations in Judging Effectiveness

AA evokes strong opinions, ranging from being the *most* effective programme available (Synder, 1980; Vaillant, 2003, 2006), being effective for only 5% (Bufe, 1990. Ferri et al’s (2009) Cochrane review on AA effectiveness led to reports claiming AA was considerably less effective than spontaneous remission. Kurtz (1982:38) argues that ‘Few deny AA’s therapeutic successes’ and that 98% of professionals, working in addictions treatment, support AA. Miller et al (1993) propose that one in ten of those seeking treatment, will attend some form of Twelve Step treatment modality in their lifetime: a strong case for thorough investigation based on sheer weight of numbers alone. Humphreys (2004) asks why one might evaluate a voluntary organisation, which demands no public financial support, requires no licensure or strict membership rules. Humphreys regards evaluation of AA as a ‘social responsibility’, extending the

argument that public claims of effectiveness leaves addicted persons vulnerable to potentially ineffective or harmful interventions.

When reviewing studies on the effectiveness of AA, the significant criteria are set out in the Maryland Scale of Scientific Methods, which focus on problems of internal validity (Sherman, 1998). Internal validity criteria are used to illustrate the varying strengths of the study designs. Randomised Controlled Trials (RCTs) evidence high levels of internal validity. RCTs, such as Project MATCH, demonstrate the ability to control the sample, standardise the intervention and measure against a placebo or another intervention. Thus Farrington, (2003), argues, RCT's allow a high level of treatment efficacy to be deduced. Humphreys and Rapport, (1994) argue that the 'dose' measure, such as working the Twelve Steps, cannot be standardised if one is truly measuring the effects of a self-help group free from professional intervention. Morgenstern and McKay (2007) caution that AA effectiveness studies have generated some impressive findings, but the domination of this model has come across serious limitations, and that new paradigms ought to be considered.

In AA research, the primary condition is alcoholism, the mediator is AA engagement and the outcome is the final 'event', which is assessed as a measure of effectiveness, usually abstinence rates. Generally, research (Project MATCH, 1993, 1997, for instance) has split outcomes into two measures: primary measures are related to alcohol consumption (percentage of days abstinent - PDA - and drinks per drinking day -DDD). Overall, pre-treatment alcohol consumption averaged 15 drinks per-drinking-day. In the post-treatment, assessment at six months, this decreased to three drinks per-drinking-

day. Secondary outcome measures consisted of levels of potentially improved psychosocial functioning. Ashton (1999) and others (Tonigan, 2009) regard the splitting of outcome measures when assessing AA effectiveness as justified when considering AA's position on abstinence, and in relation to the secondary benefits that abstinence brings to an individual. AA literature states a 'new freedom and happiness' will be experienced, and, in particular, relating to self-efficacy measures, 'We will intuitively know how to handle situations which used to baffle us' (AAWS, 2001:83, 84).

Mediators can be divided into other categories, such as cognitive and social. Research has been done studying intrapersonal variables that reflect cognitive changes in the individual. Morgenstern et al (1997) took four mediators: self-efficacy, primary appraisal, cognitive and behaviour coping and commitment to abstinence. The strength of Morgenstern et al's (1997) study demonstrated that AA affiliation (a composite measure of AA's practices derived from AA literature) led to a strengthening of cognitive mediator variables, such as commitment to abstinence, thus increasing rates of abstinence. Participants attended an average of 3.1 AA meetings per week. Of these, 22 percent drank at least once at the six month follow up. The result demonstrated that lower levels of primary appraisal (an assessment of one's alcohol problem severity) and low affiliation scores, adequately predicted relapse at the six month follow up. Therefore, increased or mediated levels of commitment to abstinence increases motivation for abstinence.

Social moderator variables in AA, such as access to pro-abstinent social networks (the AA Fellowship) and recovering role models (AA Sponsors), have also revealed positive

mediating effects on primary alcohol-related outcomes, subject to levels of participation (Humphreys, 1999; Langabaugh et al, 1998; Kaskutas, et al 2002; Kelly et al 2011). The rationale for a shift from more cognitive or ‘psychotherapy technology’ models, to a focus on the therapeutic effects of a pro-abstinent social environment, are that the underlying psychopathological theories that explain the *maintenance* of problematic drug and alcohol use are assumed to work in reverse. That is active participation in one’s pro-drinking social networks, predicted relapse. This finding led researchers to begin to re-frame their understanding of alcohol dependence as a function of one’s social context and environment. The problem is how the person orientates themselves towards individuals who affect and are affected by their drinking behaviour, such as drinking supportive networks of relationships versus pro-abstinent friendship networks: to whom does one turn for support, and what is the nature of that support (Ashton, 1999).

Kaskutas, et al (2002), hypothesised the mediational effects that positive social support (the ability to borrow money and help with babysitting), accessed via a pro-abstinent network (family members, friends, AA members), may have upon abstinence. Those persons with support from people met at AA, were 3.4 times more likely to have remained sober at the three month follow up interview, echoing similar results demonstrated by Humphreys et al (1999) and equally positive results from Litt et al (2008) that encouraged individuals to participate in AA group social activities. Put simply, those that included AA persons into their social network, *and* sought help from those persons, were more likely to remain abstinent. However, the nature of that help

sought did *not* specify if help included AA specific activities, such as working through the 12 Steps with the aid of a sponsor.

Kelly et al's (2001) analysis revealed that the social recovery process in AA, is enhanced, in terms of abstinence, by participation in low-risk abstinence based activities. Attempting to isolate AA's effectiveness, the authors used lagged mediational analyses. Results in changes in alcohol usage, demonstrate that for every pro-drinking network tie, this resulted in 9.6% fall in percent of days abstinent, and for every pro-abstinent network tie, there was an increase of 3.4% in percent of days spent abstinent. The authors claim AA's social effect work by decreasing one's ties to pro-drinking networks, whilst increasing pro-abstinent network ties. In addition, having an increased pro-abstinent social network exposes the individual to activities participated in during social interaction with this network. The methods and analyses stop short of elucidating the nature of these activities, and any further effects on abstinence rates.

These studies demonstrate that AA's, while positive, in terms impacting upon alcohol consumption, effectiveness is difficult to determine. Efficacy, most likely lies intra-personal coping mechanisms, cognitive changes in self-efficacy (Morgenstern et al, 1997) and social support opportunities available in pro-abstinent networks (Kaskutas et al, 2002), and in AA's effects on the composition of social networks, either pro abstinent or pro-drinking.

2.3.2 Alcoholics Anonymous Studies across Three Eras

Tonigan's (2009) first era stretches from early post-war studies till around 1990 (for example, Ogbonre and Glaser, 1981; Trice, 1970; and McCowan, 1989); the second era research, from 1989/90 till 2001; and the third era of research is from 2001 up to the present. These studies typify the progressive nature of statistical analysis that take into consideration the plethora of AA's practices and beliefs, in accounting for the effectiveness of AA (Kelly, 2003).

First Era (1950-1990)

Phase 1 studies tended to be single-group and cross-sectional by design. These studies - based on assumptions that AA group dimensions, such as size, context and dynamics, were fixed and stable - appeared to neglect active change mechanisms. Findings were largely small-scale, quantitative, correlational, and often overstated effectiveness largely as the result of one or more of the following problems: sampling error; attritional bias; lack of comparison groups; failure to test the null hypothesis; and an over-reliance on uncorroborated self-reports (for instance, Carroll and Fuller, 1969 ; see also Emerick et al, 1993).

Methodologically stronger studies that attempted to measure AA's positive effects, include Ditman et al (1967), Brandsma et al (1980) and Walsh et al (1991), incorporated randomisation in their cohort allocation. However, Ditman's cohort was under threat of legal sanctions should they drink, which may fundamentally impacted on motivation

and therefore effectiveness. Smith (2007: 71 & 112) suggests that court-mandated AA attendance in the first instance had been met with resistance, however some coerced individuals had eventually converted to AA's beliefs and practices. Coerced attendance runs counter to AA philosophy, specifically Tradition Nine and Twelve, which speak directly to notions of coercion and 'attraction' as undesirable strategies (AAWS, 1952: 176, 184). Humphreys (2004) notes that Ditman's study also failed to assess psychosocial functioning or monitor individuals in the control group who may have sought other interventions for alcohol problems.

Brandsma (1980) and fellow researchers, recreated AA meetings and took a register of attendance, thus removing AA's anonymity requirement. In addition, the researchers also contacted individuals in the study if they missed a meeting, mitigating against the voluntary nature of AA. Confounding results further members of the study took it upon themselves to attend AA, outside of the study conditions. Further weaknesses in the selection and exclusion criteria, lessened the overall reliability of conclusions to be drawn as individuals with severe alcohol problems were not selected. However, members of the AA group condition, did have lower levels of alcohol consumed on drinking days, 2.5 vs 11.2, as opposed to the other experimental conditions.

Walsh et al (1991) assessed AA as a standalone intervention and AA plus an in-patient treatment, as the two experimental conditions. Members of this study cohort were initially sampled from an employment assistance program, for workers experiencing alcohol problems. The negative consequences for non-compliance with the interventions, undermined relatively small positive outcomes. Findings suggested, that

the AA-only cohort did have reduced negative outcomes; but for individuals with serious co-morbid characteristics, AA alone was an insufficient intervention.

Second Era (1990-2001)

Research in this era was characterised by a more sophisticated application of psychometric and statistical analyses (Tonigan, 2009; Humphreys, 2004). During this phase, AA researchers began to statistically control for individual differences, such as alcoholism severity (Timko et al, 2000) and psychiatric problems (Connors et al 2001), the rationale being that these may confound possible benefits derived from AA participation, such as motivation for change (McKeller, et al, 2003). By incorporating a longitudinal research design, causality could be more reliably inferred from studies by considering temporal ordering; (Ouimette, et al, 1997; Tonigan et al, 2000; Moos and Moos 2006).

Project MATCH (1997, 1998) was the largest and one of the most expensive studies in the field of alcoholism research (Cutler and Fishbein (2004: 1). The importance of this study in relationship to AA was the Twelve Step Facilitation (TSF) component. The study was a randomised, multi-site clinical trial of 1726 patients with a DSM-III-R diagnosis for alcohol abuse, assigning participants to three different treatment modalities: Motivational Enhancement Therapy (MET), Cognitive Behavioural Coping Skills Therapy (CB), and Twelve Step Facilitation (TSF). The objective was to ascertain whether outcomes could be improved by randomly matching individuals to either of the treatment modalities.

The TSF intervention, based on AA's Twelve Steps, and encouraged participants to attend AA. Other treatments did not overtly encourage AA involvement, but no attempt was made to stop other individuals assigned to the MET and CB groups, from attending AA. On average clients who were assigned to TSF performed better on abstinence measures (Ashton, 1999). TSF emphasised that alcohol dependence can only be 'arrested' through abstinence, in accordance to AA's fundamental belief on alcoholism also (AAWS, 2001 & 1952). The TSF component produced greater levels of AA meeting attendance and abstinence rates in this group were higher than the other two intervention (CB and MET). Of the TSF group, at one year 24% were abstinent, compared to 14% MET and 15% CBT (Project MATCH, 1999). Project MATCH data, from across all sites and settings, showed that the greater AA involvement a person had, resulted in positive, yet modest effects on drinking outcomes: 8% fewer days spent drinking after three years (Tonigan, 2010). Critically, these results have been challenged (Ferri et al, 2009). The key finding from Project Match, was that, amongst individuals for whom membership to pre-treatment social groups that *encouraged* drinking, TSF and engagement with AA, resulted in higher abstinent rates for this group.

Third Era

This latter phase of AA research is characterised by a shift in understanding of the nature of AA practices, and a broadening of the definition of outcomes in terms of 'recovery'. Taken together this shift in understanding has allowed studies to incorporate measures associated with AA practices that occur dynamically.

Recovery is a shifting concept, indicators of successful recovery may change as a person remains sober and in AA for increasing lengths of time. Understanding AA's therapeutic practices incorporate the dynamic production of behaviour change and recovery occurring in a dynamic context. For example, attending AA meetings, working the Twelve Steps and employing a sponsor, change occurs through *mutual sharing* (AA meetings) and *helping others* (Twelfth Step principle and the practice of sponsorship). *Mutual sharing* is analogous to observational learning (Bandura, 1971) or group theory dynamics (Yalom, 1995); and *helping others* is analogous to adaptive social networks (Connors et al, 2001; Kaskutas et al, 2002; Kelly, 2011). In terms of Self-efficacy, motivations for abstinence are mechanisms through which AA's specific practices exert beneficial effects. Bandura (1982) proposed that perceived levels of self-efficacy accounts for changes in coping behaviour. These changes are produced by different modes of influence. AA's Twelve Step Program specifically targets 'illusory inefficaciousness' patterns of belief and behaviour. Taking psychologically impaired cohorts into consideration, Connors et al (2001) and Tonigan (2003) found that, participants in AA were resistant to drinking at the three year follow up point, and had greater lengths of continuous sobriety through enhanced senses of self-efficacy. For Timko et al's (2000), eight year study, 47.5% of the AA group were abstinent and at the eight year mark, 48.5% reported total abstinence.

Focusing on AA's beneficial effects such as coping skills, self-efficacy and facilitating pro-abstinent cognitions, have been evidenced across a wide range of studies (Bond, Kaskutas, & Weisner, 2003; Connors & Tonigan, 2001; Humphreys, Mankowski, Moos, & Finney, 1999; Kaskutas, Bond, and Humphreys, 2002). Humphrey's (2004) notes that

self-efficacy can be bi-directional in terms of success measured by abstinence. Humphreys explains that members display *lower* levels of self-efficacy, in terms of appraising capabilities to drink alcohol safely. This therefore serves to *increase* self-efficacy concerning abstinence. This positive effect can be explained: AA doctrine suggests one should surrender (Step One) all notions of control over alcohol consumption. Rather than a reflection of self-efficacy, this is as a function of acceptance of AA's ideology and philosophy of alcoholism (Antze, 1976; Kurtz, 1977; Sommer, 1997; Smith, 2007). Investing time to participate in AA's therapeutic activities, produce more positive outcomes. The 'experience' of being a member of AA is multidimensional, and needs to be understood as thus (McKellar, et al, 2003).

2.3.3 AA's Claimed Success and Studies Using AA Survey Data

AA's core text, *Alcoholics Anonymous* (AAWS, 2001, p. xx), claims a 75% sobriety rate for alcoholics, 'who had really tried the program'. The 75% sobriety rate is often the most quoted statistic and first published in 1939 (Arthur, 2008). AA co-founder Bill Wilson based this analysis on a total of 94 people. A breakdown of the figures from his 1938 survey suggested that 'one-half have had no relapse at all. About 25% are having some trouble, or have had some trouble, but in our judgment will recover. The other 25% we do not know about' (Arthur et al, 2008: 15). This qualification of success was issued, 'of all the people that have been *seriously interested*', meaning that the 75% were in fact a subset and not all 100% of people who tried AA. Later, a revised figure appears in the second edition of *Alcoholics Anonymous*, stating that 'Of alcoholics that can to AA *and really tried*, 50% got sober at once...' (AAWS, 2001: xx; my emphasis).

Arthur (2008) notes that those early members of AA conducted rigorous ‘pre-screening’, on merits regarding motivation, a clear example of selection bias.

According to McIntire (2000), the 1990 survey, claims AA’s success rate as being 5%. The author argues this is a misinterpretation of the data, based on attrition rates after a 12 month period, 95% of ‘newcomers’ had dropped out. The problem stems for the conceptualisation and measurement of what constitutes a ‘newcomer’, what is understood by the term ‘really tried the program’. McIntire (2000) and Arthur (2008) suggest that the AA success rates are, in fact, commensurate with the founding member’s initial estimates. This finding is concurrent with Kaskutas’s (2009) analysis of AA survey data, which reported that half of the respondents were sober for 5 or more years.

2.3.4 Meta Analytic and Systematic Reviews of AA’s Effectiveness

Tonigan et al (1996) assessed 74 AA studies eligible for meta-analysis, and the purpose of this was to study the size of the effect AA had on drinking-related outcomes. Of the studies included, most were correlation; most had not included third-party corroborative evidence to substantiate claims made in self-reports, or reported on participant socio-economic statuses. The authors found much better drinking outcomes after AA involvement, and that attendance at AA meetings produced improved psycho-social functioning. Psycho-social domains investigated, included problems pertaining to debt, legal issues, familial conflict. Tonigan et al (1996) noted that most of the studies sampled, focused not on AA but were AA-inspired: treatment content for participants

had incorporated some features of the AA program; but what form these took, for example the Twelve Steps, how many or how often these Steps were undertaken, was not reported.

Kowanacki and Shadish (1999) reviewed the results of 21 randomised controlled studies of AA and considered assignment conditions, attrition rates, outcome measures, types of control groups and voluntary v's coerced conditions. The authors used effect sizes which compared AA efficacy in relation to other treatment/no treatment control groups, to draw out causal inferences. Three studies used a coerced sample; these were atypical of most AA studies and the results evidenced negative effect sizes- Brandsma et al (1980), -0.98 Ditman et al (1967) -0.38 Walsh et al (1991) -2.54. Stronger results from Tucker and Gladdsjö (1993) from a voluntary group showed a positive effect size of 0.58. The authors suggest these coerced individuals suffer at the hands of 'real' AA members as an explanation for these negative results. In addition, coerced individuals may not have the prerequisite motivation enshrined in Tradition Three, thus lacking a 'desire' to stop drinking (AAWS, 1952).

Kowanacki and Shadish's often quoted finding, that AA is no better than other treatments and could be 'worse than no treatment', depicts a blurred 'picture' of AA effectiveness. In all five of the randomised studies that sought to assess AA, the authors report that certain AA practices, having a sponsor and engaging with the Twelve Steps, evinced positive results: various AA components were more effective than non-AA treatments. Kowanacki and Shadish called for better designed, randomised controlled

trials to elucidate the casual effects of AA, while acknowledging that AA participants, ‘do well’ comparatively to those who either are coerced or do not attend.

Ferri et al (2009) conducted the most up-to-date meta-analysis on AA effectiveness. Of the 117 studies considered, only eight met all the inclusion criteria. All of these were randomised controlled studies. Ferri et al’s (2009) results provided no conclusive evidence that AA helped patients to accept therapy, or that AA, compared to other interventions, helped reduce negative drinking behaviour. The study highlights the difficulties in assessing AA effectiveness. Other measures of effectiveness, such as quality of life and better psychosocial functioning, should be considered as measures of benefit derived from AA participation. Psycho-social measures are in keeping with the definitions of ‘recovery’, which cover a variety of problematic social, psychological and clinical problems associated with substance misuse (UK Drug Policy Commission, 2008).

From a methodological perspective, comparing AA with a control, would allow for more simple but more accurate measurement of AA effectiveness. This suggestion is methodologically practical, but is severely limited when considering the ethical dilemmas, such as barring a participant to a possibly helpful intervention (Krentzman, 2007). Krentzman notes further that, randomised clinical trials on AA are ‘impossible’. Fluid membership, variation in AA meeting content, and self-selection, all impact upon scientific methods of investigation.

2.3.5 AA Affiliation, Individual and Cultural Characteristics

The basic text, *Alcoholics Anonymous* (AAWS, 2001: 17), states ‘We are average Americans. All sections of this country and many of its occupations are represented as well as many political, economic, social and religious backgrounds. We are people who normally would not mix’. Timko (2009) argues that AA’s philosophy is broad enough to encourage interpretation across diverse and special populations. As AA’s only membership requirement is ‘a desire to stop drinking (AA Tradition 3, AAWS, 19952: 143), it is assumed that AA’s beliefs and values have remained stable enough to continue to attract diverse populations. The degree to which one participates in AA activities can be regarded as a measure of affiliation: a commitment to specific practices associated with AA (Caldwell and Cutter, 1998; Cloud et al, 2004).

The Alcoholics Anonymous Involvement and Affiliation Scales were conceived in the context of Project MATCH (1993, 1997). This study, developed a reliable and valid assessment scale of AA-related practices and behaviours (for example, Humphreys et al, 1998; Tonigan, 1996; Morgenstern et al, 1997). Cloud et al (2004: 1120) note that amongst these ‘veteran’ Twelve Step researchers, there exists an agreement as to what activities and beliefs constitutes affiliation. These are as follows:

1. Attending meetings
2. Working the Twelve Steps
3. Identifying with the Twelve-step program (considering self a member, organising life around AA, believing involvement is important to recovery)
4. Experiencing a spiritual awakening

5. Using program resources for help or guidance (other members, sponsors, meetings, literature, prayer or higher power)
6. Involvement in higher-level activities (celebrating sobriety birthdays, being a sponsor, reading or studying program literature, interacting with recovering members outside meetings, providing volunteer services)

Ogborne and Bornet (1981: 670; Ogborne and Glaser, 1982; and Hurlburt and Fuqua, 1984) suggest that individuals that affiliate strongly with AA display cognitive simplicity, existential anxiety and a tendency to conform. Those suffering from greater levels of alcohol abuse severity (Krentzman, 2011), problematic familial contexts, and reduced psychological functioning, were also found to affiliate with AA (Emerick et al, 1993). Basic, shared demographic variables of the 'stable AA member' were being a male, single, having familial problems. Reflecting the changing characteristics of AA members, AA now included women and men of all ages, a diversity of ethnic backgrounds, professions and sexual orientations (Krentzman, 2008).

Montgomery (1995: 245) found no evidence for 'affiliative need', and assert that the evidence indicates no typical 'AA personality'. Research regarding more fixed demographic variables, also suggests that women (Forcehimes and Tonigan, 2003), those with greater educational attainment (Terra et al, 2007), represent demographic groups with a higher likelihood of joining. Findings from the U.S, suggest that African Americans, also affiliate with AA in large numbers, but differ in levels of participation to White members (Kaskutas, Weisner, Lee, and Humphreys (1999), but AA may not be culturally appropriate for all Native Americans (Spicer, 2001). Amongst the Hispanic

communities in the US, there is evidence of rising rates of alcohol and alcohol related problems (Arroyo et al, 2002). Conflicting studies suggest that Hispanics are more likely to attend AA (Caetano et al, 1993), less likely to attend (Arroyo et al, 1998), and that there is little ethnic preference for AA compared to other alcohol treatments (Humphreys and Moos, 1996). Hoffman (1994) identifies how Hispanic AA meetings have adapted, culturally, to integrate the ‘machismo value complex’, such as ‘credible’ levels of masculinity into the meetings. Borkman (2009) observes that overall, attitudes towards members of AA from minority backgrounds are, ‘somewhat more tolerant than the surrounding cultural milieu’ (Borkman, 2009: 27), but generally persons join AA groups that reflect similar characteristics, with values commensurate with their own (Mankowski, Humphreys, & Moos, 2001).

The literature emanating from AA studies emphasises three key elements which constitute affiliation: identification and association with other members, working the Twelve Step Program, and the development and maintenance of a spiritual dimension. These elements are also commensurate with AA’s core tenets (AAWS, 2001).

Summary

AA’s effectiveness has been interpreted as at best no worse than other interventions (Kownacki and Shaddish, 1999; Cutler and Fisbein, 2004; and Ferri, 2009). While attendance at AA meetings has been correlated with abstinence (Vaillant, 2003, 2006), the therapeutic value and practices investigated in AA meetings has been found to ‘work’ (Arminen, 1996, 1998, 2000), as with other components such as sponsoring

others (Pegano et al, 2004; Whelan et al, 2009; Kingree and Thompson, 2011), a spiritual dimension (Zenmore, 2007; Tonigan, 2009) and ‘God belief’ (Krentzman, 2011), have also been found to augment recovery in AA.

Tonigan’s (2009) third era research suggests that the key to understanding one’s success in AA lies in the inter-connectedness of those individuals and the unique properties that AA relationships foster amongst members (Longabaugh et al, 1998; Kaskutas, 2002; Witbrodt and Kaskutas, 2005; and Kelly, 2011). As yet unclear are the unintended therapeutic and social consequences of active membership in AA’s pro-abstinent support network. For example, AA literature suggests that when sobriety is stable, and members are ‘immersed’ in AA, members help each other into beneficial employment positions (AAWS, 2001), thus suggesting other less clinical but nonetheless helpful forms of opportunities that may help sustain recovery.

Common themes that represent elements of the AA recovery program are found amongst all of the literatures assessed. These are best understood as meditational components. Of note, it is only through attendance at AA meetings that one becomes exposed to the psychological and sociological benefits of AA. Accessing a Sponsor, practicing the Twelve Steps, and engaging with the AA Fellowship (adaptive pro-abstinent support network, Kelly, et al, 2011), can only be achieved by first attending an AA meeting. Connors et al (2001) and Kaskutas (2002) suggest that AA’s effectiveness is mediated by participation in pro-abstinent, social networks, which increase an individual’s confidence (self-efficacy) in avoiding high-risk situations. The implications for professional alcohol treatment workers are that AA can provide immediate entry to a

network of individuals who are available to support pro-abstinent behaviour. In more simple terms, the literature reviewed demonstrates that, once a person is sufficiently motivated to engage with AA, the individual is encouraged to participate in AA's therapeutic practices, attending meetings and working the 12 Step program. Thus engagement AA's results in changes in personal agency, self-efficacy for example. These changes increase the likelihood of attaining and maintaining abstinence. These salient components identified from the literature will be used to develop an original model of behaviour change, and once developed, how this model guides the methodology and the analysis, in the methods chapter and subsequent analytic chapters.

Chapter 3: AA's Mediated Behavioural Change Model: A Conceptual Analysis

Kowanacki and Shaddish (1999: 1898), suggest that 'dismantling studies', may be appropriate to understand, 'the ingredients present in the AA experience that are most helpful'. This chapter aims to describe the 'ingredients' and place these in a model that will illustrate AA's mechanisms for change. The first section of this chapter describes how the model moves from a four point conceptualisation to a, three part component structure at the end of the chapter. This model represents an original contribution towards understanding AA's therapeutic mechanisms, which illustrates this as a dynamic and circular process of recovery, one that is commensurate with AA's own belief that recovery is an ongoing, life-time commitment.

Figure 2: AA's circular process of recovery



This basic model has been constructed from an assessment of AA's literature (AAWS, 2001&1957), and academic studies regarding AA's 12 Steps (Witbrodt and Kakutas, 2005; Whelan et al, 2009), for example. As this study involves multiple cases, 'pulling' together concepts that prior knowledge, deductive reasoning, identifies as relevant to answering the central research question: *How does AA's 12 Steps and Membership of the Fellowship of Alcoholics Anonymous Work for Addressing Drinking Problems?* Further, this approach helps the researcher to specify who will and will not be studied (engaged members of AA, rather than ex-members), and what conditions (abstinent) and experiences (being a sponsor/sponsee) are necessary cohort characteristics. It is noted that this will impact on the data collected and further development. Suffice to say, this is not a process model for *all* people for whom AA has been of benefit and the limitations that the sample of AA members used for this study, will be discussed in detail in chapter Four through to chapter Eight, and how this has impacted on the data.

The balance therefore is to construct a set of concepts that guide the research in a loose enough framework, to enable the complexities of experience to emerge inductively, but to allow for enough cross-case comparison to make the findings meaningful (Miles and Huberman, 1994). For example, research has yet to uncover, what, if any, are the negative effects of the sponsor/sponsee relationship? One of the key problems in assessing the positive effects of working the AA Program has been trying to disentangle concepts and practice. The model presented above begins help separate the basic components necessary for behavior change. Complexities arise partly due to AA's literature, particularly regarding Step Twelve (AAWS, 1952: 109). Embedded in this Step are the notions of spirituality, sponsorship and fellowship, which coalesce to constitute recovery. These are AA's 'elusive components', which help members achieve abstinence.

Humphreys (2004) points out that both AA and professional treatments share some shared objectives, not least to help reduce or eradicate alcohol consumption. Therefore, future research into AA, should acknowledge the benefit of adopting other data collection strategies. Kowanacki and Shaddish (1999: 1907) suggest a shift in methodology, advocating for qualitative strategies to understanding AA's complex and diverse practices. Borkman (2009: 12; see also Morgenstern and McKay, 2007) argues that contemporary studies are constrained by 'frameworks that cannot easily accommodate non-scientific paradigms'. In a similar vein, Kurtz (1992) maintains that standard treatment evaluation techniques constrain methods of investigation, which deny the phenomenological experience of change in AA. Following these methodological suggestions, it is proposed that a qualitative research strategy be employed to uncover the how members of Alcoholics Anonymous 'work' the Twelve Steps, and what effect this process has had on alcohol dependence.

Having constructed an original ideal/hypothetical model that represents a 'cycle of change', these components needed 'populating', with theoretical perspectives analogous to each of the model's constituent parts. Connecting the findings from the literature review to the construction of the theoretical framework, one can observe how motivation is discussed in AA's Step One (AAWS, 1952: 23), regarding the potential loss of, 'health, their families, their job'.

3.1 Introduction

The purpose of this chapter is to build a conceptual model. From the literature reviewed in Chapter Two, three concepts emerged that help understand AA's mechanisms of change. Motivation presents the first of a three-part arrangement of concepts that overlap, motivation, structured social engagement and personal efficacy, which culminate in abstinence. This chapter explores theories that, will help analyse the data. These concepts explain the various components associated with how an individual comes to effectively change their behaviour upon entering Alcoholics Anonymous. Specifically, the concept of motivation will be 'unpacked' in the following section. The approach taken mirrors that found in Chapter Two. Selecting relevant discourse from AA's core literature and demonstrating the conceptual relationship with the elements studied here, drives further the analysis of AA's mechanisms of change further.

3.2 Motivation

Motivation and agency lie at the heart of all discourse of purposive action. High motivation to change predicts better outcomes amongst AA members: coerced samples tend to fare worse; and studies using quantitative methods which approximate randomised control trials demonstrate poor outcomes. Tonigan (2009) reflects that Dittman et al (1967) is the often cited study that 'proves' AA is ineffectual amongst individuals forced, under threat of legal sanction, to attend AA. The task remains to 'unpack' and illuminate how an individual moves from a coerced state, to a person motivated to stay sober and continue involvement in AA's structured social engagement. AA (1952: 24) states that, 'Under the lash of alcoholism, we are driven to

AA...’, this ‘lash’ may come in various guises. Forms of coercion to be considered in this section include pressures emanating from both the criminal justice system and the medical profession. These are to be considered as *external* and *formal* pressures. In addition, an individual may experience pressure from members of their respective social and family networks, including close friends, business associates and work colleagues. These are also *external* pressures but they are *informal* in nature.

3.2.1 External/Formal Pressures

Legal Pressure

‘Today I can say that I am really grateful to that judge who sent me here [AA]. At first, I really resented him for telling me I had to go. But now I see he may have saved my life’ (Smith, 2007 *ibid*: 72, my parentheses).

Wild (2006) notes that the overall effectiveness of formal legal pressures to facilitate entry into drug treatment is a highly contested area of research and practice (contrast, for example, Anglin 1988, and Farabee et al 1998, with Stevens et al 2005). Seddon (2007) argues the case for a distinction between *coerced* and *compulsory* treatment ‘options’. Coerced individuals retain an element of choice, legally mandated individuals, under threat of incarceration, have considerably less ‘choice’. Longshore et al (2004) warn against the false assumption that all legally mandated individuals are *unwilling* and *uninterested*. Polcin and Weisner (1999) developed measures which overemphasised the objective nature of legal pressures to enter treatment. Wild (2006) (and others) have argued that coercion is an inherently subjective experience, and

therefore best conceptualised as having two components: *external* and *internal* pressure (Seddon, 2007: 273). The key to understanding the difference, or *perceived* difference, is whether one *believes* these pressures have influenced their overall decision to enter treatment. The same level of pressure from the criminal justice system may be applied categorically. However, the threat of legal sanctions may be differentially understood, depending on past experience and perceived legitimacy of the criminal justice system. Marlowe and colleagues (1996) found, from a cohort of 260 subjects, 25% of subjects were referred through a formal agency (such as probation), but of these only 3% rated legal pressure as influencing treatment entry.

Medical pressure

‘My doctor was the one who said I’d better try AA, and save what liver I had left!’ (Smith, 2007: 71, exclamation in original).

Gallanter (1999: 716) credits AA as having ‘...contributed greatly to diminished morbidity and mortality in the alcohol dependent population’. Polcin and Weisner (1999) note that treatment ultimata received by an alcohol dependent person from a health care professional tended to influence treatment entry more strongly than admonishments from family or friends. Alcohol dependence severity, measured as on the Alcohol Severity Indictaor (ASI) scale, demonstrated that two thirds of the authors sample had scores above the median. Medical pressure expressed as an ‘ultimatum’ was a strong predictive factor in treatment entry for severely afflicted alcohol users.

3.2.2 External-Informal Pressures

Social Pressure

‘A friend was in AA, and she had stopped drinking completely, and was doing really well. I didn’t think I was alcoholic, but I knew I should drink less. So when she suggested I go, I did’ (Male 5 years sober cited in Smith, 2007: 73).

While Polcin and Weisner (1999) suggested that informal, familial and friendship networks had less of an effect than medical pressure on individuals to enter treatment, the authors found that social pressure of this type happened more frequently. Marlowe et al (1996) empirically tested non-legal coercive measures, finding that substance misusers rated legal dictates less significantly than interpersonal conflicts and emotional disturbances in making a decision to enter treatment. Marlowe and his colleagues’ argument is that an individual will respond differentially in behavioural terms. When escaping or avoiding a *socially* imposed sanction made by friends or family, such as being made homeless, the aversive stimuli differs from the *legal* perspective on coercion because ‘threat’ precedes the ‘target event’- treatment. Thus the negative consequence would be eliminated upon entering treatment. The authors develop a systematic analysis, measuring the amount of pressure experienced across various psychosocial domains. In conclusion, the authors argue that informal pressure is effective when members of the person’s social network are involved (1996: 81). Marlowe and colleagues fail to elaborate further the exact reasons for this ‘success’. Liepman et al (1989) suggests that familial intervention can be strengthened to maximise leverage, if an alcohol-dependent person’s social network is advised *before* such an intervention occurs. Essentially, the person’s social network is educated and attuned to their respective roles in the alcoholic’s life, taking care to differentiate

‘enabling’ behavior from positive intervention techniques. Briefly, ‘enabling’ occurs when, unwittingly, a person is indirectly contributing to or allowing the target individual’s destructive drinking to continue. Liepman et al (1998) demonstrated positive results, albeit from a small sample (28% of social networks that actually went to the intervention stage). Techniques used when dealing with aggression re-framed anger towards the person’s ‘illness’, thus separating, to a degree, the individual from their actions. The authors conclude that the preceding conditions that precipitate entry to treatment do *not* have to approximate AA’s ‘Hitting bottom’- ‘...you must wait until people hit rock bottom before they can be helped’ (ibid: 217). Although as Greil and Rudy (1983) describe, ‘hitting bottom’ is ‘ideologically prescribed’ in AA: various low points that occur in an alcoholic’s drinking career commonly coincide with an individual’s first contact with AA.

The Transition from External to Internal Pressure

As Seddon (2007) argues the link between coercion and motivation becomes apparent when one considers how these ‘forces’ are experienced subjectively. Coercion can be understood as a set of external pressures, which include both formal and informal. Models of behaviour change seek to understand what moves a person from a state of unawareness to awareness in relation to a drinking problem. Thereafter, how does this new-found awareness translate into action?

Armitage (2009:196) reports that Prochaska and DiClemente’s (1983) trans-theoretical model (TTH) of health behaviour change has ‘received unprecedented research

attention'. Armitage (2009) states the argument succinctly: negative health behaviours are a dominant cause of mortality. These deaths are at best preventable, or at least modifiable: TTM has been applied in relation to weight loss, smoking cessation, alcohol and drug abuse, condom use and medical compliance (Velicer, et al, 1998). Prochaska and DiClemente's (1983) model is a theoretical, integrative description of how people modify a problem behaviour or adopt a more positive form of behaviour. No clear consensus exists on TTM's overall validity. Cahil et al (2010:2) find no unequivocal evidence TTM is '...neither more nor less effective', while others have argued that there are in fact more stages of change present (Kraft et al, 2007). Callaghan, et al (2007) argue that Prochaska and DiClemente's original model, which represents the hierarchical tenet of TTM, is flawed. The stages of behaviour change in TTM are based on six conceptually discrete stages a person passes through. These are:

- *Precontemplation*: perceives no problem, no intention to alter behaviour
- *Contemplation*: problem acknowledged
- *Preparation*: intent on action
- *Action*: overt action and some success. Abstinent from one day, to six months.
- *Maintenance*: working on relapse prevention techniques
- *Termination*: Temptation non-existent, high degree of confidence across all previously regarded high risk situations

Progression through these stages is not linear; more of a cyclical, 'clock-wise and anti-clockwise' pattern of behaviour is demonstrated. A person may regress. To a degree this is expected, given the high relapse rates amongst alcohol and drug users (Velicer, et al,

1990; Makela, 1996). Migneault et al (2005) report, there are other dimensions present which describe where a person is in relation to each of the five stages of change. These dimensions include the following: *processes*, *decisional balance* and *self-efficacy*. In the following section, decisional balance will be explored in greater detail. The properties of this concept are conceptually analogous to AA's theory of change. The pre-requisite psychological state an individual must arrive at, before committing to the AA Twelve Step program, is clear 'fit' with this construct. Migneault et al (2005: 438) describe 'processes' as, 'a set of activities in which individuals engage during behavioural change'. As such processes and self-efficacy are covered in the sections, structured social engagement and personal agency.

Decisional Balance

'Some day he will be unable to imagine life either with alcohol or without it. Then he will know loneliness such as few do. He will be at the jumping-off place' (AAWS, 2001: 152).

Velicer (1998) and colleagues explain these dimensions - *processes*, *decisional balance* and *self-efficacy* – as having operationalised as psychometric constructs. These constructs can be applied to assess where, psychologically or behaviourally, an individual may be on each of the five stages. For example, work developed by Janis and Mann (1977, cited in Migneault et al, 2005: 438) on decision making attempts to address decisional balance by weighing the pros and cons an individual perceives when continuing or terminating a negative behaviour.

To understand how this ‘decisional balance’ corresponds to behaviour change it is necessary to sketch the dynamics of this psycho-social variable. As a starting point, persons who have experienced some or all of the external, formal and informal pressures can be assumed to be *contemplators*: considering their situation in relation to changing behaviour. Ajzen’s (1991) theory of planned behaviour (TPB) conceptualises attitudes according to positive or negative evaluations of behaviour. Armitage et al (2003) argue that this evaluation determines underlying behavioural beliefs. Within this construct, TPB, the social pressure exerted upon the individual shapes a ‘subjective norm’, understood in this conceptual analysis to represent the perceived effects of entering treatment. As a corollary to subjective norms ‘behavioural intention’ is informed by the strength of intent to act - to what lengths would a person go to change a problematic behaviour? The tension present in conceptualising this component of behaviour change is partly overcome by assessing *attitudinal ambivalence*: ‘[being] unable to imagine life either with alcohol or without it’ (AAWS, 2001: 152, my parentheses).

Armitage et al (2003) observe a person may hold supportive and non-supportive beliefs *simultaneously* towards a behaviour. The ephemeral calming effect drug or alcohol abuse has on an individual works both psychologically and emotionally, thus providing ‘...negative reinforcement via amelioration of an unpleasant negative affect...’ (Witkiewitz, et al 2005:16). Thus, as these ‘attitudes of ambivalence’ are equalized, the pros and cons considered, a cross-over effect characterizes a person’s thinking, which locates individuals at the contemplative, preparation or action stage. As the ‘decisional balance’ becomes ripe for tipping the person becomes more receptive to the notion of

positive change and more capable of processing salient information, as they prepare to take action (Armitage and Connor 2000).

Epiphanies and Spiritual *Compulsion*

“If there is a God, let Him show Himself! I am ready to do anything!” Suddenly, the room lit up with a great white light...And it burst upon me that I was a free man’ (in Kurtz, 1979: 19&20).

This is the story Bill Wilson (AA co-founder) tells of his spiritual experience. It is documented that from that day, to the time of his death, Bill Wilson never drank again, making it his life’s mission to help other alcoholics achieve sobriety (AAWA, 1984). Perhaps least understood of all, and particularly pertinent to members of AA, some individuals report a profound religious or spiritual experience: a *compulsion* to mend their errant ways and end negative drinking patterns (Keller, 1990). However, people reporting religious or quasi-religious experiences often report they were *compelled* by such an experience rather than coerced (AAWS, 2001). Kurtz (1979&1981) argues that AA’s notion of spiritual ‘conversion’ happened in a more gradual way. It is noted that Wilson had recently become acquainted with William James’ *The Varieties of Religious Experience* (1902/1985). Recognising that the ‘thunderbolt’ experience was unlikely to be shared by many, Wilson observed that the chief characteristics which would precipitate a shift towards spirituality were characterised by internal negative psychological and emotional states, ‘...pain, suffering and calamity. Complete hopelessness and deflation at depth...’ (Wilson, quoted in Kurtz, 1979:21). In this

regard, the compulsion to act comes from a metaphysical source rather than sources of a more tangible nature. Wilson and his fellow architects of the early AA Twelve Step Program were careful to make the distinction between 'spirituality' and 'religion', for fear of alienating possible new members (Chappel, 1990).

Ellis and Schoenfeld (1990) argue that AA's 'brand' of religious motivation may be objectionable to many potential members, while others (Denzin, 1987, Hortmann and Tonigan, 2000) regard the centrality and 'guiding' nature of a belief in a Higher Power as having a positive effect on an individual's recovery. Ellis and Schoenfeld (1990: 462) surmise that potential AA members may find spirituality and the concept of a Higher Power problematic. 'Divine Intervention may seem as implausible as the reality of the Tooth Fairy'. Importantly, much of the literature on the spiritual dimension and experience, emphasise that these changes in belief, are gradual and largely un-dramatic, nevertheless they are regarded as profound (AAWS, 2001).

Zinnbauer and Pargament (1998) explain the differences between two compatible paradigms - classic and contemporary religious conversions. The 'classic' conversion follows biblical conceptualisations, drawing from Saul's conversion on the road to Damascus. This change is sudden or dramatic, but in this narrative form change is always for the better. Contemporary paradigms focus on the educative, gradual process of change whereby the actor actively searches for self-realisation. Combining both elements, the authors present a model of change based on a 'crisis' conversion, preceded by stressful life events. These changes are intrapsychic and occur as previous beliefs and modes of living become untenable: 'Existence itself has become the problem...The object is to transform an entire life, to create a substantive change in

both destinations and pathways of living' (Pargament, 1997: 248, cited in Zinnbauer and Pargament 1998: 163). Involving the sacred, a conversion of the religious type as explained by Zinnbauer and Pargament (1998), involves the self-identifying with a sacred force, which alters that person's perception of reality. A sacred force can include groups of peers that offer acceptance and a socially supportive function. The sacred object then becomes a guiding force that connects the person to the inner self and to other members of the organisation. Formerly negative connotations of the self, cease to cause emotional disturbance, as feelings of self-esteem and self-efficacy confer a greater capacity to deal with life's demands.

Pressure to enter treatment emanates from a variety of psychosocial domains. Adverse social consequences experienced by those in active addiction are likely to increase as negative patterns of behaviour become more deeply entrenched. As a consequence of such behaviour, contact with external formal and informal pressures will occur more frequently and with greater intensity. How an individual perceives these pressures and then internalises the information will inform their decision making. Armitage et al's (2003) theory of 'attitudinal ambivalence' offers an insight into the effects on behaviour change. The authors postulate that more ambivalent attitudes render individuals more pliable; increasing the likelihood that persuasive information will be processed rather than disregarded out of hand.

AA's Step Twelve encourages members to 'pass on' their message of recovery to other alcoholics (AAWS, 2001; 1957). AA's theory that one becomes 'ambivalent', unsure

whether he or she can continue drinking, finds a conceptual fit with Armitage et al's (2003) 'attitudinal ambivalence'.

As constellations of pressures gyre the individual, a decision to change or enter treatment occurs. Those with higher levels of motivation fare better in treatment settings than those subjects with lower levels of motivation. However, even pre-treatment high levels of motivation do not guarantee success. Maintaining treatment gains, such as increased psycho-social functioning and abstinence, remain the chief goal for therapists, policy makers and, not least, the individuals themselves.

As an individual enters AA, they become exposed to the Twelve Steps and other associated mechanisms of change and benefits. Further, AA's ideology encourages the belief that without membership to AA, the person is unlikely to achieve permanent abstinence alone.

3.3 Structured Social Engagement

'Human activity, that is, comes first: but the specific activity that leads to sobriety is the alcoholic's surrender to the fact that he or she needs Alcoholics Anonymous' (Kurtz, 1979: 184).

The following section represents the second part of the conceptual framework, shedding further light on AA-related activities that lead to sobriety and behavioural change in.

Human social systems consist of individuals interacting in order to ‘...strive towards the achievement of external and internal goals’ (Von Cranach, 1986:193). These systems consist of groups or units. Within each group reside individuals, each of whom have become part of a group, the purpose of which is to achieve some objective that, unaided, is beyond their personal capacity. For the purpose of clarity I refer to groups as representing AA groups and meetings. These groups comprise of social networks of individuals. Found within these networks and groups is the concept of social capital. Participation in structured social engagement enables access to social capital for the benefit of the individual. Further analysis will draw upon the notion of ‘collective efficacy’ and how this concept can be used in order to explain the successful completion of group objectives.

3.3.1 Social Capital

Social capital is defined by its function. [...]Like other forms of capital, social capital is productive, making possible the achievement of certain ends that in its absence would not be possible (Coleman, 1988: 97).

Social capital is an aggregated concept consisting of many elements. Individuals with certain predisposition and beliefs are nurtured by institutions and organisations that give rise to social capital. Scholarly interest finds a footing in the apparent ability of some people and organisations to overcome problems, such as economic instability or high crime rates, while others struggle. The absence of social capital is therefore understood to be the cause of such social problems (Johnston and Percy-Smith, 2003).The link between levels of social capital and individual/collective outcomes are crucial for positive change (Brehm and Rahn, 1997).

Stolle and Rochon (1998: 48) assert that groups rather than individuals can achieve more working as a collective. The existence of social capital, the authors argue further, can, *inter alia*, curtail crime and make governments more effective. Membership to voluntary associations produces strong member-orientated bonds which increase levels of civic participation. Membership to associations enables cooperation and increases trust amongst members, not always for the wider good of society (Putnam, 1995).

A broad range of social science disciplines have used the concept of social capital in relation to understanding such disparate social phenomena as families, schooling, public health, and democratic participation (see Portes and Sensenbrenner, 1993; Portes, 1998). Underscoring the 'attractiveness' of the concept is the simplicity of social capital's 'core' description of function and effect: '...the goodwill that is engendered by the fabric of social relations and that can be mobilised to facilitate action' (Adler and Kwon, 2002: 17). The substance of social capital - goodwill - is a valuable resource; it exists amongst friends and acquaintances, constituting forgiveness, trust and support (ibid). Embedded in the social structure, lies both the source of social capital and the individual. Accessing social capital is contingent on the location of the individual in the social structure and which organisations/networks, both official and unofficial, an individual belongs to.

The provenance of social capital can be found in the work of Pierre Bourdieu (1979 & 1985). For Bourdieu, social capital is instrumental: investment and participation in groups consolidates group effectiveness and confers individual level benefits. Bourdieu's rationalistic model of interaction in social networks ultimately, 'ends' in

increased capital for the individual. The exchange social capital for intangible ‘goods’, such as favours received or support, depends upon the number of people in his or her network and the varying amounts of social capital each network member has recourse to. Glanville and Bienenstock (2009) argue that social capital ‘inheres in social relationships’. Within these relations social capital, rather than existing as something tangible, is created by investment in relationships. The ‘fundability’ of social capital can therefore be passed between members of a network: ultimately, providing support for an individual is transformed into a ‘consumable good’. AA’s slogan, ‘You have to give it away to keep it’, crystallises this process: successful recovery is contingent on supporting others (Borkman, 2006).

AA is a social structure and functions to help other alcoholics to achieve and maintain sobriety. Available social capital in AA is the potential for the individual to access its resources to achieve their interests. An increase in one’s social capital is the product of successful interaction. Coleman (1988: s98) asserts that ‘...social capital is productive, making possible the achievement of certain ends that in their absence would not be possible’. This is directly comparable to how AA initially conceptualises recovery: that the individual alone cannot recover, but as part of a group the individual can. Tradition One states ‘Our common welfare should come first; personal recovery depends upon AA unity’ (AAWS, 1952:133).

3.3.2 Access to Resources: ‘Stocks’ of Social Capital in AA

Boisjoly et al (1995) define how social capital can be operationalised in terms of a family’s ‘stock’ of social capital. The authors study the levels of social capital available:

specifically the amount of social capital a family has 'banked'. This is termed 'stock' and used in an economic sense. Boisjoly et al argue that the amount of 'stock' a family possess is an indicator of how much time and money can be called upon in an emergency at some point in the future. This 'stock' of social capital is fixed geographically. As a family moves geographical location, the amount of social capital a family has to draw upon depletes. This may result in social isolation and the authors made no theoretical suggestions as to how quickly this 'stock' may be re-accumulated. AA is, essentially, an open-access network spanning continents, with a structure that is highly accessible. AA members who re-locate are quickly able to access an AA meeting in the new locality. There, the 'new' AA member has a greater capacity to re-accumulate levels of social capital at an accelerated rate, compared to non-AA members. AA's basic text speaks of AA members 'lending money and securing jobs for each other' (AAWS, 2001: 161). This is consistent with Bourdieu's notion of resources which constitute social capital (Bourdieu, 1986). Thus, AA offers a form of social capital that can be drawn upon; an 'overdraft facility', when a person moves geographically, to be called upon instantaneously. This includes borrowing money and receiving help finding employment, in addition to access to AA's therapeutic environment and acceptance into AA's wider social network.

3.3.3 Recovery Capital

White (2004) describes recovery as a 'fulcrum of change', operating to change treatment policy, as individuals living with addiction move from hitherto hidden existences to less stigmatising 'roles' as recovery orientated groups become more visible publicly. Cloud and Granfield (2008) acknowledge that, while addiction cuts

across all socio-ethnic-economic boundaries, the impact of addiction on individuals is experienced differentially. The authors develop the construct of 'recovery capital' by employing the concept of social capital, as a means of defining the levels of resources accessible to individuals striving to overcome addiction: 'Recovery capital is the sum total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation' (Cloud and Granfield, 2008: 1972). By identifying the various sources of capital, social, cultural, physical and human, which have been operationalised in successful addiction cessation, the authors sought to assess the amounts and types of 'recovery capital' accumulated to achieve this objective. Taking social capital as the sum of all resources possessed by membership to durable networks, recovery capital constitutes three other components. Physical capital embodies material and economic wealth and characterises a person with a degree of financial stability. Human capital captures the values and beliefs associated with membership to a particular social group. Persons operating within groups that conform to societal norms are at an advantage, comparatively, over those to whom society has 'rejected' and have come to adhere to more deviant forms of behaviour and beliefs. Thus recovery capital, according to Cloud and Granfield (2008, Granfield and Cloud, 1999), represent the capacity, quality and range of resources which exist, both internally and externally, that can be drawn upon in the recovery process. Granfield and Cloud (2001) found that most of their respondents had firm connections to family and friends and stable employment, which were negatively affected during addiction, but did not suffer irreparable damage, thus reducing social and individual deterioration. Maintaining recovery was augmented by engaging with spiritual and religious activities, further education and participation in community volunteer projects, allowing for new meanings to life - meanings which are

incompatible with substance misuse. Ultimately, successful recovery was governed by the levels of capital accrued by social interactions.

Davis and Laudet (2011) conceive of recovery as ‘contagious’: a powerful force that causes a ‘ripple effect’ impacting upon a recovering individual’s family and wider community. For agencies and professionals working in the recovery field, building recovery capital is a social ‘enterprise’; but supporting individuals as they re-enter society post-treatment means facilitating person and interpersonal transitions. Following Sampson and Laub (2003), Davis and Laudet (2011) promote the establishment of attachments to conventional/supportive persons, stable employment and transformation of personal identity. These are goals that, for those with less ‘recovery capital’, ought to be primary targets for improvement, as those with greater baseline recovery capital predict overall better outcomes across psychosocial domains and functioning (Laudet and White, 2008).

3.3.4 Transferring Social Capital and Supportive Network characteristics

Coleman (1988 & 1986) develops a concept for studying the effects of differential levels of social capital a person has or has access to. Rejecting both extremes - the notion of rational action, which accentuates individualistic, goal-orientated modes of action; and ‘oversocialised’ conceptions of action, which are predominantly shaped and constrained by social norms and the environment - Coleman argues these constraints leave little room for individual volition.

For Coleman (1988), human capital is embodied in the knowledge and skills of an individual. Employing this, the sponsee acquires a level of reflexivity as they work through the Twelve Steps with the aid of a sponsor. This is how human capital is created by changes in the individual: to the extent that social capital becomes exchangeable, the transference of knowledge from the sponsor to the sponsee results in an increase in social capital. Social capital is therefore located in the relations among AA members. In this sense, recovery in AA depends upon a *resource*: knowledge of the Twelve Step program. The sponsor offers advice on the Twelve Step Program: ‘crisis intervention, guidance and life direction...’ (Crape, 2002: 292). This resource is then appropriable, and appropriated in a concrete sense, as knowledge relating to the skills necessary for permanent sobriety. These are passed through interpersonal relations: recovery by mutual aid.

Levi and Yeung (2006) studied persistent dyadic relationships in relation to social networks. The authors identify three core facets of these dyadic relationships that characterise an enduring persistent tie: *individual*, *dyadic* and *structural* characteristics. Each of these levels can be observed in the formal one to one relationship that is normatively associated with the recovery process in AA.

Studying the effects of friendship ‘decay’, Levi and Yeung (2006) propose certain individual characteristics which sustain friendship networks. Durable individual characteristics thought to underscore the sponsorship dyad are being of the same sex and having permanent continuous sobriety for at least two years. Changes over the life course can have an effect on network structures: being married and having children

shifts the composition of networks and the intensity of ties to individuals not sharing these characteristics.

Levi and Yeung (ibid) suggest that the dyadic nature of a relationship that endures involves a degree of shared emotional intensity. This bond can be understood to represent elements of the relationship and shared individual traits. The elements necessary to make a sponsor/sponsee relationship work are as follows: i) Knowledge of the Twelve Steps on the part of the sponsor; and ii), shared individual traits which represent an attempt by AA to match members: ‘Often a newcomer feels most at ease with a sponsor of similar background and interests...’ (AAWS, 2005:5). Following Louch (2000), persons of similar status and background are more likely to share values, common interests and tastes. Similarly, Binder et al (2012) found that the quality and duration of friendship ties is determined and maintained by supportiveness, openness and interaction. With the shared goal of maintaining sobriety through membership of AA, and finding common agreement across a range of subjects not related to AA, the sponsor/sponsee dyad functions and remains a positive interaction over many years (Crape et al, 2002; Young, 2010; Wheelan et al, 2009).

Rynes and Tonigan (2011) postulate that productive and generative sponsorship activity lies in the opportunity to build a relationship unaffected from previous negative drinking behaviours. This engenders trust, thus allowing an ‘uncontaminated’ supportive relationship to flourish. It is the quality of these close relationships, particularly in the early days of recovery, and the increased availability in accessing the sponsor, which promotes better abstinence outcomes.

Brown and Ross (2010) studied the effects of social capital and desistance, focussing on mentoring programs in the criminal justice system. Brown and Ross identify that greater time periods spent cultivating a positive relationship between the mentor and mentee, benefitted the mentee. Encouraged by the mentor's approval, the mentee is more likely to model pro-social values and behaviour exhibited by the mentor. The authors sample consisted of only women. Assessing women's post-release contact with mentors and mentees, the authors observed varying patterns of contact. Despite relatively high rates of attrition, analysis pointed to the benefits of 'a trusted non-judgemental ear [...], a person who could provide alternative ways of looking at problems' (ibid: 41). In terms of accumulating social capital, mentors provided employment and housing references, speaking on behalf of mentees in court and accessing education information. This type of support activated social capital, by linking in the mentee to a pro-social non-offending community. Psychologically, the mentored women reported that the positive affirmations given by the mentors inhered an intrapersonal sense of importance, as a worthy human being, free from previous stigmatised concepts of self. The therapeutic dimension of the relationship is demonstrated by the high levels of confidence the women felt in talking about past, painful experiences. The women reported these were areas of their lives that were too difficult to discuss with family and friends; they felt they didn't have to 'hide' these experiences from mentors.

The relevance of Brown and Ross's (2010) study is clear, as one of the chief aims of this study is to assess how AA's therapeutic practices, may also support the desistance process amongst the study cohort. The benefits of a supportive, one-to-one relationship and membership to a pro-social, non-offending network share many characteristics to

AA practice of sponsorship and interaction with other abstinent members of the AA community (Ratliff, 2003).

Structural Characteristics

The structural features of AA revolve around the AA meetings. As such, members often attend more than one meeting a week, across several local venues (Smith, 2007, Hoffman, 2006). For Levi and Young (2006), the dyadic tie retention is facilitated by local structure. Commonly, meeting one's sponsor at other meetings, as a function of attendance rather than a pre-planned meeting, demonstrates a level of embedding within the organisations. This dynamic enables members of the social network (AA) to remain in contact over longer periods, thus promoting the longevity of the relationship. This is of particular importance, as the individual, and the dyadic relationships which occur, are also embedded within the larger friendship networks which exist in AA. With a cohesive set of guidelines for recovery and governance (Twelve Steps and Twelve Traditions), AA produces dense social bonds, amongst its members. Kadushin (2002: 76) reports that, where these dynamics are observed, 'cooperative motives may engender a sense of community...'. Thus, amongst such a community, trust is promulgated through adherence to the norms of reciprocity and to the objectives of the group. In this sense, the individual's 'safety/sobriety' is entrusted to the organisation. The more experienced members look after those less-experienced, on the understanding that, as experience of sobriety and the AA program is gained, this is then passed on. The net effect on the network is one of increased strength. However, the normative rules of simple exchange are suspended, as the 'return' does not necessarily come from the receiver, and there is a time delay effect to this process. This process is analogous to

Kadushin's (ibid) example of American Frontier 'barn raising', as trust is placed in the system as a whole to achieve the objective. Likewise, Putnam (1995) argues that intense interactions, which take place amongst networks with dense ties, offer the individual a more expansive perception of self. As the self becomes re-orientated towards the achievement of group aims and objectives, the sense of 'I' develops to a sense of 'we', thus ...enhancing the participants "taste" for collective benefits (ibid: 3).

3.3.5 Collective Efficacy

Bandura (2002) argues that social-cognitive theory focuses on three different forms of agency: personal, proxy and collective. Taking the latter form, collective efficacy is located in the minds of group members, in their behaviour as they act in co-ordination with each other, or towards a shared goal or belief. AA actively asserts that the isolated alcoholic cannot recover on self-will alone: 'Alcohol, now becomes the rapacious creditor, bleeds us of all self-sufficiency and all will to resist its demands' (Step one, AAWS, 1952:21). Therefore, individuals joining AA seeking positive change towards alcohol are taught this can only be achievable through interdependent efforts (Bandura, 2002). Thus the concept of collective efficacy is the ability of the group to help an individual. Kurtz (2002) maintains Alcoholics Anonymous *is* its members: the efficacy of AA as a group is not merely the sum of the skills of each member. What inheres in AA's collective efficacy is a shared belief in the ability to overcome alcoholism: 'an emergent group level property' (Bandura, 2000: 76). The function of perceived levels of group efficacy instils in the person new to AA that the Twelve Steps 'work' is to help an individual recover. As individual members convey their 'experiential knowledge' (Borkman, 1976), through the process of 'sharing' at an AA meeting, the message

becomes clear. As each member reiterates the therapeutic value of the AA program, a concordant and consensual message is communicated. Judging the collective efficacy, based on other's testimonies, the group member is encouraged both by these testimonies and by other members wishing to help. Bandura would term this a 'socio-structural practice', which embeds constraints (warnings regarding the pitfalls of not following the AA program), but also provides the opportunity for personal development: learning from listening. These transactions operate on the individual, but by adopting new forms of behaviour, positive generativity affects AA's social system as a whole.

3.4 Personal Agency

A person learns to tell 'their story' in AA within the context of the AA meeting. The contexts in which stories are told shape their development according to the normative rules learned and applied in each differing context. These normative modes of storytelling reflect significantly the construction of personal identities: they help us make sense of and organise our lives, particularly in relation to stressful life events (Reissman, 1993). A teller...takes a listener into a past time or "world" and recapitulates what happened then to make a point, often a moral one...Respondents narrativize particular experiences in their lives, often where there has been a breach between ideal and real, self and society (Reissman, 1993:3).

3.4.1 Story Telling in AA: The Narrative Account

Kurtz (1991: 71) proposes that ‘what made the program work was the telling of their stories by new sober alcoholics’. The process of reciprocal healing takes place in AA, as one alcoholic talks openly and honestly about their experience as a drinking alcoholic, to one who still suffers. Thus AA teaches that ‘Our stories disclose in a general way what we used to be like, what happened and what we are like now’ (AAWS, 2001: 58). The device of storytelling in AA is particularly useful to help members organise and make sense of, not only their past lives, but their *potential* lives ahead. During this often difficult and transitory phase of AA involvement, the therapeutic value of story-telling serves to ground the new member in AA philosophy and instil a new identity infused with hope. AA co-founder relates this experience of talking to another alcoholic: ‘...*he was the first living human with whom I had ever talked, who knew exactly what he was talking about in regard to alcoholism from actual experience. In other words he was talking my language*’ (AAWS, 2001:180, italics in original). Objectively, past events cannot be ‘known’. What exist are present re-constructions of the past. Memories interact to produce and edit a narrative account; employing key events, to which the individual attaches new meanings to these events. The personal stories of recovery recounted in AA’s central text, *Alcoholics Anonymous*, depict conceptual and behavioural stages of change, which are, in part, analogous to ‘*redemption scripts*’, the notion of *re-biographing*’ and ‘*knifing off*’ (Maruna, 2001). Each of these conceptual processes discussed in greater detail, making direct links between these concepts and AA’s core therapeutic practices.

3.4.2 From Condemnation to Redemption

Stories in AA follow a normative pattern, guided by a chronological and linear structure. This temporal ordering of events signifies an individual 'in-flux', psychologically and in a given social context (McIntosh and McKegany, 2002). The listener is taken through a series of events which led to first contact with AA - learning about recovery in AA, making reference to the Twelve Steps, a Sponsor, and overall gratitude to the AA Fellowship (Arminen, 1999, 2001). The content of these stories have themes embedded within them. Usually there are references to loss of control and 'hitting bottom'. They are an illustrative guide that reflects a normatively found range of affective behaviours amongst AA members, such as loneliness (Allen, 1981). Cain (1991:235) specifically observes the general story structure in AA, identifying '...categories such as, first drink, negative effects of drinking, progression of drinking, suggestions (by others) that drinking may be a problem, denial, attempts to control drinking, entering AA, giving AA an honest try, and becoming sober'. This establishes a common experience and identity amongst AA members. This thematic typology of events, behaviours and consequences form the basic content of discussion in AA meetings. Significantly, the structural arrangement moves the narrative account towards a more positive conclusion, as a person narrates their experience of 'getting well' and how these transformations, both behaviourally and cognitively, are understood as part of a new 'sober' identity (Roberts, 1988).

Maruna's (2001: 85) study of serious offenders demonstrated the necessity of creating a coherent sense of their lives in order to successfully desist from criminality. Restoring their life histories helped define a new 'ethical identity' for offenders. Finding

themselves locked into negative ‘condemnation scripts’, and conceptualising themselves to be irrevocably pre-determined by past events, which condemn offenders to a ‘criminal self-story’, impacts negatively on the offender’s capacity to change, or ‘*make good*’. For Maruna, the ‘redemption script emerges as a pivotal device in the narratives of desisters. The AA Twelve Step program makes the process possible - the creation of a positive self-identity - by following key Steps.

3.4.3 Re-Biographing

Braithwaite (2002) notes that re-biographing is an intentional practice in restorative justice. This form of storytelling serves to connect the offender, the victim and various family members - in effect to re-humanise each participant and to generate a therapeutic alliance whereby offender neutralisations of the act can be challenged.

Narratives in AA perform both transformative and transforming functions. Personal stories, rooted in past experiences, are re-evaluated through the lens of recovery propounded by AA. In this sense, narratives are aligned with the notion of redemption, but importantly these past stories are ‘edited’ accordingly: rewritten in relation to and for a new ‘community’ of individuals with whom they wish to strongly identify with and be identified. In Maruna’s study (2001:93) offenders separate out offending behaviour, in effect quarantining this behaviour in the past and asserting that this was not the behaviour of the ‘real me’. For the desisting offender, this capacity to quarantine a ‘toxic’ past allows a conception of the ‘real me’ to emerge: a stable core of ‘goodness’. An understanding of stability and change in identity despite and because of

past behaviour is key to positive change. This process reduces the tension caused by levels of cognitive dissonance. While the toxicity of previous behaviours is not denied, it is reframed, placing the responsibility and motivation for previous misdeeds on the former self, preventing contamination of the present self. Thus a level of cognitive consonance is achieved as retrospectively the offender claims that they are ‘not like that anymore’ (ibid: 7).

This process is partly evident in AA’s Twelve Step program. The individual experiences the same dissonance, then consonance, but with an important difference: how one conceptualises the causes for past misdeeds. In AA, defects of character are one of the chief drivers of problematic behaviour (AAWS, 1952). These defects of character are never fully eradicated; they are managed and held in abeyance with the aid of the Twelve Steps. Importantly, the key difference in AA understanding of a former self and Maruna’s conception is that Maruna’s desisters revert to an ‘unspoiled’ identity. Through re-biographing one’s past, criminal actions are considered to have occurred unintentionally, as the result of a somewhat ‘alien source’ (Petrunik and Shearing [1988], in Maruna, 2001). AA’s program teaches that the ‘spoiled’ identity was and is always present. The sources of this spoiled identity are defects of character that manifest themselves in deviant, anti-social actions. Recognising these defects of character, and working to ameliorate the worst effects of these, using Steps Six and Seven, re-biographing in AA frames the alcoholic with co-existing strengths and defects of character co-existing. Character defects are central to AA’s recovery philosophy, they are regarded as causal and are of functional relevance. Overcoming this possible ontological dualism, AA suggests that one ought not to set perfection as the ultimate

goal, as this would inevitably lead to a zero sum game; rather the aim is to ‘strive for perfection’, being ‘...ready to walk in that direction’ (AAWS, 1952: 70).

3.4.4 Scripts and the Frameworks for Identity Change in AA

Braithwaite (2002) and colleagues (Braithwaite and Roche, 2000), in their research on restorative justice processes, make a clear distinction between forms of responsibility. Critics, (Peele and Brodsky, 2000; Bufe, 1998) claim that AA’s focus on the ‘disease’ model of alcoholism allows alcoholics to expunge responsibility via the AA Twelve Step program which promotes an active rather than passive conception of responsibility for past actions, with an obligation to make amends where possible for harms done. The cognitive and behavioural mechanisms embedded in the Twelve Steps, such as Step 5, 6, 8, and 9, require an individual to assess harms done (Step 4), discuss these with a Sponsor (Step 5), make a plan for restitution (Step 8) and then make direct amends (AAWS, 1952). Enabling an individual to assess themselves through the working of the Steps allows a person to survey their past lives. The ‘vehicle’ by which this ‘survey’ is undertaken, comprehended and then conveyed, is in the first instance a written excursion. This is then transformed into a narrative exercise, as an individual discusses and assesses past miss-deeds with a sponsor. This results in a transformation of a negative understanding of one’s past to an essentially ‘valuable’ self-narrative script, from which lessons can be learned and passed on in AA meetings. Moreover, this fulfils one of AA’s fundamental therapeutic goals: ‘to share experience, strength and hope’ (AAWS, 2001).

Strikingly absent from empirical studies (Maruna, 2001, Farrall and Calverly, 2006, Thune, 1977 and Braithwaite, 2002) is an account of exactly *how* the individual comes to reconcile past harms inflicted on people and deal with feelings of guilt. As Braithwaite (2002:11) argues, the 'Restorative processes put the problem in the centre of the circle, not the person'. AA (AAWS, 1952: 86) confers the opposite: setting a more pragmatic therapeutic goal which leaves the *person* in the centre of the circle, and enjoining the recovering alcoholic to 'pay, or promise to pay, whatever obligations, financial or otherwise, we owe'. This is literally being prepared to knock on a door and say sorry, having 'the readiness to take the full consequences of our past acts and to take responsibility for the well-being of others at the same time' (ibid: 89). The trajectory to desistence and sobriety in AA incorporates restitution for harms done, thus issuing a finalising act of 'making good' in its most literal sense. Farrall and Calverly (2006: 105) assert that when desistence occurs, the individual is 'no longer subject to the negative, unwelcome and uncomfortable emotions' associated with offending behaviour, such as guilt and shame. The authors continue: 'Peter, when he was using heroin, felt he was unable to avoid acting selfishly'. Peter, having admitted borrowing £20 from his Grandma, purports to be free of negative emotions that characterised his former existence, but nowhere in Peter's account does he confirm he paid the money back, or what it is he does to look after his 'Grandma' after years of neglect. Emotions are controllers of behaviour in an anticipatory sense. Desistence and recovery often bring to light episodes of negative behaviour consistent with an offending/alcoholic past. What is unclear in Farrall and Calverly's account is how one manages negative affective states, and what impact this has on the desistence/recovery process.

AA teaches (AAWS, 2001: 82) that abstinence is not enough; merely ‘stopping’ is a good start, but ‘...a long way from making good to the wife or parents whom for years he has so shockingly treated’. Step Nine offers a more complete process of atonement to individuals wishing to right the wrongs of the past, allowing a sense of ‘emotional closure’ to occur and thus personal growth. Bauer et al (2006) describe eudaimonic well-being involving pleasure in one’s life, but emphasises meaningfulness and growth as opposed to a feeling of satisfaction: how good one feels about one’s life. Ego development in eudaimonic well-being is characterised by a more nuanced understanding of self and the self’s relations to others. Bauer and colleagues demonstrate eudaimonic well-being using narrative identity accounts. To simplify, AA and the Twelve Steps provide an opportunity for complete atonement and growth. In Calverly and Farrell (2006), the accounts given demonstrate a high level of ‘centrism’: the ‘I’ is still the unit that must be protected, and the main benefit occurring from desistence is reduced anxiety, fear and other ‘uncomfortable emotions’: ‘*I love it because I don’t have to look over my shoulder. I’m happy, free. I don’t have to...*’ (Ibid: 106, my emphasis).

Rotenberg (1987) identified a generative form of therapeutic re-biographing, which entailed a re-interpretation of past events. . For this, an individual can ‘correct’ the past to suit future goals and orientations, providing this process has been through the ‘formal’ framework for redemptive scripts, such as completing AA’s Step Four and Five. Identifying the most shameful and degrading past event, brought about by excessive alcohol/drug using or offending behaviour, these ‘stories’ now stand as uncensored allegories which can be used to help others. Nouwen (1972) termed this transformation of people, from a shameful undisclosed narrative to a more open

narrative, to be used as a therapeutic ‘tool’ to ‘wounded healers’. White (2000) underlines the implicit theory that people who have overcome similar adverse life experiences have a more nuanced and attuned understanding of those events and concomitant emotions. Groesbeck (1975:122) defines the ‘wounded healer’ akin to homeopathic medical treatment: the ‘simile phenomenon, *like* is cured by *like*’. The recovering/desisting ‘ex’ embodies both the problem/disease and the cure. The knowledge the wounded healer has, that he or she is afflicted by an incurable wound, and that participating in the cure/therapy, is the only way to arrest further manifestations of the problem: alcohol usage and/or offending behaviour. Groesbeck (ibid) draws attention to this phenomenon in the psycho-analytic approach: that the therapist must be aware of and stay in touch with their own wounds, thus allowing the healing process to begin: ‘...he works not only on the patient, but on himself. He remains forever a patient as well as a healer (ibid: 134). As an individual finds a new understanding of self, agency may then be re-directed towards a concerted effort to change.

The veracity of a narrative may be called into question vis-a-vis what really *happened*. Presser (2009: 184) departs from narrative as a report and interpretation. Employing a post-modernist conception of a *constitutive view of narrative*, Presser argues that the ‘truth’ in narratives is ‘fragmentary and, discontinuous’ replete with inconsistencies and contradiction (Shwartz and Friedrichs, 1994). By assessing the narrative as a whole, rather than bracketing discrete acts, constitutive narrative, effectively side-steps the goal of ‘truth’ by making the narrative itself an equally valid subject for analysis. Presser asserts key points that are useful for understanding a recovery from a constitutive view of narrative. First the primacy given to linguistic expression and linguistic devices for understanding the self, as an ongoing ‘project’, constantly being re-interpreted and

understood, but within the confines that a ‘...social order and culture make available’ (ibid: 185). Second, the social order and culture available to the recovering alcoholic in AA is the recourse to AA’s main texts and participation in group therapeutic activity. These practices help structure thought and behaviour. Following a constitutive narrative approach, a framework of understanding is learned by the individual and is thus retrospectively imposed on past experiences and events. This new discourse of recovery targets events, attaches new meanings to these events and through the oral tradition in AA of sharing-this process, ‘...illuminates the agentive practices whereby culture shapes individual action (Presser, 2009: 190). As a structuring device, the narrative, ‘situates stories as antecedents to crime’, and in a similar vein, AA’s stories situate the drinking alcoholic to the now, sober member of AA (ibid: 178).

Presser (2009), highlights the ascendancy of the narrative approach to understanding the aetiology of offending in recent years. Presser argues for a re-conceptualisation of the narrative, not merely as a report of temporally ordered events and experiences, but, narrative presenting a ‘life-world’ experience shared by members of a group and specifically oriented towards a plot. The centrality of a plot in the narrative explains the ‘why’ element, in terms of causes of offending/alcoholism. Thus a sense of coherence is imposed, allowing for an emergent identity that is recognisable and stable over time. Presser’s key argument is that narrative is formed in relation to the narrator’s interlocutors, and examples are selected based on cultural and social criteria according to relevance as the situation demands, for a ‘recovery audience’, in an AA meeting. Presser (2004) notes that the research context shapes the narrative, as with other social settings and social encounters.

3.4.5 Connecting Personal Agency, AA and Structure

Narratives may allow a person to reconcile with, and break from past misdemeanours, as Presser (2009) demonstrates, or through a process of '*re-biographing*' (Rotenberg, 1987), re-orientate one's personal narrative towards achieving future goals, but just how does one connect to the structures in society to access these goals.

Vaughn (2007) attempts to delineate the reasons why individuals desist from criminal behaviour, highlighting weaknesses in theories that remain bonded to notions of structure and agency. This relationship between the active agent and structural constraints leaves, according to Vaughn, accounts of desistance lacking in analytic interpretation. As the agent affects change in the societal milieu, authors such as Sampson and Laub (1993) omit to adequately explain the process by which the desisting person, originally submits to the forces that encourage the pursuit of culturally (and legally) acceptable goals. Rather than depicting, as Sampson and Laub (ibid) do, a reductionist account centred on rational choice making, Vaughn proposes that a framework for understanding desistance has to move beyond, an account that describes a person's satisfying immediate preferences, whilst simultaneously balancing being bound by norms 'locking' a person into conforming action. Further, Vaughn argues, an agent must therefore have a capacity for deliberation, and enhanced ability to become reflexive before pursuing a course of action.

The connecting or 'middle step' that Vaughn leaves unaccounted for is, how one develops, in concrete terms a capacity for deliberation and reflexivity. While Vaughn

and others (Giordano et al, 2002), state this happens via ‘enhanced internalised control’ brought about by ‘new found commitments’, what is assumed is an pre-existing capacity, however limited and hitherto not described, to be more reflexive. The ‘vehicle(s)’ that move a person to an enhanced cognitive state regarding the self, are never fully specified.

The panoply of potential courses of action are mediated by AA involvement. As a person commits to AA’s reflexive practices, which are developed in Step 10 (AAWS, 1952: 88), individuals are encouraged to, ‘take personal inventory’. The purpose is to correct errors in judgment when potentially coming into conflict with others or in situations that may result in conflict. AA’s theory (AAWS, 2001) of the recovering alcoholic, judges a person to have an under developed capacity for reflection, ‘no one can make much of much of his life until self-searching becomes a regular habit’ (AAWS, 1952: 88). Contra Maruna (2001), one does not discover this potential capability of deliberation and reflexivity, in a, pre-criminal/law breaking past identity- it has to be learned. Once learned the desister/recovering alcoholic possess more control, capable of altering courses of action, towards achieving personal, pro-social goals.

AA’s therapeutic practices have altered a person’s outlook so that the ‘hook for change’, whether one finds oneself ‘hooked’ out of choice or ‘forced onto the hook’ (Vaughn, 2007: 394), allow for a degree of freedom, should one decide to unhook from an unfulfilling marriage or job. In concert with a new identity, commitment to desistance and abstinence, indicates an incompatibility with, previous criminal behaviour and negative drinking patterns. Thus, once stable sobriety is achieved, and cognitive

application of AA's therapeutic/reflexive enhancing practices are embedded, the person is better able to determine courses of action, for example, seeking new employment or a new relationship.

Commonalities of positive behavioural outcomes, explicitly discussed in AA's literature (AAWS, 2001: 84), 'We will intuitively know how to handle situations that have previously baffled us', are comparable with Ward and Maruna's (2007: 110) Positive Psychology human endeavours towards successful desistance include, 'mastery and creativity' while 'attending to human nature and personal fulfilment'. Ward and Gannon's (2006), Good Lives Model (GLM) of positive psychology is an inherently strengths based approach, asserting that the attainment of pro-social goals cannot be attained within a normative legal framework, for many offenders. Attainment of such goals is obfuscated, 'as a direct consequence of maladaptive attempts to meet human needs' (Ward and Maruna, 2007: 110). Similarly, AA's theory of the alcoholic report that alcoholism is a consequence, in part, due to instincts and 'an abundance of natural desires' the pursuit of such desires occurs when, 'we often let these far exceed their intended purpose' (AAWS, 1952: 66). Arnhart (1998, cited in Maruna and Ward, 2007: 112), mirroring AA's language, also identifies 'natural desires' that are entrenched in human nature. AA's 12 Step program addresses these distorted desires, based on an assumption that pursuing 'desires' or for Ward and Maruna (ibid) 'primary goods' (happiness and creativity), the criminal like the alcoholic, has offended (drunk too much) in their pursuit.

The Good Lives model operates on assumptions that orientate treatment towards focusing on a person's strengths and developing an understanding of what constitutes a good life. Pursuing a good life, requires that the individual be schooled in the development of internal resources, skills and values, while cultivating social support and potentially positive opportunities. Likewise, AA approaches the 'problem' holistically, as does a Good Lives treatment program. Rather than focussing on isolated dimensions of risk or 'character defects', the overall 'target' is the individual as a whole. A new adaptive identity needs to be fostered, one that allows a sense of meaning to emerge, but one that can also adaptively cope with conflicts as they occur in the life course, in an effort to secure pro-social goals or primary goods.

Further, to succeed whether one is attempting to desist, or maintain abstinence, a 'community that provides emotional support' (Ward and Maruna, 2007: 117), or an adaptive pro-abstinent support network (Kelly et al, 2010) is needed, if the person is to flourish (desist/abstain). Ward and Laws (2010: 20) maintain that the Good Lives Model works by, 'connecting people with valued social and personal networks'. AA becomes for its members a valued personal social and therapeutic network (Rice and Tonigan, 2011). The individual thus becomes connected to the wider structure, following 'treatment' or abstinence supported by engaging in AA's therapeutic practices. Ward and Maruna (2007) express the need to account for the environment that the individual returns to, returning to pro-criminal, pro-drinking social networks, places the person at a greater risk. Avoiding a return to environments that will impact negatively on a person's behaviour is a key objective for successful desistance.

3.4.6 Knifing off ‘Old Playmates and Playgrounds’

Individuals attempting to radically alter their behaviour, sever links to their environment, and familial/friendship networks. This process has been termed, ‘knifing off’. Maruna and Roy (2007; 107) pose a number of interesting questions and present conceptual problems with the concept of knifing off. Does one knife off past experiences, a psychological process (Maruna [2001] considers desistence a process), or does one knife off individuals associated with certain environmental situations (playmates and playgrounds). The authors ask, ‘When do the past and the present ever really meet?’, further suggesting that moving on from the past is routinely associated with knifing off, but this is more of a description without moorings to ‘an explanatory framework’. The explanatory framework proposed here argues that, in AA, the past indeed *has* to meet the present to successfully resolve previous difficulties and recovery from alcoholism: ‘if we have come to know how wrong thinking and action have hurt us and others, then the need to quit living by ourselves with the tormenting ghosts of yesterday gets more urgent than ever’ (AAWS, 1952:56). In addition, the framework wherein one might come to understand this process is through the Twelve Steps. As Farrall and Calverly (2006:104) explain, desistence brings with it the potential for negative emotions to come to the fore, concerning behaviour connected ‘to one’s previous lifestyle’. Psychologically the past is visiting the present, and in more concrete terms, as Maruna and Roy (2007) suggest, one time associates and friends may still come knocking at the door of the ‘knifer’.

To be clear, knifing off in AA includes ceasing to frequent old haunts, be it the bar or street corner, a complete abandonment of pro-drinking friendship networks (see Kelly,

2009) and a complete resolution of past conflicts. Limiting one's opportunities, restricting hitherto known freedoms to frequent bars by joining AA, offers the AA member a set of structural arrangements that aids the process of knifing off. If one adheres to AA's suggestion to attend "90 meetings in 90 day", practically speaking this limits opportunities to visit high risk, pro-drinking environments. As described in Chapter Two, the ability to be immediately immersed in the social world of AA is appealing to those motivated to change based on the severity of their alcoholism and the chaotic nature of their lives (Hoffman, 2006; Smith, 2007). Activities and behaviours such as socialising in bars are normatively proscribed in AA. Essentially this is a 'common sense' perspective; but there is a discernable linkage to social control theories that explain curtailing deviant behaviour (Hirschi, 1969). Subsequently, as a person wishes to invest in the bond between themselves and the AA group, attachment occurs as norms of behaviour are internalised, thus demonstrating commitment to the AA Program. Motivation to adhere to these norms of behaviour comes from acceptance to the group of the individual who has a reputation of someone willing to 'go to any lengths' (AAWS, 2001:76) to sustain sobriety. This further cements a reputation in AA, as an active member building their recovery (Roberts, 1988; Smith, 2007).

Summary

For Coleman (1988a) and Bourdieu (1986), social capital is a property that an individual possesses. Putnam (2000) regards social capital as occurring as a result of collective efforts and interests combined. AA's Tradition One states 'Our common welfare should come first; personal recovery depends upon AA unity' (AAWS, 1952:133), capturing the relationship between the individual and collective, in what can

be understood as AA's 'bridge' between the two. Once an individual has joined an AA group, working the Twelve Steps with a sponsor begin to have an effect: increasing levels social capital. Collectively, the individual strengthens the organisation by being prepared to help others new to AA. This key principal is embedded in AA's Step Twelve as, '...he tries to help his brother alcoholic...' (AAWS, 1952:113).

Bandura (2002:76) states that collective efficacy, 'resides in the minds of group members' and that this is demonstrated through behaviour of AA's members. Personal narratives 'shared' in the AA meeting, provide a collective experience with which the individual can identify. Bandura warns against the limitations of measuring group efficacy, '...via group discussion is subject to the distorting vagaries of social persuasion, by individuals who command power...' (ibid). AA mitigates against this type of influence emanating from individuals who command power, through adherence to the Twelve Traditions. Tradition Four, warns that AA members are, '...largely a band of ego-driven individualists' (AAWS, 1957: 146).

Participation in structured social engagement gives an individual access to persons with knowledge of AA's Twelve Steps and memberships to a pro-abstinent support network. This network provides flexible, 'on-demand' support and may also help secure other benefits and opportunities. Groups of individuals with a shared common interest coming together to help each other, is not an uncommon social phenomena. The intra-personal benefits that structured social engagement may confer on an individual, particularly in relation to maintaining abstinence, indicates radical change in identity and behaviour. The focus now shifts to understand how personal agency is developed. The narrative

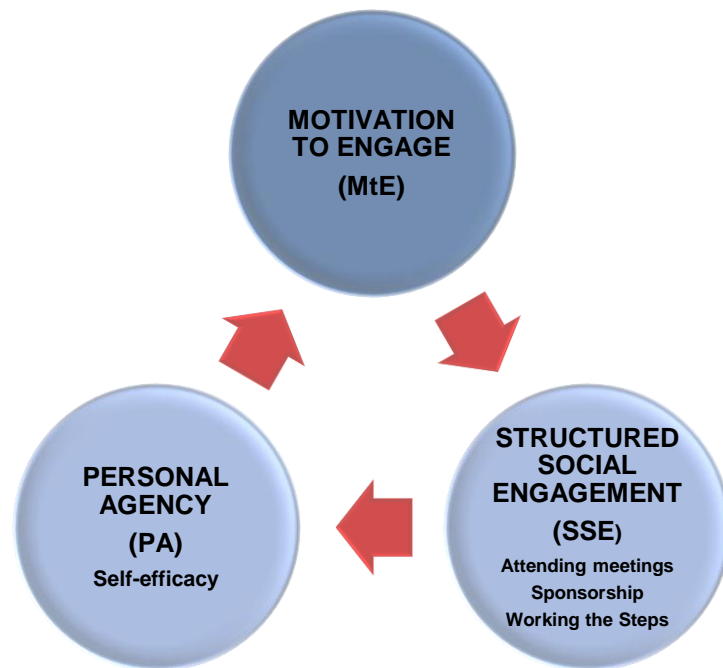
accounts which individuals construct have the power to re-shape past events and potentially alter future behaviours.

The capacity to exercise control over one's behaviour, environment and the ability to plan future participation in events is at the core of what it is to be human. This freedom to act, albeit not necessarily under circumstances of one's choosing, marks the degree to which one possesses personal agency. The ability to cope with high risk situations where alcohol is freely available to the recovering alcoholic, speaks directly to the concept of self-efficacy. AA's clear statement of self-efficacy reads, 'we will intuitively know how to handle situations which used to baffle us' (AAWS, 2011:84). Bandura and Schunk (1981) explains the effect: people have to constantly make decisions toward various goals to be achieved, based on self-appraisals of efficacy. This agentic perspective allows the individual a level of autonomy in their ability to shape their reaction to events as they encounter them in their environment (Bandura, 2001). Bandura (1990: 155), asserts in more simple terms that self-efficacy beliefs endow an individual with the ability to '...stick it out through tough times'. AA (AAWS, 1952:112) asks, whether an individual can '...accept poverty, sickness, loneliness, and bereavement with courage and serenity?', and it claims the answer is 'yes' (ibid). Chapter Six investigates these 'tough times', which threaten disengagement from AA's therapeutic practices, and the resources called upon, by the cohort, to respond to these threats.

The purpose of this chapter has been to build a model of AA-mediated behavioural change. By connecting salient findings from the literature, social and psychological mediator's identified as having a positive effect, and reviewing AA's literature the model's basic components are thus illustrated below. For example, AA's literature speak of handling, 'situations that used to baffle us' (AASW, 2001: 84). Conceptually, this relates to the psychological literature regarding personal agency, to further define this, Bandura's (2001), studies on efficacy provide the theoretical rationale for inclusion of this mediational component.

In simple terms, the model 'grew' from interrogating the literature. The components are, motivation to engage (MtE) with AA, and structured social engagement (SSE) which constitutes AA's therapeutic practices. Lastly, personal agency (PA) considers the effects on the individual. Diagrammatically the model below illustrates a 'virtuous cycle' of change that is a hypothetical model of psycho-social and behavioural stages a person moves through to achieve abstinence.

Figure 3 - Hypothetical Model of AA Mediated Behavioural Change: Basic Components



Each of the basic components of the model has a theoretical underpinning. Constellations of pressures to change, emanate from various external actors and institutions. These can be familial, legal, or medical, as pressure ‘builds’, shifting from externally recognised forces to an internal, pressure that is experienced subjectively. This drives the motivation to engage with AA (MtE).

Acquiring a sponsor and attending AA meetings, constitute structured social engagement (SSE). These activities have been theorised to offer the individual an opportunity to access hitherto unavailable ‘stocks’ of social capital. AA offers a pro-abstinent support network that is flexible, where one can find the skills and knowledge to stay abstinent, amongst persons sharing the same goal and values.

How one remains abstinent are at the heart of the analysis of this thesis. The conceptual model helps to understand these elements and also guide the methodology, in Chapter Four.

Chapter 4: Methods

‘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.’

(AAWS, 2001: 568).

4.1 Introduction

As yet, researchers have not investigated how the Twelve Step Program is operationalised: how the individual uses the Twelve Steps on a daily basis, and how this leads to long-term abstinence and positive behavioural change.

This chapter describes the methodology used to study how AA’s therapeutic practices are subjectively experienced. The structure of this chapter is threefold. First, the aims of the study will be discussed. There also a discussion of how the aims connect to the two proposed models of change, deductively arrived at. These are the basic three part component model and, the second model includes temporal effects of AA membership, and moderators- individual, group and dyadic stressors.

Second, the research strategy employed will then be justified in terms of the study objectives and the cohort selection process. Finally, ethical considerations will be addressed: the associated difficulties with researching an organisation which protects the anonymity of its members; as well as using the concept of anonymity as a spiritual principle. The section explains how these difficulties were overcome.

The findings detailed in later chapters Five, Six and Seven, represent data collected from semi-structured interviews with 20 long-term abstinent members of Alcoholics Anonymous. Documentary analysis was carried out to triangulate interview data, with key AA texts (AAWS, 1957 & 2001), in an effort to reveal both similarities and inconsistencies in the data.

4.2 The Aims of the Study

Alcoholics Anonymous (AA) is the world's largest and most recognisable recovery 'programme', and central to AA's recovery philosophy is the Twelve Step Program (Slaymaker and Sheehan, 2009). AA makes many claims in its literature about the Twelve Step program's effectiveness (AAWS, 2001: 84). The majority of previous research has focussed on outcomes, centred largely on relapse/sobriety results measured post-treatment (Emerick, 1987; PROJECT MATCH, 1997; Morgenstern, et al 2002; Kingree and Thompson, 2011; Magura et al, 2012). Qualitative studies on AA's mechanisms of support and recovery are few. This study aims to explore how AA's primary therapeutic components are used by long-term abstinent AA members. Therefore, the principal aim of this thesis is to explore these components and their interaction with, and within, the individual. From the literature reviewed in Chapter Two, three key concepts were identified as having positive, abstinence-promoting effects. Chapter Three considered these concepts as a conceptual framework, thus providing a guide to a rich pool of theoretical perspectives from which to draw, 'fleshing-out' the original model derived from Chapters Two and Three. The literature reviewed was divided three ways to reflect these key concepts: first, prior motivation to

seek help; second, structured social engagement in inherent therapeutic practices; and third, changes in personal agency.

Therefore, the principal aims of the study are:

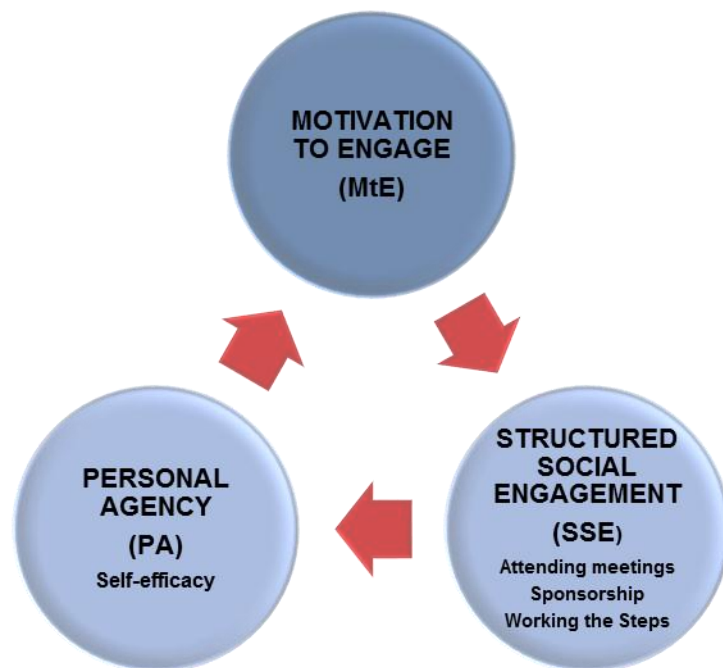
- To provide an in-depth account of what it means to be a member of AA.
- To understand how ‘working’ the Twelve Steps impacts upon drinking.
- To compare these empirical findings with the operational model and ‘mechanisms for change’ as described in the main AA texts.
- To investigate the long-term effects of sobriety amongst this cohort of alcohol-abstinent AA members.

These aims make theoretical and conceptual choices for the models more explicit and at an empirical level guide what I want to know, by channelling the data collection in a more focused way. Implicit and embedded here are some of the implications for the criteria set out later in this chapter for the necessary cohort characteristics, and the limitations of data derived from this cohort, also discussed in Chapter 8.

The nature of the central research question is essentially an inductive one, *‘How does AA’s 12 Steps and Membership of the Fellowship of Alcoholics Anonymous Work for Addressing Drinking Problems?’* Therefore, the two models illustrate the development in deductive reasoning. Sketching out an ideal model the ‘virtuous cycle’ of change, which is an extension of the simple circular process of change (figure 2, page 82), becomes a hypothetical model of AA mediated behavioural change- the basic

components. The second model incorporates temporal components, such as moderators that may threaten disengagement from AA, stressors the person experiences, and the temporal effects, beneficial changes in person narrative and identity. The ‘book-ends’ of the second model reflect a hypothesised beginning and end state for chronically engaged members of AA. As the trajectory of recovery proceeds over time, and moderators are experienced (stressors), the concepts thought to mediate engagement with AA and recovery are best illustrated by ‘mapping’ the basic components onto the elongated ‘helical’ figure.

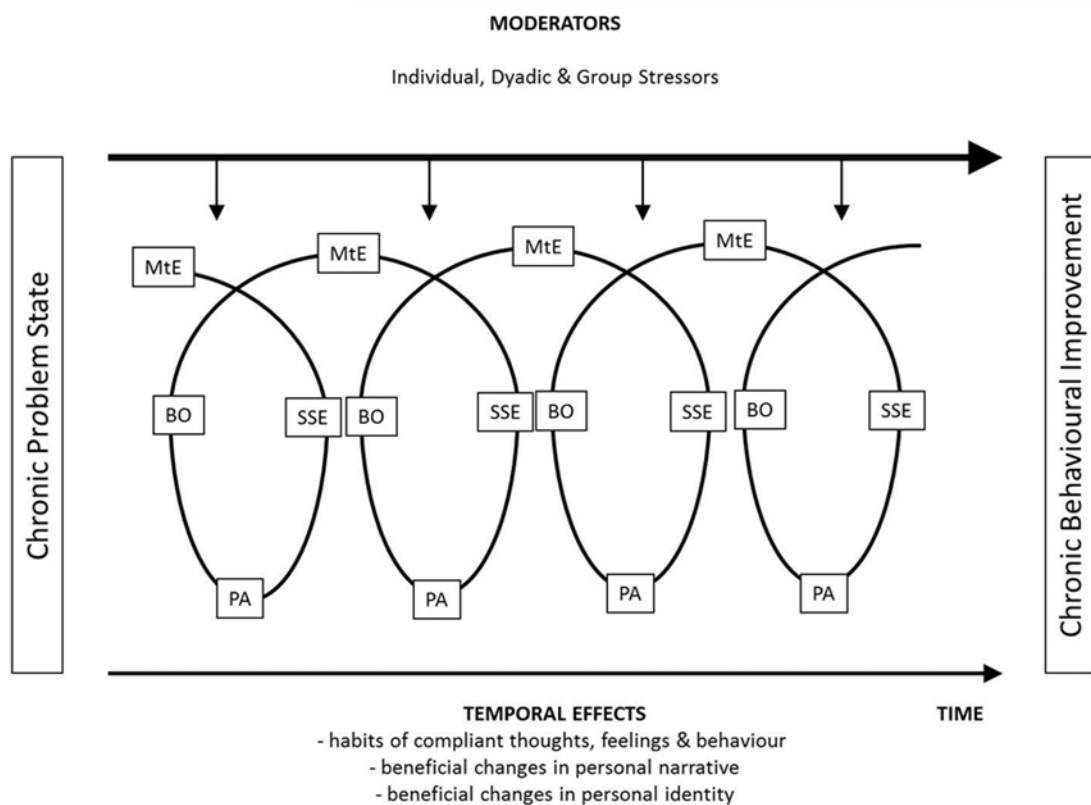
Figure 4 - Hypothetical Model of AA Mediated Behavioural Change: Basic Components



Miles and Huberman (1994) argue that conceptual frameworks, help to expose and illustrate relationships to the phenomena under investigation. Dividing these into concepts that ‘hold’ discrete practices, such as sponsorship, helps to frame ‘bounded decisions’ regarding data collection. These are bounded in two ways. First, by prior research into the topic, illustrating the relationship between AA’s therapeutic practices, and mapping these onto a theoretical framework. This process then that will guide

interview schedule, and help inform the second model, for example moderating variables, such as stressors, seen in the figure below.

Figure 5 - Hypothetical Model of AA-Mediated Behavioural Change: Temporal Components



The purpose of AA is to help people achieve abstinence, the motivation, once an individual has joined AA is to stay sober. Logic therefore dictates that a temporal dimension ought to be included in the analysis. In order to assess AA's effects upon the individual, the above model elaborates further on the processes that are associated with AA. The temporal model has been built from a deductive process. A priori knowledge has thus guided which domains to research further, and in terms of therapeutic process (es), the trajectory of recovery is considered, as the person moves from a chronic

problem state or 'rock bottom' (AAWS,1952), to chronic behavioural improvement. One can see how the basic component model now sits with a temporal framework. At this point the model leaves one component unaccounted for- behavioural outcomes (BO). Determining what these behavioural outcomes are, perhaps those incidental to abstinence, is the task of the analysis following the empirical work to come, involving an inductive approach.

4.3 Methodological Approach

4.3.1 Basic Approach in Relation to Overall Research Strategy

The methodology adopted for this study is founded upon a constructivist ontological position. Ontologies offer perspectives to understand social realities (Bryman, 2012). Members of Alcoholics Anonymous understand themselves as part of the organisation which is constructed by the perceptions and actions of each individual member which are expressed verbally. In this sense, the reality of Alcoholics Anonymous is accomplished by people continually interacting, according to how they interpret the lessons expressed by other AA members and from the AA literature. Constructivism refers to a position in methodological theory that situates the reality of the subject (in this instance the AA member) as an ongoing social construction.

Epistemological considerations take into account how research seeks to understand its subject matter; it is the basis for knowledge construction (Bloor, 1997). An interpretivist

epistemology supposes that the objects under investigation in social science, namely human actors, are reflexive agents. This reflexivity gives the human agent the capacity to think and interpret situations which confront them in differing ways (Young, 2010). By employing an interpretivist approach which seeks to understand how human actors interpret the world they inhabit, we can see how shared understandings create social realities and shape interactions (Shinebourne and Smith, 2009).

The justification for using an interpretivist epistemology is grounded in the type of questions/topic areas which are being investigated by the researcher (Hammersley and Atkinson, 1995). These questions ask the respondent to consider how the process of change has occurred. These processes and experiences are complex and have occurred over time. It is necessary to explore how each individual has interpreted the cultural conventions, or AA's philosophies and therapeutic practices which have shaped meaningful experiences (Sommer, 1997). Therefore, the design and methodology of such a study demands an in-depth interviewing methodology, to uncover how this has happened and to what effect. The themes covered aim to broaden the understanding of the subjective experiences of the cohort, and to account for the use of language in AA.

Themes and topics to be covered in the interviews include:

- The non-abstinence based benefits of being a member of AA
- Reflections on the process and experience of working the Twelve Step Program
- The experience and effects of sponsorship in AA.
- Perceived success of AA in supporting problematic drinking

- Perceived extent to which the AA Twelve Step Program has affected other social and personal dimensions.

4.3.2 Research Design

As the research focus is on the description and on examining ‘mechanisms for change’, the study used a cross-sectional retrospective case study design. This design combined interviews with individuals involved in AA with a documentary analysis of core AA texts. The design provided in-depth data that will allow the examination of the interconnections between the objectives outlined. The rationale for a cross-sectional approach is simple. Each participant declared membership to AA, and had long-term abstinence rates of between five and thirty years. This approach allowed the participants to explore past experiences based on their retrospective accounts, and myself to follow up these accounts, in terms of present behaviour and attitudes. Thus, the connections between the individual as a drinking alcoholic and a sober alcoholic, were effectively drawn out.

Given the time constraints on data collection, for this study and the relatively stable nature of the cohort, a longitudinal design was ruled out. This was because each individual had achieved long-term abstinence. A longitudinal approach would not capture any significant changes in behaviour between interviews, spaced out over a year. The goal was to gather, accurate and detailed ‘pictures’ of each person’s experiences.

This approach will be essential for probing the mechanisms which underpin change, drawing on Farrall and Maruna's (2004) construction of desistance as an on-going process that requires maintenance. This conceptualisation of desistance, as one of continual change through self-examination using the Twelve Steps and attendance at AA meetings, supports much of AA's model of recovery as an ongoing 'project'. The maintenance of permanent sobriety/desistance is partly facilitated by regular attendance of AA meetings, and, in terms of relapse prevention, this is a central principle of the AA recovery model (Denzin, 1987). In addition, AA's normative practice of 'working the Steps' is a continual process requiring the close guidance of an AA sponsor. Understanding this process is fundamental to explaining the mechanism of change required by an individual to be successful as an ex-problem drinker.

4.3.3 Access and Sampling

Access

Based on past research, a relationship with a 'gatekeeper' flourished; and with this person's help I generated the interview sample of AA members. Relying on a gatekeeper is necessary, given the nature of the organisation; Alcoholics Anonymous holds that anonymity is the key 'spiritual' principle that is embedded in the Twelve Step Programme of recovery. Among AA members, anonymity is guarded for practical and personal reasons. The selection criteria were fully explained to the gatekeeper; and he approached potential respondents, providing them with the Participant Information Sheet (PIS). In addition, the PIS was made available at AA 'open' meetings, for other interested members of AA to consider participation. Those who indicated they were interested in participating were invited to contact the researcher. Potential respondents

who made contact had the research explained to them in greater detail, including an account of exactly what it will involve, the selection criteria, providing an opportunity for questions. Those who agreed to participate, signed a consent form.

Purposive sampling

In terms of operationalising selection, the gatekeeper approached potential respondents, providing them with the Participant Information Sheet. Two years of continuous sobriety is the suggested minimum requirement for sponsoring others. On the advice of the gatekeeper two years was also considered a sufficiently long period of abstinence, for inclusion in the study. Working with the gatekeeper, and bearing in mind the aims of the study, helped me to determine the type of information needed and the qualities/characteristics each of the respondents needed to possess.

As this was a small-scale qualitative study, the aim was not to generate a ‘representative’ sample from which we could draw generalisations to the entire population of problem drinkers or members of AA. Rather, the aim was to create a sample that would allow an exploration of a diversity of perspectives which could shed light on the study’s research questions. Participants were identified based on certain characteristics outlined below. Key variations in the sample included gender, age, time abstinent and offending histories. To this end it was necessary to rely on the ‘gatekeeper’ to help construct a cohort of respondents who matched the selection criteria. These criteria were:

- Readily identify as a member of Alcoholics Anonymous.

- Have a minimum length of sobriety of at least two years.
- Currently have, or have had in the past, an AA ‘sponsor’.
- Have been through the Twelve Step Program.

The central research question, the literature review, the aims and the hypothetical models proposed all direct sampling procedures. Impacting further on this process was the reliance on the gate-keeper. In sum, these constraints limit the conclusions drawn. A detailed description of how the models were developed and the associated choices for the research questions, represents facets of the phenomena to be investigated, and by virtue of this fact, have influenced the selection criterion set out above. At the outset, this study was conceived of as an investigation into the relative experiences of engaged AA members with stable sobriety, years of un-interrupted continual abstinence. This helped set the boundaries and scope of the study. However, nesting a small sample in the wider context of AA and the estimated 4,400 meetings per week in the UK, analytically means that no case for representativeness can be meaningfully argued for. However, by specifying the salient findings from the literature review, detailing the processes that shaped the construction of the hypothetical models derived from a deductive process, lends weight and confidence to the analysis, and the conclusions. One probable impact on the data gathered and therefore the findings, is an *elite bias* effect. Miles and Huberman (1994:263) argue one might rely too heavily on data elicited from more articulate individuals. This bias effect, may be levelled at this cohort as persons sampled have tended to be professional, and all of whom have a University degree. Sampling across socio-demographic variables, for example, accessing individuals without a university degree, or for whom employment could be categorised as ‘manual labour’, is a consideration worth noting. The impact on the data may have

revealed differing notions of pro-social goal attainment. With regards to Personal Agency (PA), a concept integral to the hypothetical model, pursuing further education and training in regard to employment, may not be a discernible ‘goal’ for persons that regard the education system as having a stigmatising effect on their employment status (c.f Willis, 1977). Reflecting on this, constructing a cohort from a variety of locations may have mitigated this elite bias effect, but with AA’s fluid membership and opposition to membership details in any form, this task would require more time and a much more detailed inclusion strategy, and perhaps a complete shift in methodology.

Interviewing individuals new to AA was not possible for two reasons: one ethical, one analytical. First, AA principles hold that new members need to have an exclusive focus on their recovery where they will be nurtured and protected by other members. This is a key principle in AA, which is enshrined in tradition five: ‘Each group has but one primary purpose - to carry its message to the alcoholic who still suffers’ (AAWS, 1952: 154). A new AA member would be considered to be still ‘suffering’ the acute effects of alcoholism, and emotionally vulnerable. Second, as the key objective of the study is to uncover AA’s mechanisms of change, individuals needed to be sampled on the basis that they have been through the Twelve Steps and have had a sponsor, who has guided them through this process.

A sample of 20 respondents provided enough in-depth data in order to help understand the mechanisms of change, and the shared stock of meanings commonly understood and experienced by the participants. All of the respondents agreed to take part in the study. A number of individuals had said it had ‘done them good’, to be given the opportunity to talk freely about their experiences, beyond the usual constraints placed upon

‘sharing’ in AA meetings. One woman, remarked she was, ‘glad you’re [the researcher] here reminding me’ a reference to her dire health before achieving abstinence, and gratitude for her life as a sober person, according to AA’s principles of recovery. Others considered it part of their ‘duty’ to ‘pass the message on’, the message of recovery that AA works, and is integral to the Twelfth Step. Significantly, this formed the basis for their acceptance to be interviewed.

The table below represents the study cohort. All of the respondents have been sponsored, but four, were not sponsoring others at the time of the interview. The relevant information is given regarding the pseudonyms used, age, gender, years of continuous sobriety (YoCS), employment, sponsoring status and crimes committed.

Figure 6 - Cohort Descriptors

	Age	Gender	Sobriety length	Occupation: past and present.	AA Sponsors status
Angela	Late 60s	female	20 YoCS	Retired public sector care.	Sponsoring 3
Andrew	Early 60s	Male	25 YoCS	Addiction treatment field	Sponsoring 2
Brad	Mid-fifties	Male	21 YoCS	I.T management	Sponsoring 3
Michael	Late 30s	Male	5 YoCS	Legal services	Not sponsoring
Elaine	Mid-fifties	Female	20 YoCS	Education; retired	Sponsoring 4
Jill	Mid-fifties	Female	14 YoCS	Medical; retired	Sponsoring 1
Jake	Early 40s	Male	17 YoCS	Public sector, care work	Sponsoring 2
Jane	Early 40	Female	20 YoCS	Legal services	Sponsoring 1
Lenny	Early	Male	9 YoCS	Ex-emergency	Sponsoring

	40s			services. Currently in education.	2
Loz	Mid-thirties	Male	8 YoCS	Ex-military. Currently in media	Not sponsoring
Mary	Mid-forties	Female	13 YoCS	Criminal justice agency	Not sponsoring
Mathew	Early forties	Male	7 YoCS	Public sector, mental health	Sponsoring 1
Penny	Early fifties	Female	12 YoCS	Ex-sales. Currently employed by Terry	Sponsoring 2
Patrick	Early forties	Male	11 YoCS	Senior manager, public sector	Not sponsoring
Phil	Early 50s	Male	20 YoCS	Medical	Sponsoring 3
Ryan	Early 60s	Male	26 YoCS	Numerous positions/jobs. Currently retired	Sponsoring 3 including Lenny
Richard	Early 60s	Male	30 YoCS	Numerous positions/jobs. Currently retired	Sponsoring 5
Sam	Early 30s	Male	9 YoCS	Student	Sponsoring 1
Sarah	60 years old	Female	26 YoCS	Nurse	Sponsoring 3
Terry	Early 50s	Male	6 YoCS	Owns a cleaning firm. Employs Penny	Sponsoring 2

4.3.4 Methods and the process of analysis

Reading AA's core texts

A close reading of the basic texts of Alcoholic Anonymous (*Alcoholics Anonymous*, and *The Twelve Steps* and *Twelve Traditions of Alcoholics Anonymous*, AAWS, 2001 & 1952) was carried out in relation to the program of recovery, as set out in these core texts. Following Atkinson and Coffey (2004), the organisation Alcoholics Anonymous

can be understood as a complex, self-documenting organisation, which produces texts ‘as a way of representing themselves collectively both to themselves and other’ (ibid: 56). The analysis of these representations will help to contextualise behaviour, by casting light on how individuals take instruction from texts, such as the basic text *Alcoholics Anonymous*, and how they interpret them in ways which facilitate behavioural change. These documents, and the socio-historical context in which they were produced, are significant parts of AA’s program which have not changed since formal codification in 1944. This includes the first 164 pages of the book, *Alcoholics Anonymous* (AAWS, 2001), which contain the Twelve Steps and specific instructions on what they mean and how to carry them out.

Having familiarised myself with AA’s core literatures (AAWS, 2001 & 1952), I was struck by the frequency with which respondents referenced these literatures. The manner in which key experiences had become understood and orientated towards these literatures, as a means of providing ‘validation’ of their identities was striking. This analysis formed a core finding: an insight into how the discourse of AA had become firmly rooted in each respondent’s experience of change and recovery.

Narrative interviews

Each participant was asked to take part in one semi-structured interview, lasting approximately an hour, with members of an AA community. As the subject under discussion is highly emotive, no definite time constraint was placed upon the interview. The research cohort comprised of approximately 20 participants. Interviews examined the narratives of recovery, constituted by the process of working the Twelve Steps.

Previous research has shown (Borkman, 1976; Denzin, 1987) that the narrative account is used in the AA setting, and is an effective tool with which an individual connects significant experiences over their life course. The individual can thus re-interpret these meanings from a new positive perspective. Analysis will allow for the identification of turning points in the desistance process (Sampson and Laub, 1993). This method is closely aligned with the nature and practice of AA, and the stated process-focussed aims. This approach contrasts sharply with the largely quantitative research that has 'failed' to establish a consistent outcome (Ashton, 1999).

Analysing the interviews

The interview part of this study is based upon the semi-structured model, in which 'the interviewer remains free to build conversation within a particular subject area, to word questions spontaneously, and to establish a conversational style' (Patten 1987:109). Westby (1990:102) suggests that this type of interview allows for respondents to reveal, 'their perceptions of the world, behaviours, values and beliefs'. This understanding is formed through gaining an emic perspective, which is defined as an 'insider's or native's perspective of reality', and therefore will be particularly useful in studying the meanings attached to being a member of Alcoholics Anonymous (Fetterman, 1989: 30). The primary objective is to generate data that gives access to the subject's experience, and to relay these experiences in detail.

Lofland (1971: 76) states that the object of ethnographic interviews is 'not to elicit choices between alternative answers to pre-formed questions but, rather, to elicit from

the interviewee what he [or she] considers to be important questions relative to a given topic'. As such, semi-structured interviews function to find 'what kinds of things are happening [happened]' Fetterman, (1989: 41) argues that this approach 'avoids the artificial response typical of controlled or laboratory conditions' and relies upon the researcher using their own senses. The ability to respond in a reflexive manner to information being gathered is crucial to exploring how individuals in AA have interpreted their experiences. The ability of the researcher to allow enough latitude in the respondents' accounts to 'weave' back and forth, yet guide the narrative 'flow', enabling genuinely revealing perspectives to unfold.

Trust is central to the interviewer/interviewee interaction. In this regard, an investigator needs to cultivate a strong interviewer/interviewee rapport. A good rapport, and a sense of trust and understanding between parties are essential to carry out successful interviews (Johnston et al 1995; Westby, 1990; Stewart and Cash, 1988). Spradley (1979) argues that making repeated explanations for the interview, restating what informants say, and asking for use rather than meaning, represent three principles which facilitate the development of rapport. Establishing a good rapport also allows for supplementary questions to be asked which explored other dimensions relating to key experiences, thus allowing for new findings to emerge.

The interview process

Each interview began with a question that followed the same theme. The respondent was asked about their initial experiences of joining AA. The interview format allowed

enough flexibility for related themes regarding motivation to emerge, such as familial pressure to engage with help for excessive drinking. An informal conversational style of interviewing was adopted to facilitate a relaxed atmosphere, encouraging trust and confidence. From the table of cohort characteristics, one can see that the majority of respondents came from professional occupations and this affected the interview process, on reflection. It can be fairly safely assumed that the 'social distance' between myself/researcher and the respondent, was consequently lessened (Silverman, 1997). Most of the professions listed necessitate a university degree. Three of the respondents held sociology degrees, while others had qualifications in cognate disciplines. A genuine mutual interest in 'social problems' and subsequent, off-tape conversations, unrelated to this research augmented rapport.

An aide-memoire was used to provide a range of related topic areas to be covered. At this point, a note of caution must be addressed. AA members, by virtue of their commitment to one of AA's therapeutic 'sharing' of experiences in AA meetings, become highly skilled 'story-tellers'. Having re-counted their personal 'narratives of change' many times, over many years, avoiding a 'polished' life-story was key to exploring other dimensions of the experience of being a member of AA.

The style of questions asked became key to avoiding the 'polished' AA account. Following elements of Hollway and Jefferson's (2001) approach, that good rapport is insufficient to uncover inconsistencies and contradictions in narrative accounts, respondents were encouraged to 'freely account'. For example respondents were asked, 'Can you tell me about your experience of sponsoring'? Following Gadd (2004: 387),

questions to responses were framed in such a way in order to explore further issues, for example, ‘can you tell me some more about that experience’. Specifying an experiential account helped avoid the pitfalls of generating data based on a person’s intellectual understanding of the question being asked as well as eliciting a ‘polished’ account that may have been given to an audience many times in AA meetings (Järvinen, 2001). This approach proved fruitful as respondents seemed to understand the notion of ‘experience’, yielding new themes and some raw expressions of emotion. Asking Elaine to relate her experience of sponsoring new members in AA, elicited a highly emotional account of how one of her sponsees committed suicide. Thus, open, ‘experiential’ questions(ing), have shed light on the yet un-explored and possible detrimental effects of sponsoring in AA.

The process for analysing interviews

After the interviews had taken place, each interview was transcribed. Reading through the transcripts allowed me to become familiar with the content and to identify patterns and concepts relevant for analysis. In addition to this approach, themes emerged as I contrasted the responses to particular questions, with core AA literature, this is an element of grounded theory. Grounded Theory (Glaser and Strauss, 1967), allows the researcher to test emerging themes, or hypotheses, as the data collection proceeded. This approach was used in the analysis process, as interesting findings emerged, they were coded for. The example, ‘use of AA discourse/language’, developed into a theme and helped form a theory of recovery. Emerging from the data was the frequent use of AA’s discourse, expressions either directly or indirectly ‘peppered’ respondent’ narratives. Glaser (1965: 438), asserts the constant comparative method, ‘*is* designed to

allow, with discipline, for some of the vagueness and flexibility which aid the creative generation of theory'. Subsequently, the data collected evidenced that individuals were using the therapeutic discourse of AA, to 'scaffold' their recovery. The repetitive use of these 'linguistic-echoes', helped a person build a new identity as a recovering alcoholic in AA.

The analytical framework was primarily derived from the model drawn from the review of the literature. This is in opposition to a purely grounded theoretical approach to data analysis, as I approached this study with a pre-conceived set of concepts and hypotheses to test. Further, the identification of key concepts, were arrived at through engagement with the literature. Ordering the data within this analytic framework, and grounding this existing knowledge in the respondents' narratives, allowed for data comparison. There then began to emerge a variation of experiences, related to relevant areas for analysis. Coding followed the structure of the analytic framework. For example, therapeutic practices, such as sponsorship was a dimension for study in structured social engagement. Answers elicited to questions exploring the experience of sponsorship, were coded for and helped to test empirically that part of the model of recovery. The fluid nature of a semi-structured narrative interview allowed for related themes to emerge. The negative consequences of sponsorship represented new findings. As this theme emerged, I was able to make a note of this and follow this up in further interviews, paying particular attention to the mechanisms or coping strategies employed by the respondents as these challenges were experienced. Subsequently, these negative effects became conceptualised as events that threatened engagement to AA. The basic analytic model, discussed in Chapter Three, was modified to incorporate these

‘stressors’, focussing specifically the analysis towards the nature of these events, the focus of Chapter Six.

Throughout the analysis process, I was reading carefully and conscious of the fact that the respondents’ stories were reconstructions of past events which may be told for a particular listener/audience. Individuals attach subjective meanings to past experiences: this is part of AA’s mechanism for change, as a person renegotiates a new identity for themselves, within the therapeutic framework of AA. The telling of stories in AA serves a particular purpose at a single point in time, and are presented to be interpreted in a particular way, usually to demonstrate to the listener(s) that progress is being made in his or her recovery. As such, notes were made during the interview so that any inconsistencies and tensions in the accounts being given, could be analysed through intra- and inter-case comparison.

4.4 Ethics and Practical Consideration

This research took place in northern city. This was for a number of reasons, the city had been the site of previous research undertaken on this topic, and trust had developed over a period of years between the local AA community and this researcher. Key to the success of the project was the relationship between the researcher and the Gatekeeper. Frequent meetings were needed between myself and the Gatekeeper over several months to allow a cohort of participants to be built.

The interviews took place, individually either before or after an AA meeting. Choosing to interview respondents at ‘open meetings’ was the most practical solution to maintaining interviewer safety, and, had the participant wished, the interview would be terminated, and the individual could vacate the premises easily. These were meetings that the general public were welcome to attend, to observe the proceedings. This was essentially a publically accessible space, but could be used in order to have a private conversation.

Participation Information

Expectations were made clear, before being asked to participate in the study, the researcher’s expectations of respondents were made clear and the implications their participation may have, and that opting out at any stage was always possible. Informed consent was obtained by providing potential respondents with a Participant Information Sheet (appendix B). Respondents were all given the opportunity to raise any queries, and it was explained that participation was entirely voluntary, and that consent could be withdrawn retrospectively without having to give a reason. The researcher provided respondents with his contact details, and advised individuals to raise any concerns or queries about the project, without hesitation. It was also made clear that, withdrawal from the project would require no explanation. The study was to be introduced by describing what it was about, who it was for; answering any questions respondents might have about how they were selected, and how the research results will be used.

4.4.1 Informed Consent

All potential respondents were given an information sheet, detailing all of the relevant information (see information sheet – appendix C). The respondents had opportunities to ask questions. Some of the respondents took up this opportunity, particularly post-interview as the conversation turned towards other areas of AA that some respondents felt ‘needed’ further research, such as perceived negative reporting of AA in the media.

The respondents were asked to complete an informed consent form, asking that they understand what their participation meant, and that they consented to take part in the research (see consent form). Respondents were then be asked to read and sign an informed consent statement (see Appendix A), indicating their consent to participate in the interview process. A written summary of anonymised results will be made available to respondents following completion of the research study. At the end of the interview, each respondent was given a copy of the written consent form and assured that all the information given would be stored securely and their anonymity would be preserved.

Participant Distress

As the sample of interviewees were at a minimum of 2 years abstinent, and well-established, in AA as active members and as skilled reflexive agents, all of the participants were well used to recounting past events. As practiced and experienced members of AA, all participants had, on previous occasions, recounted negative and positive events, reformulating these as positive lessons to be learned from and shared with others. This is part of the Twelve Step Program. This practice of ‘sharing’ forms

the basis of all meetings of Alcoholics Anonymous, and is considered a necessary part of the recovery process, and also part of practising the Twelfth Step.

Due to the nature of the interview questions, some participants might experience distress during or post-interview. However, distress did occur during one respondent's interview. As a 'seasoned' AA member with 20 years of continuous sobriety, she eschewed phoning her own sponsor and merely asked if we could pause the interview and take a cigarette break. Having composed herself after a period of approximately 10 minutes, the interview proceeded, with no additional breaks. In addition to these measures, all the respondents were encouraged to talk through any distressing elements, post-interview with their respective sponsors.

4.4.2 Confidentiality and Anonymity

Interviews were recorded on a digital recorder by the researcher with the respondents' permission, and backed up as MP3 files onto a password-protected, non-networked computer, encrypted using 'TrueCrpty' software. Only the researcher and supervisor have had access to these files. The files are retained for a period of five years under the custodianship of the principal PhD supervisor, after which they will be destroyed. The identities of the research participants were anonymised, and interviewees are now only identified by the use of pseudonyms following the process of transcription. Moreover, respondents have been informed that anonymised quotes and transcriptions may be used in future publications. Guaranteeing the anonymity of the respondents in a study such as this, where disclosure of past criminal behaviour would lead to loss of reputation or

employment, was of paramount importance. Many of the respondents are in positions of authority and responsibility, as the cohort descriptors suggest. Each participant was given assurance that no information would be imparted that could identify the person, and that their responses would not be shared with other members of the cohort. The cohort did comprise of sponsors and sponsees, for some, this dyadic relationship had proved problematic, the details of which are discussed in Chapter Six. I was asked on a number of occasions, who else I would be interviewing, I had to remind the participants that confidentiality had also to be respected in this regard. During the interview process, respondents were informed that they were under no obligation to disclose any information they were not comfortable with. One participant, when asked about their experience of practising Step Four (see AAWS, 2001: 64), declined to give any details. Participants were assured that their responses were confidential, and that no information which might identify them would be used in future publications without their agreement. This was to be made clear in the participant information statement.

Conclusion

In order to fully understand how AA works as an organisation, and how the Twelve Steps work to facilitate abstinence and the cessation or amelioration of other problematic behaviours, it is necessary to *talk* directly to individual members of AA. Borkman's (2009) analysis (see also White and Kurtz, 2009) explains the paucity of qualitative empirical work as the result of 'current AA researcherswhose secular frame-works cannot easily accommodate non-scientific paradigms...' (Borkman, 2009: 12). This state of the current research can possibly be explained by the fact that, AA has been, consistently, more accessible to researchers working in the United States than

those in the UK. Further, the adherence to the quantitative model of research methodologies may say more about the overall ‘cultural’ preferences of the US social science academy to opt for a quantitative approach, than any deliberate attempt to eschew more qualitative paradigms of research (Young, 2011).

The interviews generated a source of high quality data, rich in detail, revealing the processes involved leading up to and subsequent engagement with AA. The chosen methodologies, combined documentary analysis and interviews, allowed me to ‘check’ and identify findings against the AA literature.

There are some drawbacks to the methodological approach adopted for this study. Every effort was made to recruit persons from a diversity of backgrounds. As I was heavily reliant on the co-operation and help of the gatekeeper, this was only partially achieved. The cohort, in basic terms were white, and the respondents are mostly educated to degree level and consisted of seven women and thirteen men.

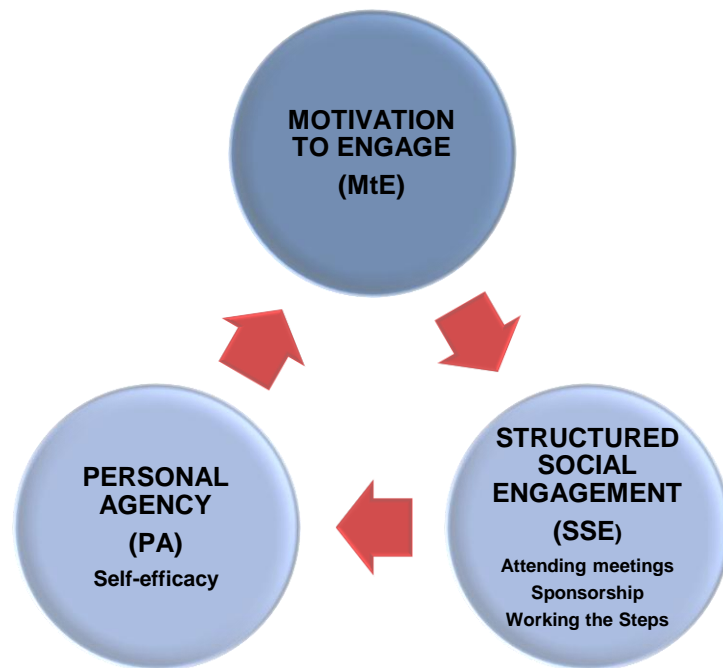
As this was a localised, small scale study, extrapolating the methodological approach and applying this to other geographic regions, would have been desirable but unachievable owing to time constraints. There is however a convergence of experiences that the cohort have experienced. Therefore, the study offers a theory of recovery in AA, as these accounts represent an insight into the views of the participants, and it is their ‘journey’ through AA’s therapeutic mechanisms for change. The following chapters, Five, Six, and Seven present an analysis of how one experiences engagement

with AA and initial behaviour changes; then how a person remains engaged with AA, under conditions that threaten disengagement. Chapter Seven discusses what the long term effects of such engagement are, paying particular attention to criminal behaviour.

Chapter 5: The model: From a Vicious Cycle of Decline to a Virtuous Circle of Change

This chapter sets out to test the conceptual model, presented diagrammatically below, using data from interviews conducted with a cohort of long-term abstinent members of Alcoholics Anonymous. It is therefore the aim of this chapter to explore which of the conceptual elements of the ‘virtuous circle of change’ feature most prominently in the narratives given. There is variation in the findings. Some excerpts support and concur strongly with the concepts presented in Chapter Three which represent Motivation to Engage (MtE), Structured Social Engagement (SSE) and Personal Agency (PA). Additional data reveals new findings relating to the benefits of membership to AA, such as employment opportunities provided for new members, perhaps not ‘well enough’ for the open job market by existing long-term abstinent individuals. This evidence lends particular weight to the argument that membership to AA increases a person’s social capital.

Figure 7 - Hypothetical Model of AA Mediated Behavioural Change: Basic Components



The first part of the model is motivation. Individuals present a common set of negative experiences, a ‘package’, which in AA is a necessary precursor to positive change. As a concept, motivation can be understood as forms of pressure. These emanate from various spheres in an individual’s social world. Broadly, these pressures are external in nature, both formal and informal. Informal pressure may come from family and friends, while formal pressure is exerted by the medical profession and the criminal justice system. As noted in Chapter Three, once these pressures reach an optimum level, pressure is internalised, experienced at the subjective level, and an individual becomes ready for change: the decisional balance has been ‘tipped’ favourably towards positive change. For the purposes of this study, this marks the entry of an individual to AA.

Structured Social Engagement is the second component in the model proposed in Chapter Three. Once a member has joined AA the transition to recovery takes time, often years, and is aided by AA's Twelve Steps, sponsorship and relationships formed amongst AA's wider social network. During and thereafter this period of engagement, the individual experiences the positive changes in identity which result in new-found interest in more generative activities.

Personal Agency, is the final component, and the analysis that follows, demonstrate how one builds a sense of personal agency within the framework of AA. The primary 'vehicle' for change in AA is 'storytelling'. As Kurtz (1979/1981) explains, having made the decision to engage in AA, and thus participated in AA's forms of therapeutic structured social engagement, the recovering alcoholic has developed a new sense and understanding of their own personal histories. Once developed, these narrative accounts have a transformative effect on an individual. An increased sense of personal agency results in members of AA reporting positive achievements following engagement in education and employment.

5.1 Motivation: An Awareness of the Pressures to Stop

Pressure to change comes from many sources. The following section on motivation is demonstrated by the responses given by the cohort, pressure to change is experienced in combination, coalescing 'within' the person. Change then occurs as this pressure is experienced subjectively. The following section demonstrates various examples of pressure exerted on the individual while in active alcoholism. This begins a dialogue, a

narrative flow of experiences that describes how the respondents arrived at the decision to engage with AA.

5.1.2 Informal Social Pressure: Family and Friends

Polcin and Weisner (1999) argue that pressure from family and friends to enter treatment did not feature highly as a motivating factor in their study. The narratives of the recovering alcoholics interviewed for this research did however suggest that pressure from family and friends had a strong influence in the decision to seek help.

Mary's alcoholic drinking pattern, and the subsequent breakdown of both her marriage and problematic relationship with her children, results in strong threats from her husband to involve social services in the care of her children.

XXXX (ex-husband) was going to phone social services and going to have the kids taken off me; he wasn't going to come and take the children, he was going to have them taken off me [Mary, early 40s, 14 years continuous sobriety].

Similarly, Elaine narrates her experience regarding the care of her children and increasing pressure from her husband. The level of threat that Elaine experiences is less than in Mary's case, but this example demonstrates the mounting pressure Elaine is experiencing and her perceptions of her drinking problem.

...it was my husband really, who, who, who kept trying to tell me that every evening when everything was done and we would sit down in, in the sitting room, put the television on, some music or something I would be in and out secretly drinking [...] I wasn't drinking before I went to work yet, and he complained and he moaned and he said, you know, I feel as if I'm married with myself, [...] he was doing all the shopping,

all the cooking, all the cleaning, all the washing, he was running the family ... [Elaine, mid-fifties, 20 years of continuous sobriety].

Elaine's account, while similar to Mary's in content, begins to 'unpick' the dynamics of narrative formation in AA. The key phrase, 'I wasn't drinking before I went to work *yet...*' illuminates how recovering alcoholics retrospectively understand their problematic drinking as developing in phases. There are two analytic points to be made here. The word 'yet (s)' is a cautionary device used in the AA meetings that has a twofold purpose. The first usage is particularly in the presence of a potential new member, who may be aware of their problematic drinking but is unconvinced of having 'full blown alcoholism'. 'Yets' in AA are examples of the further, potential negative consequences of drinking: 'I hadn't lost my husband/wife/job/driving license, yet'. The underlying message the newcomer receives is that, if you are an alcoholic of our type and you have *yet* to experience these losses, the progressive nature of alcoholism in AA will surely deliver these 'yets' to you. Second, the 'yet' in Elaine's narrative indicates that, while her drinking was causing strain on her marriage, her drinking would descend, thus demonstrating one of the key indicators of alcoholism/alcohol dependence: loss of control. Further examples of these 'turning points' or stages in the drinking careers of AA members are found frequently, as respondents narrate the various negative consequences of problematic drinking. Phrases which denote these stages are typically framed as, 'that's when my drinking properly took off'; and similar examples are to found throughout the narratives given in this study.

For others, removed geographically from close family, pressure from friends provides the cognitive stimulus to consider attending AA.

So when George [surname] said to me “I don’t think alcohol’s your friend” it was, it was that seminal moment, it was that golden moment that I call it, that not everybody has. [...]It was just the right moment and to be truthful part of the reason why I sat and listened to her was ‘cos I’d bashed, I’d took a chunk out of my nose that night [Andrew, early 60s, 25 years of continuous sobriety].

Andrew’s account demonstrates two key points or moments which are necessary precursors to change. First, having suffered a degree of physical harm as a direct result of excess consumption of alcohol, a trusted friend gently suggests alcohol is not Andrew’s friend. Second, the ‘golden moment’ comes: Andrew is ready to listen. This stage in an individual’s journey towards positive change will be returned to later; but it is worth noting that the well-timed, firm but gentle pressure from a trusted friend often renders a previously resistant individual more susceptible to advice.

Self-Motivated: An Intellectual Approach

Missing from the literature on motivation to attend treatment and adopt positive changes in behaviour is the self-motivated ‘investigator’. Rare though are the individuals that make the decision to seek help based purely on rational judgements.

I went home that night I did a bit more Googling and searching the internet, I said I’d already done some investigations of my own as to, you know, my general wellbeing or my situation, a lot of it seemed to have a connection to drink. [Patrick, early 40s, 11 years of continuous sobriety].

Similarly, Penny describes her decision to attend AA as based on a simple rationale: that she needed to be around other abstinent alcoholics.

Actual fact, I realised I would need to mix with people who didn't drink so I actually saw AA really as a network I went there to network, an intellectual decision. Good enough reason. [...] It was purely intellectual motivation [Penny, mid-fifties, 12 years continued sobriety].

Penny's explanation of first attending AA, and her thoughts on what attracted her to the organisation, stands out from the literature on the initial pressure an individual begins to attract before making contact with AA.

5.2 Internal Pressure

As Seddon (2007) argues, external pressure subjectively experienced becomes internalised, thus resulting in motivation. The transformation of external to internal pressure in an individual produces strong motivation to seek treatment. However conceptualised, defined and thus deployed in empirical studies, motivation is a critical element in participation and retention in treatment (ibid). Wilbourne and Miller (2002) argue that understanding motivation lies at the core of how professionals think about addressing problematic substance misuse. Further, the concept of "in denial", the authors argue, is redundant as an explanation of resistance: a "primitive ego defence" loosely based on psychoanalytic theory. AA's theory of alcoholism and, concomitantly, treatment stands directly in opposition to the author's assertions. Thus, 'We learned that we had to fully concede to our inner most selves that we were alcoholics. [...] The delusion that we are like other people, or presently maybe, has to be smashed' (AAWS, 2001: 30). The collapse of this 'delusion' is central to overcoming denial; the explicit purpose of Step One is to address the problem of denial.

5.2.1 The ‘Revolving Door’

In AA, the phrase ‘revolving door’ is used pejoratively and is reserved for those individuals for whom ‘getting’ the AA program (that is staying sober) proves difficult. Over time, certain individuals become revolving door members, and are held as cautionary examples to newcomers to avoid a pattern of relapse.

I’ve been doing this for 9 years on and off (AA), on and off, on and off and the last 6 months had just been depressing I mean thoroughly, thoroughly depressing, just the, the actual waking up in the morning and going to bed at night was hard. It was hard, It was jus, it just become too hard and I’d started to think about death and, you know, it was dark, it was dark. It was... Is it worth it anymore? The debts were 70, 80 grand... um, I’d nothing to show for, for my life um, and I couldn’t cope with, like, ruining any, and more peoples’ lives. I just couldn’t cope with that [Michael, late 30s, 6 years continued sobriety].

At the time of the interview Michael is more than 5 years sober. His experiences of life spent in and out of AA mirror Maruna’s (2001:152) findings on the ‘burnt out’ effect amongst offenders: ‘And I’m sick of it, just purely sick of it [...] I just want it to go away and leave me alone. But it’s hard. You know what I mean’. Maruna (2001) argues that human service professionals experience burn out but do not resign, or, with reference to criminality, ‘the experience of burnout did not have anything like a perfect correlation with desistence’ (ibid). Maslach and Jackson (1981:99) state that ‘Burnout is a syndrome of emotional exhaustion.’ In later work, Maslach and Schaufeli, (2001) find that negative outcomes can lead to substance abuse and lower levels of self-esteem.

5.2.2 Psychological Pressure

Negative psychological issues feature strongly in respondent's narratives when describing events preceding the decision to join AA. Suicide attempts are common amongst the individuals in this study.

Um, but I did want to take my own life at 17. Er, [pause], er, I was taken seriously and I ended up in a local mental hospital for about 3 weeks. Um, I didn't respond to any counseling or any treatment. I don't know why, I just wouldn't open up... I don't know what I wanted, I don't know what I wanted to say to anyone anyway. I wanted someone to give me the answer and not me tell them what the problem was [Patrick, early 40s, 11 years continuous sobriety].

Patrick later describes in the interview what the 'answer' to his problem was. Patrick had spent years in denial about his sexuality. Following a troubled adolescence and early adult life, alcohol played a prominent and destructive role in Patrick's life. Upon entering AA, he eventually accepted his alcoholism and his sexuality.

Further experiences of suicide followed the threat or the breakdown of the family unit.

Mary explains how, in the absence of her family, she takes an over-dose.

And then the boys went to Sweden to visit their dad, and I just lost it, I completely lost it... I thought, they are so better off without me, because I'm such a fuck up, I still had a job, but I was off sick, and I took another overdose. [...] Took, fecking load of Diazepam, and I lived, I couldn't fucking believe it; I remember waking up and thinking, what the fuck? [Mary, early 40s, 14 years of continuous sobriety].

Further evidence of severe mental distress resulted in Matthew being hospitalised for

his depression and alcoholism.

...my boss, was the manager of a psychiatric crisis service. He contacted the psychiatric service where I lived and arranged for them to assess me [...] And then I was taken into hospital and given a number of, well, what I think was detox number 14 but I'm not sure [how many] I've been through... [Matthew, mid Forties, 7 years of sobriety].

Contact with medical professionals, as a result of acute alcohol problems, is a common experience amongst AA members in this study. Moos and Moos (2006) examined key predictors of relapse and remission amongst the treated and untreated, amongst persons with alcohol use disorder. Depression and associated symptoms, such as thoughts about suicide, featured strongly amongst the author's cohort. Likewise, Laudet et al (2000) found, amongst a cohort of 310 dually-diagnosed individuals, 89% had at least been hospitalised once for mental health problems.

5.3 The Transition from External to Internal Pressure

The following section illuminates the change in an individual's perception of their alcoholism, as the forces of external pressure are experienced subjectively. This process follows closely the model of change presented by Prochaska and DiClemente's (1983) transtheoretical model (TTH) of health behaviour change. Pre-contemplation and Contemplation are the particular stages of TTH model represented here.

5.3.1 'Blame' and Responsibility

One of AA's key philosophical principles is the notion of responsibility. Step One asks that a person 'accepts' their problem. From this initial admission, the other 11 Steps can

be understood as an individual taking responsibility for their recovery. This is exemplified in ‘The Serenity Prayer’, collectively recited at the close of every AA meeting: ‘...to accept the things I cannot change the courage to change the things I can, and the wisdom to know the difference’ (AAWS, 1947).

...you know, I suppose the alcohol had induced sort of borderline sort of depressive traits for most of my twenties which I blamed on other things, I blamed on my relationship with my father, and I blamed on, um, I was diagnosed with arthritis when I was nineteen, I blamed it on that, I blamed it on the psychological damage of working in a psychiatric hospital; I blamed it on all sorts of things, um, but I suppose there comes a point at which you run out of excuses or the excuses don’t work anymore [Brad, mid-fifties, 21 years of continuous sobriety].

Brad neatly summarises all the key external and internal pressures which ultimately led to his finding AA and accepting help. The acceptance of help and one’s ‘condition’ as an alcoholic is the first step towards recovery and taking responsibility. Two key stages of Prochaska and DiClemente’s (1983) TTH are represented here. Pre-contemplation, Brad discusses previously-held beliefs which he perceived as the causes of his negative drinking pattern. The Contemplation stage has occurred as the respondent has ‘run out of excuses’. The problem has been acknowledged, a prerequisite for the successful transition to the preparation stage in the TTH cycle.

5.3.2 Decisional Balance: Ready to Listen

Motivation to change and join AA comes from a variety of sources. Andrew spoke of that ‘golden moment’, a window of opportunity when an individual becomes ready to listen. Likewise, Angela’s ‘golden moment’, comes as a consequence of the negative

effects of excessive drinking her psychological and physical state has left her receptive to AA's message of recovery.

I phoned AA and they said there's a meeting tomorrow, um, can you get to it? [...] I was two or three days without a drink was significant for me because I felt rough enough and shaky enough and nervous enough that when somebody offered me a solution to the problem I was ready to grasp it [Angela, late 60s, 21 years of continued sobriety].

As the 'decisional balance' becomes ripe for tipping, the person becomes more receptive to the notion of positive change, and more capable of processing salient information as they prepare to take action (Armitage and Conors, 2009). Application of DiClemente and Prochaska's (1983, 1984) TTH model helps us to understand Andrew's shift from contemplation (a person is aware of their problematic behaviour) to the preparation stage: the offered solution would be grasped. As Armitage et al (2003) have argued the TTH model incorporates two psycho-social variables: decisional balance and self-efficacy. The confidence an individual possess in their ability to perform certain tasks, or behaving in a certain manner, is conceptualised as self-efficacy. Building self-efficacy (the belief that one may achieve a stable and abstinent life) is AA's *raison d'être*. How this is achieved is central to our understanding of AA as an effective psycho-social intervention, and is the focus of the remaining chapter.

5.4. Structured Social Engagement

'Few indeed were those, who, so assailed, had ever won through in singlehanded combat. It was a statistical fact that alcoholics almost never recovered on their own resources' (AAWS, 1952: 22).

The focus of this section is to uncover what constitutes involvement in terms of structured social engagement. For many, the first point of contact with AA is an AA meeting. As a human social system, AA functions to enable individuals to come together to solve a collective problem. This problem in AA is considered unassailable by the individual acting alone. Kurtz (1979) argues that the prospective members, and current members of AA, are encouraged to believe their personal recovery and sobriety are contingent on membership to AA.

5.4.1 AA Meetings

But you know it's not rocket science: I'm a recovering alcoholic, so I go to AA and talk about it [Ryan, early 60s 26 years of continuous sobriety].

AA meetings quite often offer the first place an individual feels welcome and accepted in for a long while. This is a common experience amongst AA members attending their first meeting. Often, as a result of years of destructive drinking and associated negative behaviour, AA offers a substitute for former social and family networks, as one of Smith's (2007:34) respondents' states:

'This is my family now. My folks washed their hands of me a long time ago'.

Similarly, Jake recounts how he was accepted by other members of AA, he was usually never invited to 'keep coming back' to social situations, due to the often violent and criminogenic nature of his alcoholism:

My first experience of going to AA was – it was – the people there were just like sort of warm, friendly, I didn't feel like they wanted anything off of me, although I was a bit sceptical because of the circles I was around, of like dog eat dog, sort of thing –[...]I found the people seemed to be really genuine, and people stopped said keep coming back, [...] I can remember my first meeting, and some of the people that were there are still there now, [...] And I look up to 'em, I still look up to 'em, because, if it wasn't for them people, I wouldn't be where I am today, you know, sort of like, supported me, stuff like that [Jake early 40s, 17 years of continued sobriety].

The meetings, in the first instance, provide acceptance and support. As a new member embeds themselves in the organisation, the frequency of AA meetings, along with the advice to attend '90 meetings in 90 days', offers a structure to a previously chaotic lifestyle. The ability to join a 'warm, friendly' group, which will support the goal of abstinence while ameliorating emotional difficulties such as loneliness, is at the core of AA and has been demonstrated to predict remission from alcohol abuse (Laudet, 2000). Forming stable relationships with other recovering alcoholics in AA, based on trust and a mutual understanding of a shared past and future goal, is also facilitated by attendance at AA meetings.

5.4.2 Dynamics of Relationship Formation in AA

Once a person finds themselves involved in AA, new modes of communication are discovered and learned. As a corollary effect of this engagement, new relationships are formed. A useful starting point for analysis is to understand how AA's mechanisms of support are developed through interaction. The 'scaffolding' of recovery begins to be constructed by the language of shared meaning. Narratives in AA are characterised as 'brutally' honest and explicit in nature, which engenders trust and reciprocal 'sharing'. Following this, each member becomes attuned to and more confident in talking about

their experiences. This is accomplished in such an explicit manner that it would be considered socially unacceptable and offensive outside of the therapeutic environment of AA. Enduring and trusting relationships develop: AA members often characterise these relationships as distinct to those formed with non-AA members. As Elaine succinctly states:

The relationships that I've got in AA are a lot deeper than I've ever had outside of the fellowship [Elaine, mid-fifties, 20 years of continuous sobriety].

The nature of recovery from alcoholism in AA necessitates a level of honesty among, essentially, a group of strangers, and this builds confidence. Confidence to speak of one's 'darkest secrets' stems from the realisation that past actions and negative behaviours are not unique to that individual. Loz explains the initial dynamics of relationship formation in AA:

...you get relationships that are very close very fast, it sort of bypasses the initial um, getting to know someone because within the space of a few, a, a few hours, even, you could have told someone your deepest, darkest secrets, um, and they will have done the same. So, over the period of a few weeks you become just really close to people you've only just met its just 'cos of that shared experience and you both know what each other's talking about 'cos you're both alcoholics and can both relate to the fact that you shit the bed and if you said that to a lay person in the street they'd look at you [Loz, 34 years old, 8 years of continuous sobriety].

Allen et al (1981) argue that alcoholics in treatment begin the process that erodes loneliness through interaction with others. Ending this loneliness happens as an alcoholic in AA learns that their uniqueness of experience is a shared experience. The

long-buried psychological and emotional issues which precipitated and drove the individual to drink, will come to the fore in sobriety and are treated using the Twelve Steps. Anger, guilt, shame, all indices of negative affect regulation, pose challenges for the recovering alcoholic (Kelly et al, 2011). These practiced modes of behaviour and understandings of self have served a protective purpose for the alcoholic: to preserve the myth of control, pride, secrecy, and to facilitate impression management (Goffman, 1959).

The AA process of recovery is in part biographical. Through learning the language of AA one begins the process of re-structuring the non-drinking alcoholic self. Recovery is maintained, partly, through the development of key, functionally supportive relationships. This dialogue, which occurs between individuals or is shared in meetings, exists to re-affirm that the old-self, the drinking alcoholic that suffered various dimensions of degradation, is to be kept in the past. By locating experiences in the past, and engaging in AA's therapeutic mechanisms, individuals are drawn closer to the goal of recovery. Importantly, these experiences are re-lived and shared in an allegorical sense, to remind the narrator and listener that 'one drink' is all it would take to reverse any gains made in recovery (Denzin, 1987).

5.4.3 Sponsorship and Working the Twelve Steps

AA (2008) reports that 75% of its members acquire a sponsor during the first 90 days of recovery. Having a sponsor is integral to the process of recovery in AA and is an effective mechanism by which a person engages with behaviour change. One of the key

predictors in maintaining abstinence has been the role of sponsoring in AA (Tonigan and Rice, 2010). Sponsorship allows a new member to anchor their unstable and negative experience in a person with knowledge and experience is staying sober, for whom recovery and the Twelve Steps are familiar (Denzin, 1986). Being a sponsor marks a person out in AA as one who can be trusted to give good advice, and guide a sponsee through the principles set out in the Twelve Steps.

I think... if you asked me what, what's the biggest influence in your recovery that's helped you to stay sober it's sponsoring. It's sponsorship because every time, every time I sit down with someone to do some Step work, um, I, I'm, I'm, I'm going through it myself, I'm reaffirming it myself [...] It's a recommitment, it's a reaffirmation for myself to what it means to be able to work this Step[...]... and, and that's been the key for me and that's not been easy and I didn't actually start seriously sponsoring people 'til I was 6 or 7 years sober [Elaine, mid-fifties, 20 years of continuous sobriety, my parentheses].

Elaine's experience reflects the positive benefits of sponsoring people in AA, and how that continues to impact on her own recovery. There are a number of limitations and drawbacks to sponsoring AA, and these will be discussed in Chapter Seven.

Jill gives a precise account of her active role as a sponsor:

[I have a] sponsee – who's very, very, early days who has lost a lot, so we're just taking things very, very, slowly at the moment, she was here on Saturday for a couple of hours; she's doing ok, she's doing ok, she's not had a drink since the beginning of August, she's done two months, so she's making progress, and it is about progress, not perfection, we've started to talk about the steps now and I'd like to see her making a move now to say right, I'm ready now, to do the steps, but it's got to come from her. I've told her I won't put up with her procrastinating much longer, because, sometimes, you just need a boot up the backside, and I'll be the first to be booted up the backside, so, I'll boot others up the backside. So, that's good, we're building a good

sponsor/sponsee relationship and just taking it steady at the moment [Jill, mid-fifties, 14 years of continuous sobriety].

Following Coleman (1988), social capital exists in the relations among members of a group. A sub-category of social capital in Coleman's formulation is human-capital. This is a non-tangible 'good' that can be passed from person to person, as a skill that, once acquired, may help that person achieve a goal or objective, one that is not possible individually. Through participation in AA's various forms of structured social engagement, social capital is accessed at AA meetings. There, an individual finds a sponsor, a trust-dependent relationship in which human capital facilitates productive and positive activity: time spent with a sponsor supports the goal of abstinence. As a resource, membership to AA may also perform other functions, which while not explicitly therapeutic may also help an individual's circumstances.

5.4.4 Benefits of Membership to AA's Wider Social Network

For many of the respondents, years spent in active alcoholism has diminished social functioning and social skills. A commitment to engage in AA social activities as well as AA's therapeutic practices help a person break away from a previous negative conceptions of self, AA effectively absorbs this negative self-concept. As Denzin (1987) observes, as an individual learns the language, practices and rituals of AA, a new forms of understanding and behaviour emerge.

Improved Social Functioning

Sarah's experience of active alcoholism is characterised as a lonely existence. Feeling isolated, Sarah explains that she lacked the necessary social skills to make and maintain stable and positive relationships. Through active participation in AA's supportive network, Sarah overcame some of her inner most fears of self-consciousness.

Because I guess I'd been lonely all my life, but it had never been a problem. And suddenly it was, and I realised I had to change – either change or drink again. Or be miserable for the rest of my days. So I did, and it was the hardest thing that I ever did, but I started to make friends in AA, go out on girls' nights, and things like that, was awful for me, agony.

Interviewer: Really?

Sarah: Agony, I hated it, absolutely hated it, used to dread it when it was coming up. There were a little bunch of us and we used to meet in each-others' houses.

Interviewer: Is this the NEWTS ?

Sarah: Yeah, yeah.

Sarah: Yes, yes. It's going back quite a way, but yeah. I used to always insist on driving, though I was always offered a lift, because it meant I could escape. I used to take my car everywhere so that I could escape. Never did escape, never did leave early. But I did it and I think after about two years, I was at one of the girls' houses and we were having a picnic, BBQ outside and it suddenly struck me, I'm enjoying myself, but it took me two years, two years of feeling uncomfortable, insecure, it was awful.

Interviewer: So, you're nine years without a drink at this point?

Sarah: Yeah.

Interviewer: What was the thing that made you think to yourself, ‘I’m enjoying myself,’? Can you remember?

Sarah: I was relaxed. I was relaxed and I was able at last to be myself. I’d spent a lot of time not knowing who I was, and in recovery, and before of course, but in recovery, and not really knowing – when I was in the hospital, in the psychiatric units, I was sent very frequently off to these sort of social skills classes and things, dreadful things, and I just found them so unbearably uncomfortable, but the other thing was that in those days, I didn’t do anything, so I had nothing to chat about. I had no idea how to chat [Sarah, 60 years old, 26 years of continuous sobriety].

Sarah refers to a ‘tongue in cheek’ group of women friends the NEWTS, which stands for Neurotic and Emotional Women’s Temperance Society. The effect on Sarah’s social and psychological development was positive, although it took many years of recovery for Sarah to feel comfortable and relaxed in company. Other forms of unofficial AA social events help a newcomer structure their time positively, helping particularly newcomers accept and learn to enjoy their new lives as a sober alcoholic.

For about five years running, I used to celebrate my AA birthday with my family and friends from AA. I’d tell newcomers they’d be most welcome and to bring their partners, cuz it can sometimes be tough on them as well see, especially in the beginning. But I’d also warn them that there would be alcohol drunk by my family who are not alcoholics, so if they thought it would threaten their sobriety then don’t come. It’s about a bridge to normal living isn’t it [Richard, late 60s, 30 years of continuous sobriety].

Richard extends the celebration of his ‘AA Birthday’ to partners of AA members. This act performs two key functions which help consolidate membership to AA. First, inviting the partners of new members can break down some of the fears and perhaps some of the mystique that surrounds AA. Second, in a relatively ‘safe’ and supportive environment, Richard is encouraging new members to build their sense of self-efficacy. Richard is quoting an often-heard term in AA: that it is a ‘bridge to normal living’. This

is living as a sober alcoholic in a world that associates alcohol with celebration, even if that is to celebrate another year of continuous sobriety for a recovering alcoholic.

Employment: The Employee

Membership to AA's wider social network also presents economic opportunities which further extend an individual's social capital and augment the recovery process. While this chapter's focus presents a model of idealised change, a 'virtuous cycle' that gives explicit accounts relating to early recovery, stable employment is also a long term effect of abstinence over many years. The extracts here are used to help understand how employment supports early recovery. Terry describes employing new members of AA that are 'unemployable', in early recovery. The following extracts taken from the transcripts of Penny and Terry illustrate AA's potential for building social capital. As is often the case with qualitative research, serendipity can present a welcome opportunity to explore a concept further. In this case the role of employment. Penny is employed by Terry. It was Penny's suggestion that Terry might be willing to be interviewed.

The Employer

'Today I own a little company. There are two alcoholic employees, who produce as much as five normal salesmen. But, why not? They have a new attitude [...] I have enjoyed every moment spent in getting them straightened out' (AAWS, 2001: 150).

Terry owns a small industrial and domestic cleaning company. He employs around 10 people and uses his position to help members of AA into work. While Terry did not

overtly allude to the above quote from AA's central text, he is following the one of the basic principles of recovery in AA, that one alcoholic should help another alcoholic to the best of their ability.

Interviewer: Can I just ask you about the fellowship and employing people?

Terry: Well, because I've been fortunate in business, [...] I'm able to offer employment to people who are perhaps trying to get back on the employment ladder, so, because they've lost everything as an individual, through their addictions, their alcoholism, if you like. Once they're at a level of sobriety with their recovery [...] once they're at a level of recovery and trust, I'm fortunate that I am able to offer positions, and I 'ave done for a dozen people in fellowship over time.

Interviewer: Right.

Terry: And there've been a couple of examples where people 'ave practically been unemployable to start off with and they've now, as well as me offering them employment, I've got them back on employment ladder [...] you know, that's just the way it is, Jamie, I've got a business, I'm in it to make money but the money's secondary, but I do genuinely see that I'm in business to be of service [...] Because I like to see the good in people, and because I wanted to 'elp people, and because it's about *practicing these principles in all our affairs*, and because I believe that God want me to 'elp other people, and I'm in a position to do it, then, I should be doing it with alcoholics because I'm an alcoholic myself... [Terry, early fifties, 6 years of continuous sobriety, my emphasis].

Terry asserts that one of AA's principles of recovery is to be of service to others, and explicitly references part of Step Twelve (AAWS, 1952:109, my emphasis), 'Having had a spiritual awakening as the result of these steps, we tried to carry this message to other alcoholics and to *practice these principles in all our affairs*'. This is another example of how the literature of AA becomes interwoven in the narratives of AA, a means by which members locate, justify and anchor their own recovery in AA discourse.

Using the concept of social capital, one can identify the substance of social capital-goodwill, existing in Terry's actions as an employer willing to employ members of AA. Adler and Kwon (2002) argue that the notion of goodwill is engendered in the fabric of social relations, such as those developing in AA. Thereafter, such relations can be mobilised to facilitate positive action, in this case job opportunities. Understanding AA as network of potential resources is consistent with Bourdieu's (1986) notion of social capital, which can be reduced to analysis of outcomes related to economic capital. The process by which this outcome has occurred, however, cannot be understood in these simple terms alone. By helping to provide employment opportunities to other members of AA, Terry is fulfilling that part of AA's spiritual philosophy as laid down in Step Twelve which asserts that recovery will yield, 'Rewards for helping other alcoholics' (AAWS, 1952: 9).

Penny articulates in concrete terms the effect that being in AA has had on her. AA has had a transformative effect and given Penny a job.

Interviewer: So, being in AA has helped in many different ways?

You mentioned you got some work in AA.

That's an understatement – it's transformed me into a completely different person and, yeah given me a job that I wouldn't have had—got that job cuz I'm able to do it, but I also believe I got it cuz of that special bond of, being trustworthy, not just stealing money or time, not stealing, trusting I'll do the right thing, turn up, not steal his customers and set up on my own – it's a lot bigger, not just being a responsible, reliable employee, I believe we do have a bond. And again, if I were to phone up and say I'm not coming in today, tomorrow, yeah, like right fine see ya. I'm totally trusted to do the job I set out to do. Life's easier than it would be otherwise, its just fucking easier, just

fucking great I'm glad you're here reminding me! [Penny, early fifties, 12 years of continuous sobriety].

Penny's account of the added benefits of being a member of AA could not be clearer. Penny reiterates sentiments that members of AA have a special relationship, '...a bond', as Coleman (1988:100 emphasis in original) argues, social capital, '...exists in the *relations* among persons'. Penny's new identity as trustworthy extends to her ability to take a day off work, safe in the knowledge that that reason will be accepted. Coleman argues further that the presence of extensive trustworthiness, enables tasks to be completed by groups exhibiting high levels of trust, with greater efficiency, than comparable groups or individuals with less trust. The quote from AA's basic text (2001), 'There are two alcoholic employees, who produce as much as five normal salesmen', supports Coleman's (1988: 99) argument that trust, is an outcome of membership to a social group or organisation that, such as AA, exhibits some of the same characteristics of a 'closed community' (alcoholics), with a high frequency of interaction (AA meetings). These elements function to increase and expedite action. To be clear, AA is a resource for not only the knowledge and skills required to stay sober but also a social structure whereby one may access the network for employment opportunities. Importantly, not every member of AA has equal access; there appear to be conditions, as Terry explained, a person needs, '... to be at a level of sobriety...'. The implication is clear, Terry can as a potential employer make judgements about an individual's participation in AA's practices, such as frequency of meeting attendance and the successful knowledge acquisition and application of the Twelve Steps.

5.5 Personal Agency

‘...if you go into a pub for no good reason then you’re asking for trouble...’ [Brad, mid-fifties, 21 years of continuous sobriety].

The following section illustrates with examples, the development of personal agency. Specifically, Bandura’s (1977) concept of self-efficacy will be used to further explain how individuals develop strategies to avoid relapse and pursue hitherto unobtainable socially approved goals. These goals and strategies employed to manage alcohol are different to the long-term changes in attitudes towards alcohol. In brief, the distinction to be made here is simple. In early recovery AA members are taught strategies of avoidance, as opposed to many members of AA with long term sobriety keeping alcohol in their homes for social occasions.

5.5.1 Self-Efficacy: Avoiding Relapse

Bandura et al (2001) explain human or personal agency in terms of social cognitive theory. Beliefs in self-efficacy, the ability to bring about desired outcomes and to successfully direct courses of action under strained circumstances, lie at the heart of how one perceives the chances of personal achievement. From the narratives given by the respondents, there are two dimensions to self-efficacy that appear to augment recovery that develop, to use Terry’s phrase, ‘in tandem’. In simple terms, AA members recognise that to be successful, to stay sober and build recovery, one should develop other pro-social, such as returning to employment or education. In terms of recovery from alcoholism, self-efficacy is referred to in both the academic and AA literature, as a capacity for successfully avoiding relapse. One of AA’s slogan’s states, ‘Don’t hang

around wet places and wet faces', neatly captures AA's simple strategy of avoiding drinking environments and people who drink.

Loz summarises a range of strategies used to manage social contexts in early recovery where alcohol is present.

When I was first around [AA slang for being a newcomer], I just used to avoid most parties and stuff like that. When I couldn't avoid 'em, I'd arrange to say, phone my sponsor an hour into the party or whatever it was. One time, at my cousins wedding, about three months in [three months sober in AA] I phoned him [sponsor] and just talked through how I was feeling. I was just fucking bored really, speeches went on for ages and I was starving. Guess it was the old, hungry, angry, lonely, tired thing kicking in. Or have the excuse that I was driving, on anti-biotics, owt like that really. When I did have to carry a drink, I'd try and remember to carry it in my left hand, just so I wouldn't accidentally, you know, without thinking, take a drink of it, always drank from me right hand see [Loz, mid 30s, 8 years continuous sobriety].

Loz refers to another of AA's slogan's that teaches a person to become a more reflexive agent. New members are taught to be mindful of feeling, hungry, angry, lonely and tired. After talking with his sponsor, Loz realised he was getting annoyed/angry [length of speeches], hungry and lonely, that is, he felt the need to speak to another recovering alcoholic [his sponsor] with more experience at dealing with situations such as weddings. Any of these physiological and psychological states are understood to put an individual at higher risk of relapse.

Here, Mary recognises the role hunger used to play in her time drinking.

Yeah, feck, you know, when I first stopped, I'd let myself get really hungry without thinking. Then, bang, it was fecking there, in the pit of my stomach the urge to drink. Because for years I'd associated the feeling of hunger with the need for a drink, so I had to almost re-train my thinking, hunger means eat, not drink: fecking idiot! [Mary, early 40s, 14 years continuous sobriety].

Kadden and Cooney (2005:75) suggest effective relapse prevention strategies ought to be orientated towards filling; hitherto time spent drinking, with more generative and creative pursuits. Taking the author's suggestions of discovering 'pleasant activities', one step further, the following extracts demonstrate the transformative effect that a short time in AA has had upon these members. From a previously chaotic and unbalanced life style, AA members quickly develop interest in activities that centre upon self-fulfilment and personal development.

5.5.2 Enhanced Self-Efficacy Beliefs

The purpose of the following section is to provide evidence from this study of examples of self-efficacy, 'in action'. That is, the development of a belief in one's own abilities to accomplish goals beyond maintaining abstinence. Ryan describes how the confidence sobriety gave him, gave Ryan the impetus to begin a university degree.

...just by being sober again for a little while, gave me the confidence to try different things. And in those days, you could apply to do a degree course without any qualifications, as long as you had the life experience. You could get through the interview, and I applied to do the Youth and Community diploma... couldn't get enough of it, it was just a remarkable experience 'cause I discovered that I did have abilities, talents, call it what you will, and I did very well at it. So much so, I went back and I did a Masters degree in my own discipline, but I also went and did a BA in

History and Politics at [a Scottish] University at the same time, and I got a job, there were a lot going on for the next few years, and I worked as a community health worker for the World Health Organisation [Ryan, early sixties, 26 years of continuous sobriety].

For many of the AA members studied here, the pursuit of socially valued goals, are the hallmarks of ‘good’ recovery. Engagement with AA’s therapeutic practices furnishes individuals with a resource to, successfully maintain sobriety. After establishing themselves firmly in the AA community, and having successfully maintained a short period of abstinence, many AA members choose to re-enter education.

Jake explicitly states how the AA program had changed his thinking regarding voluntary work, and re-orientated his understanding of past negative experiences of education.

It’s really a cognitive program this, and just going through the steps in the way it’s suggested has made me view things in a different way, and made me change my attitude, and one of my attitude things was, I’m not going to work for nothing, and I started doing voluntary work and stuff like that. I hadn’t worked since I was 18, and I hadn’t got any qualifications, and I used to put it down to being dyslexic and I blamed that. I went to college and got some qualifications [...] I could see I needed to re-educate my mind. And the courses helped to re-educate my mind as well, into main stream society. So, that was another key point, and I had some tutors who could see that I wanted to achieve and they went out of their way to help me. So, before, where I thought people didn’t like me and didn’t want to help me, it wasn’t them, it’s to do with me; it was my barriers [Jake, early forties, 17 years of continuous sobriety].

Both Jake and Ryan have criminal pasts in addition to their alcoholism. Maruna (2001) observes that a sense of optimism and greater levels of self-efficacy are useful for the desisting offender. Jake overtly admits the need to join ‘main stream society’.

Acceptance of such socially valued goals, such as furthering oneself through education, are thus understood as a pathway from a previously shameful and negative existence to a more socially accepted identity. Jake explicitly wants to invest himself in mainstream, legitimate (not drinking or offending) society. Sampson and Laub, (1993) argued that an investment in social bonds, attaching one's self to familial, employment or educational pursuits begins to exert a level of informal social control, as levels of fulfillment increase, the desire to associate with pro-criminal/pro-drinking social networks decreases. In terms of causation, both Ryan and Jake are very clear, '...being sober a little while....' (Ryan), or '...going through the steps...' (Jake) had to precede any attempt at returning to work or education.

Cognitively, Jake makes sense of his past failure in the education system, by locating the fault within him-self. Following Maruna (2001), a person can follow predetermined, linguistic expressions of redemption. The Enlightenment Model (ibid: 148), suggests that a person will hold themselves responsible for their problems, but take little credit for their resolution. Jake takes responsibility for his previous failure, but locates his success as a result of participation in AA and specifically, the Twelve Steps. As a result of his participation in the Twelve Step program, Jake's thinking has changed, opening up new possibilities in terms of doing voluntary work and gaining qualifications.

The development of personal agency and more specifically self-efficacy is the first step to maintaining abstinence outside of AA that is, putting into practice practical and cognitive strategies to staying sober in one's social environment. The examples given

above demonstrate how relapse is avoided, sometimes literally by simply not going to a party or some other similar social function. In concrete terms, to paraphrase Ryan, by being sober for a little while, self-efficacy beliefs are increased in both Ryan and Jake's ability to pursue educational goals.

As the final stage of the 'virtuous cycle' of recovery is reached, the development of personal agency, a key finding emerges from this study. In addition to participation in AA's therapeutic practices, recovery is augmented by the pursuit of socially valued goals, such as a return to employment and education. Returning to Terry's comment, these goals or pursuits occur, 'in tandem' to participation in AA.

Summary

So far, the interviewees support the 'virtuous cycle' of change model proposed at the beginning of this chapter. Initial motivation to change, amongst the cohort in this study, is generated by the negative consequences and effects of alcohol abuse. In accordance with Connors et al (2009), the decisional balance (the moment when an individual has experienced 'enough' consistent pressure from both external and internal origins), opens an opportunity for positive change. At this point, a rational choice is made to engage with AA. Thereafter, the individual joins the organisation and becomes embedded in the discourse and therapeutic practices of AA. Findings suggest that not only does the AA's social, supportive network increase social capital, by providing for example employment opportunities, but as a result of 'working' the Twelve Steps with the help of a sponsor, there is an increase of personal agency. Personal agency and self-efficacy

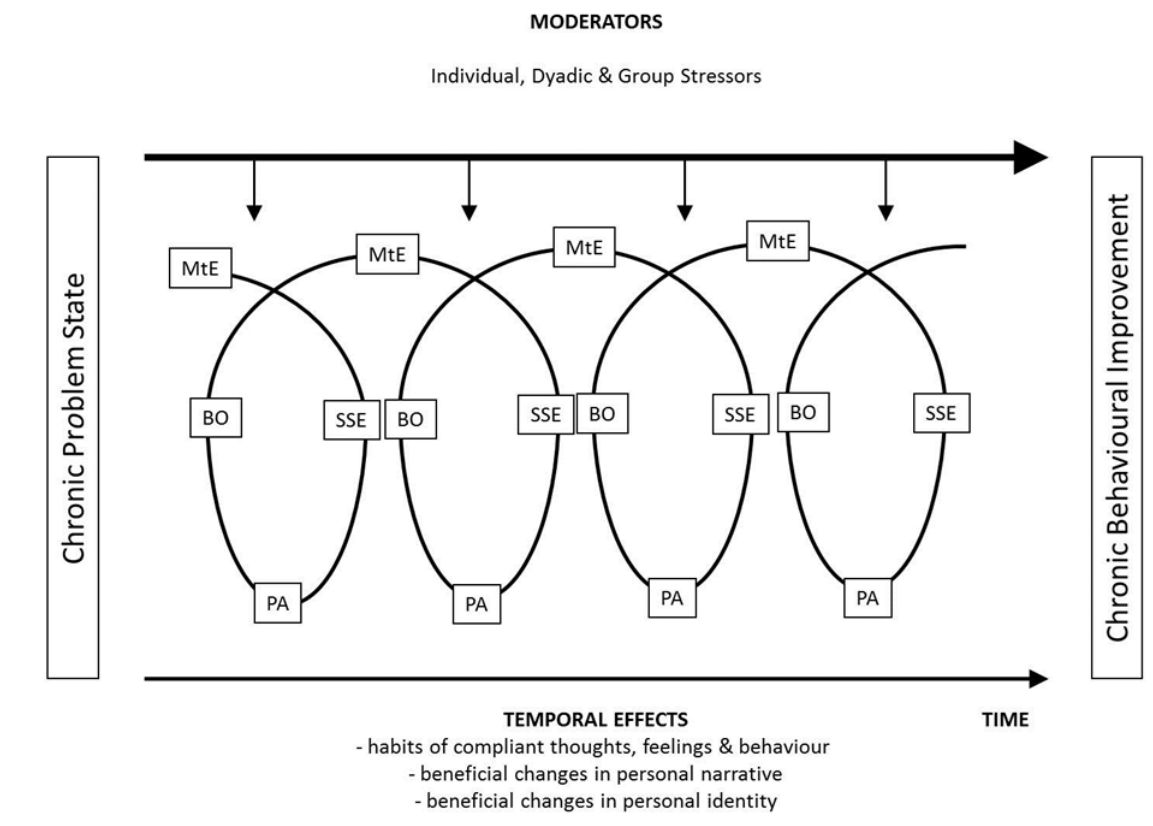
are enhanced. This results in, for example, AA members returning to education with a clearer understanding of themselves and their abilities. Presented here is a ‘virtuous cycle’ of positive change. AA members in long-term recovery engage with AA, and overall their lives improve. Research here demonstrates that psychosocial factors, such as stable employment and an improvement in social functioning, are critical in achieving and maintaining recovery from alcohol and drug dependence (Vaillant, 1995; Drake, Wallach, Alverson and Meser, 2002).

An under-researched, and perhaps the least understood dimension of recovery in AA, is how sobriety is maintained over the long term. As suggested and presented here, there is a ‘virtuous cycle’ of change, observable following motivation, structured social engagement, and an increased sense of personal agency and self-efficacy. The model shifts, and becomes elongated, resembling a helix. Diagrammatically, the model represents recovery over time, as the cohort have between five and 30 years of continuous sobriety. AA’s program of recovery as yet appears to support the model of AA-mediated behavioral change. But is this the case? In the following chapter I explore two key themes that are related to managing threats to sobriety, that is, what circumstances do individuals become exposed to, that threaten disengagement from AA and how these events are managed. There appear to be two dimensions that threats to disengagement emanate from, these are distal and proximal. An individual manages these threats according to the AA model: recourse to meetings, a sponsor and close supportive network of recovering alcoholics in AA.

Chapter 6: Threats to Sustaining Positive Change: ‘Spinning off the Helix’

Analysis in chapter Five demonstrated a ‘virtuous cycle’ of positive change, incorporating the initial motivation(s) (MtE) to join AA, AA’s therapeutic practices in terms of structured social engagement (SSE), and the development of personal agency (PA), specifically self-efficacy with regard to abstinence. Of note here, an additional component to the model to Behavioral Outcomes (BO), applies to some of the strategies used to maintain abstinence. This dimension is explored thoroughly in Chapter Seven. The purpose of this chapter is to illuminate how an individual applies those therapeutic practices when a pressure to disengagement from AA is subjectively experienced, and, more specifically, how such threats are dealt with, mitigated against or ameliorated. As the diagram below illustrates, conceptually, recovery becomes an elongated process, ‘stretching out’ over time, the goal is to *not* ‘spin off the helix’.

Figure 8 - Hypothetical Model of AA-Mediated Behavioural Change: Temporal Components



The model has shifted from the ‘virtuous cycle’ to resemble a helix. As all of the respondents have between Five and 30 years of continuous sobriety, it can be argued that engagement with AA has ‘worked’ or is ‘working’. These threats to disengagement can be understood using two broad categories: proximal threats arise from engagement with AA, and distal threats are those that occur over the life course. Broadly, these threats are dealt with by the individual in two separate ways. Proximal threats are dealt with subjectively. That is, the individual either uses their own psychological resources or finds the solution in the written texts of AA. Where there is a direct linguistic replication to be observed in the quotes of the respondents below, and in the AA literature, the relevant phrases have been italicised. Managing distal threats requires recourse to AA’s therapeutic practices and from one’s pro-abstinent support networks.

Ultimately, success in AA is always measured as the ability to manage one's life, without drinking, thus maintaining positive change and 'staying on the helix'.

6.1 Structuring Coping Mechanisms through Experiential Knowledge and Language

The purpose of this section is to demonstrate one of the key mechanisms that structure and govern the way AA members think and communicate with non-alcoholic persons in their social environments. More specifically, this analysis illustrates why an AA member would chose to deal with threats to disengagement using either their individual support network or turning to the AA literature for support. The ability to speak openly and frankly about emotional problems, to another member of AA, is regarded as key skill in dealing with threats to maintaining sobriety. Fundamentally, AA members believe that no other person, family or close friend(s) can understand a recovering alcoholic like another recovering alcoholic: 'You can secure their confidence when others fail' (AAWS, 2001: 89), or as Elaine stated,

I'm absolutely sure Bill and Bob's [AA's founders], um, [pause] best example they ever set for us was one alkie talking to another as they really understood where the other was and from...[Elaine, mind-fifties, 20 years continuous sobriety].

Relationships formed with one's close network are central to maintaining engagement with AA's therapeutic process and mechanisms. These relationships are built on a language of shared meaning and the experience of alcoholism and recovery. Before analysing how AA members deal with proximal and distal threats to disengagement

form AA, it is useful to begin to understand how AA members see themselves in relation to non-alcoholic individuals encountered in their social worlds. The rationale for such an approach is that we can begin to observe the role that AA's distinctive lexicon of recovery plays in shaping both behavioural and psychological responses in everyday social interaction.

Central to the development of close relationships in AA is the notion of difference. Maintaining a consensual identity, as a recovering alcoholic within the framework of AA, helps individuals in AA to understand themselves in relation to non-alcoholic person, during social interaction with others. The following example demonstrates how AA 'gets inside' the individual, solving the problematic state of a non-drinker in a world of drinkers (Denzin, 1987).

Lenny explains where the boundaries of trust are drawn and the limitations of what types of information can be imparted.

I've got a lot of very, very close friends from AA who I do regard as really close, who I could tell anything to and feel it would be alright in their hands. It's a different level of trust you get to someone who's not in AA. It's very hard to explain. You know, [...] my work colleague a lot, I trust her a lot, but I don't fucking trust her like that... [Lenny, early forties, 9 years of continuous sobriety].

Those "normies" don't understand us [recovering alcoholics] Denzin (1987:155, my parentheses).

At the individual level, this technique of 'othering' preserves the cognitive, emotional and experiential identification with other alcoholics in AA: 'a self-reinforcing

circularity' (Young, 2003: 400). Young's (2003) analysis sheds light on a process that creates an ontological certainty amongst members of AA. At the group level, this 'uniqueness' of the AA recovery experience, and thus the collective experience of AA members, is solidified and perpetuated as a universal 'truth' of understanding, which is communicated in the AA meetings and between AA members. As Lenny's longer explanation and Denzin's field observations both illustrate, this is an example of a linguistic strategy for bracketing out the 'other'. The term "normies" is heard frequently in AA meetings, and is embedded in the recovery discourse of AA's wider community. The implication is that the sharing of certain thoughts and experiences would appear distasteful or even offensive to the "normies". The "normies" are 'othered' as a group for whom the capacity to understand the lived experience of the recovering alcoholic in AA, is beyond their grasp. This functions to preserve the unique understanding that develops between individuals in AA.

From the literature reviewed in Chapter Two, and using examples from the narratives of the respondents interviewed, one can observe Borkman's (1976) use of 'experiential knowledge'. Borkman's (ibid: 446) analysis rests on two key elements: (i), the *type* of information shared, and (ii), the *attitude* toward that information. Lenny demonstrates the concept of experiential knowledge clearly, as the 'truth' of experience gained through destructive drinking: the *type* of information. Following Denzin's (1987) example of the 'normies', in those who do not have a problem with alcohol, one can observe this process consolidating and preserving the 'truth' of experience. Lenny's narrative example takes us further in our understanding of the limits of communicating with non-alcoholics, explaining that certain thoughts and emotions are better kept for discussion with other AA intimates. Lenny's example illustrates the *attitude* towards

that information: non- alcoholics neither understand nor speak this experiential language.

6.2 Managing Distal Threats

Many of the participants reported events that have threatened their sobriety, and therefore disengagement from AA. These are adverse life events which effect the population as a whole, not just members of AA. The argument made here is while key life events, both stressful and pleasurable are experienced whether one is a member of AA or not, the coping mechanisms employed differ. This is because the consequences for miss-handling pleasurable/stressful life events may result in drinking alcohol. Many AA members fear that failure to maintain sobriety could result in death (Borkman, 2006). Accounts of near death from drinking and those ex-AA members that have failed to maintain sobriety and have died as a result, are heard frequently in AA meetings. AA's core literature (AAWS,2001: 33), illustrates a return to drinking after a long period of sobriety, as thus, 'Though a robust man at retirement, he went to pieces quickly and was dead within four years'.

The analytic focus for the remainder of this chapter are the therapeutic mechanisms employed by AA members that are new behavioural and/or psychological responses. The following section centres on distal threats. For example, problems encountered in the work place, individual ill health and coping with the death close intimates.

6.2.1 Chronic Health Problems

This first example demonstrates the structuring and use of coping mechanisms employed. First, Penny's illness is related to her sobriety; second, her reliance upon a power greater than herself, is evidence of therapeutic use of AA's Twelve Steps. Finally, Penny accepted help from another member of AA. Suffering with chronic health problems, Penny describes this experience.

Penny: You can get sober and be sober under any conditions. Because I have had terrific health difficulties [...]

Interviewer: How did AA helped you manage those difficulties?

Penny: It didn't. It was a very big disappointment to me. It was a big wake up call. About my expectations. Because when I became really ill, I did expect that people would visit, help with shopping and that just didn't happen, same as pub really, out of sight out of mind. So that were a big, it were a massive disappointment to me. [...] I were quite sort of pissed off with people telling me I needed to get to meetings, but I couldn't – I couldn't get fucking dressed. So, yeah, it were a pisser that, yeah [Penny, mid-fifties, 12 years continued sobriety].

Penny felt that other AA members' dogmatic adherence to the belief that, whatever psychological state one is in, one ought to be attending AA meetings. Evidence supports this belief: that once regular contact with other alcoholics subsides, along with attendance at meetings, the risk of relapse increases (Vaillant, 2006; Smith, 2007).

Penny continues her account and describes how she used one of AA's therapeutic mechanisms, her understanding of Step Three.

Interviewer: so how did you manage that pissed off feeling and still remain sober?

Penny: I think hanging on to a belief, a faith – in god – a very much god of *my understanding* – not religious god, a bloke on a cloud – power. I don't know my god anyway, and I just held on to the thing of, god did not get me sober for this. I read a lot of, 'course I couldn't do anything else, other than lie about reading, [AA literature...] And in fact what happened, ironically, someone in the fellowship paid for me to have private treatment, and I did get well.

Interviewer: what was the illness?

Penny: Illness – ME –[...] From feeling let down by AA, somebody did pay for it, and it came from out of the blue, and someone I helped in the past – he would say that I would say that, and it was a gift of money with no strings attached. It were a lot of money. Yeah, that did it for me [Penny, early fifties, 12 years sober].

Penny's illness is held as an example, of staying sober under any conditions. Penny's experience of AA, initially, was one of disappointment that she had been let down. In addition, the message conveyed is ambiguous; revealing a tension in her feelings towards AA as ultimately another member of AA paid for (successful) medical treatment. Feeling abandoned by AA members, Penny turn's to her belief in a Higher Power, or God, specifically her understanding of what this concept means. Employing the language used in Step Three, '...God as we *understood* Him' (AAWS, 1952: 35, my italics), Penny asserts a God of her understanding is not a religious conception. Penny believes that in spite of her illness her sobriety comes foremost: there is a 'higher purpose' in her life. This is an implicit reference to a saying in AA: 'God didn't pull me from the raging sea, to have me kicked to death on the beach' (Wiggins and Walker, 2013). This cognitive strategy for coping is a result of working through the Twelve Step program.

As a long standing member of AA, Penny has spent time helping others, an activity identified as a protective factor in relapse prevention, as described in the AA literature (AAWS, 2001: 89) and Zenmore, (2007&2009). Helping is associated with spiritual development, and with strengthening one's own recovery. Here, Penny is suggesting that because she has spent time helping another alcoholic, as prescribed explicitly in Step Twelve (AAWS, 1952:109), has been reciprocated with a gift of money for her treatment. Ultimately successful treatment was funded by an AA member, a trusting relationship that would not have existed had Penny not been a member of AA.

6.1.2 Coping with Bereavement and Loss

As Larimer et al (1999) describe, the ability to identify, anticipate and plan for situations where an individual may be at risk is fundamental to avoiding relapse. This is central to already abstinent members of AA in terms of self-efficacy: the ability to cope with potential emotional upheavals which, previously, would have been a precursor to drinking. The strategy employed in this example is to seek out an AA meeting. AA's geographical spread allows members to access support in hitherto unknown regions. Contact with AA can easily be made in places where an individual is knowingly going to have to deal with unsettling situations.

Angela: I've lost my brother and my mother since I came into AA. My brother, my younger, um, died in 2000, and I found that very stressful, but, um, I, I, there was a local meeting [...], and that was very helpful because there was nobody else down there that I could really talk to on the same level, you know, about being frightened, and, um, scared, all of my own. [...] When my mother was ill and died ... there was a meeting in Exeter at lunchtime, and I used to go to the meeting at lunchtime, where there... again ... I used to talk to them a lot about, um, you know, what was happening and, um; and then

I'd go to see my mum and I'd feel alright being with my mum, you know, spending the rest of the day with her [Angela, late 60s, 21 years of continuous sobriety].

Angela's description demonstrates, further, how her understanding of the situation (the impending death of her mother) was anticipated, and what pro-active steps could be taken to ameliorate the worst emotional effects of this situation. By accessing the 'lunchtime meeting', Angela was able to talk to other members of AA, reaffirming her own sense of self-efficacy to achieve the desired goal: to be 'alright' with her dying mum.

Loz describes how, while visiting AA friends in America, following separation from his girlfriend, he was faced with the possibility of relapse.

I split up with a girlfriend, who I thought was the one, and it just totally destroyed me *mentally, physically, spiritually*. I was just destroyed and distraught, um, (sigh), and I was just stood. It's a nice story I've got. I was stood in a place in Chicago, so I went to see out... See, this is what AA brings you. I've got friends all over the world and I went to see some friends in Chicago, and I went to stay with them for a while [...]I could've turned left down to the seedier part of Wicker Park, where I knew there was crack, and I'd never done crack. I didn't know what I was gonna do if I'd found any, but I probably would have done it, or I could turn right where there was an off license. Instead I looked up the nearest AA meeting on my iphone and went to it ... seemed to do the trick. [Loz, mid 30s 9 years sober, *my italics*].

Loz's account further evidences the geographical spread of AA. Friends in Chicago have offered a supportive holiday from the UK during a particularly difficult, emotional period. Finding himself at risk of relapse, Loz seeks out an AA meeting. Further evidence of AA's linguistic 'echoes' of recovery can be observed. Loz frames his

psychological state using the same terminology found in AA's texts: 'for we have not only been mentally and physically ill, we have been spiritually sick' (AAWS, 2001: 64).

Ryan describes how, during his time as a member of AA, he had to deal with the deaths of two intimate partners. Both Loz and Ryan apply in common a method of mitigating against a psychological breakdown that could precede a relapse, and this was to access AA meetings and to talk to other people in AA. Ryan explicitly states that, without the help and support in AA, he would not have been able to cope with this loss and his own personal experience of rape.

My wife eventually became ill with the Leukaemia [...] Now, caring for somebody you know, you have to do everything for them. Everything. And I didn't know if I was capable. I didn't know if I had the patience, tolerance, and the courage really, because it does take a little bit of courage to fulfil that role properly. And I prayed on a daily basis to be able to do it, and I did do it. [...] I knew I wasn't capable of that sort of stuff, [...] and yet, I did it, and it turned out to be, very strangely, one of the most positive experiences of my life. But I would never have attempted it; it would have been a good one to go and get drunk on that, you know? That responsibility.

Interviewer: Yep.

Ryan: But I didn't, and I couldn't have done it without, a), the programme, b), the fellowship, or c), the belief in a power greater than me, and that's just my only way of understanding it. And when she died, in 2001, it devastated me, even though it was expected. 'Cause, when you're a carer for somebody who's terminally ill, you operate a sort of barter system with God: if I do this properly, if I get her to eat, she'll live long enough and they'll find a cure. So you've got all this rubbish going on, and when the inevitable happens, it still hits you pretty hard [...] And then I had to pick up the pieces after she died. With regards staying sober, I was OK for nine months, and then one day just struck me. I suppose it were self-pity. I don't want to be here anymore. So, my way of committing suicide was drinking. So I bought a bottle of whisky, and in the big mirror in the house where we lived, I caught sight of myself with this bottle in my hand, and that stopped me, and I picked up the phone and rang somebody, and they listened to me pouring it down the sink.

Interviewer: Did they?

Ryan: And I got to a meeting and shared about it. And that was the only time at that particular time that I wanted to drink. [...] I started to get the flashbacks again about the stuff I'd never shared, when I was in prison, and periodically, over the next few years, they got worse and worse, and then they'd go away again and then come back again, you know? And after about five years after my wife died, I met somebody else, in the fellowship, and it was when I had a particularly bad flashback in her company, I opened up and told her what it was all about, and I'd never told a living soul, shared about what had happened when I was seventeen going on eighteen. Through the field she worked in, I eventually got in touch with a CBT counsellor, and after a period of counselling, long period, and also talking about this stuff, the rape, rapes and what was done to me when I was in prison, the effects of it have lessened over the years. If I get stressed now, or am not sleeping properly, they can come back again, and what actually caused it, the time when it came back with a vengeance, when my partner obviously witnessed it, I found a photograph of me taken about three months before it happened, in Gibraltar, sat under a bloody palm tree.

Interviewer: [Laughs].

Ryan: it brought it all back to me. And that night, I was in a queue, in a garage in XXXX, to get my car washed, and I went to get change for the car wash machine, and somebody had jumped in front of me, and I just flipped, and I tried to throw him under a bus, and I knew myself what it was, then it was this photograph. [...] But me and my partner got together and we were due to get married two months ago. But in April this year, she died of cancer, which we didn't know she had, so I'm now in the stages of getting over that. But you know, it's not rocket science: I'm a recovering alcoholic, so I go to AA and talk about it, and I talk about it to people that I trust, people on a one to one, that I've known for years. Grief for an alcoholic's no different from grief for anybody else. The only difference for us is that we may use it as an excuse to lift a drink. And that's all it is, an excuse. There's no reason for me to lift a drink, just ten thousand excuses. I try to remember that, and going to the meetings and talking to people certainly helps. And I retired eighteen months ago, best career move I ever made [Ryan, early 60, 26 years of continuous sobriety].

Ryan's quote is a vivid account of how, under extreme circumstances, he remained sober after suffering the psychological consequences of rape and bereavement. Ryan sought professional help from outside of AA to deal with the psychological effects of his rape. Despite the use of professional counselling, Ryan reiterates the therapeutic value of attending. Recourse to AA's therapeutic mechanisms, a reliance on one's supportive network of recovering alcoholics, characterises the behavioural responses in the wake of distal, threats to sobriety.

In summary, the data and analysis presented here represent types of adverse or stressful life events that are common occurrences amongst both alcoholic and non-alcoholic populations. Chronic ill-health, bereavement, loss, and issues at work, have been categorised as distal threats to disengagement. Behaviourally, members of this study find a reliance on the therapeutic mechanisms provided by AA. These are accessing support either at an AA meeting, or in one's close network of recovering alcoholics, or reading AA's literature. From reading AA's literature the central tenets of AA become cognitively embedded. Understanding AA's principles of recovery, helps to frame present negative effects, allowing a degree of separation from the problem to occur. This becomes a psychological resource to be used in the event of proximal threats to disengagement. When proximal threats occur, AA members validate their responses by anchoring their reflexive capacity in AA's core literature, the Big Book (AAWS, 2001) and the Twelve Steps and Twelve Traditions of AA (AAWS, 1952).

6.3 Proximal Threats From Within AA

There are also threats to an individual which have emanated from within AA. These are the salient findings which shed further light on the functioning of the organisation. This section illustrates some of the negative consequences, or perceived negative consequences, of participation in AA. At a group level, threats have emanated from within AA itself. Examples include splinter groups form as a reaction to a perceived ‘softening’ of AA’s approach to the Twelve Steps and sponsorship. At an individual level, proximal threats may emanate from a specific individual, a fellow member of AA.

6.3.1 Dealing with Perceived and Actual Aggression

‘We are people who normally would not mix’ (AAWS, 2001: 17).

AA’s literature and the common discourse of recovery heard in AA meetings reveals that there is a demographically mixed group of persons who attend (AAWS, 2001, xxiii). Differing opinions and personalities naturally come to the fore when speaking about personal experiences and interpretation(s) of the Twelve Step program. Bullying is proscribed in AA, as it is in other civil organisations. A more usual form of aggression occurs when a new member arrives at AA meetings heavily intoxicated. Disruption can occur, as the intoxicated interrupts AA’s standardised meeting format (Denzin, 1986 & 1988; Smith, 2007). Aggression is not directed at any one individual in this context but members of AA often feel threatened and experience a degree of psychological discomfort. Older, generally male members often resolve the matter, and this may include asking the individual to leave, or removing the individual using physical force.

Andrew recounts a series of incidents that threatened his attendance at AA meetings. Using Andrew's narrative as a small case study here reveals tensions in his account regarding blame attribution. Andrew indicates he has felt bullied and victimized by another member of AA. However, reading Andrew's account it could be concluded that he was equally aggressive in his response. Ultimately Andrew dealt with the problem, another member of AA, by simply attending other meetings not usually frequented by the other person. Importantly, one of AA's key strengths as an organisation is the ubiquity of its meetings, which allow a fluid membership and promotes free movement between groups. Whether one chooses to frequent other groups is a matter of personal choice.

...there was somebody who goes to a meeting I go to who I know is not is not a simple alcoholic. He's got other stuff running alongside, and he's had run ins with all sorts of people in the Fellowship, but he sits in the meeting and he just stares at me with a really, very angry look on his face [...] I was feeling abused by this man but, for whatever reason, and whatever level it's got under my skin, my psychology, my whatever, [...] I had to say something, 'cos this was way out of line, so I took him to one side and said, "I've got to fucking tell you how I'm feeling about this, how you sit in meetings, you stare with this angry look on your face", and I said "It's not acceptable". [...] I feel really fucking intimidated by what you're doing, and it's got to stop. You're making my time in AA really unhappy" [...], and then he says "you're not going to tell me which fucking meetings I can go to" [...], and I said "that's fine, I can't but I just need to know a couple of home groups that I don't have to sit there and suffer your abuse", and he said "come outside and I'll show you what abuse looks like", you know, and I thought, I said "I don't need this, just leave it" Anyway, so.... He's not going to change so for me to be able to sit in a room with that person and feel relaxed and comfortable and not threatened or abused or anything. I haven't figured that out yet, and maybe I'll have to go and get some outside, more therapy to unpack that and find out what it's really about, 'cos I know he's pushing my buttons, and in a way he's been sent to teach me something [Andrew, early sixties, 25 years of continuous sobriety].

Andrew feels 'abused' by another member of AA and asserts that this person has '...other stuff running alongside...', with whom other members of AA have had '...run ins'. Andrew's remark, 'other stuff running alongside', is a reference to perceived issues of co-morbidity. This is a pervasive view, expressed by others in this study, that some members of AA have psychological/emotional problems other than alcohol, a point that will be returned upon in the section below on sponsorship. Part of Andrew's strategy to overcome his feelings of abuse is to ask for this person to agree not to attend some of Andrew's 'home groups'. A 'home group' is usually singular and is attended most frequently by an AA member. Denzin (1987:212) denotes a home group as one that a member may have first attended. Other members of this study describe their choice of 'home group' as defined by location or one that their sponsor also attends.

Andrew's perception of these events demonstrates a deficit in attributing intent. Aggressive behavior on Andrew's part is manifested in his verbal response, 'I got to fucking tell you...'.

Deffenbacher (2011) presents a working model of anger. The author argues that anger arises from out of three converging factors: triggering events, pre-anger state and appraisals. First, the triggering event, 'he just stares at me', determines Andrew's initial interpretation of the problem as unprovoked and threatening. Second, the pre-anger state incorporates a cultural or familial dimension. This dimension includes previously learned ways of communicating emotions, notably anger. The rules for appropriate responses are coded according to a person's cultural/familial background (ibid). Earlier

in the interview, Andrew spoke openly about some of his behaviour that he still finds problematic:

Andrew:... So, the Steps have given me a framework, they've given me an opportunity to look at my behaviour....

Interviewer: What sort of behaviour?

Andrew: Behaviours around this, this mainly kind of insecurity, mainly to do with, 'cos I'm the product of a very uncertain, emotional home, I mistakenly believe that I was responsible for how everybody was feeling. And, if you walked in here with a funny look on your face... I did it the other night, I went out for dinner somewhere and met someone for the first time who's an academic,...] And he got very quiet after dinner. Not met him, there were other people there and, of course, I came home and said "Thank you, thank you, thank you" 'cos I can be a bit boisterous and a bit gobby, but my first thought still was "I wonder if I said something that pissed him off?" And that's a long, slow job, something that I call co-dependency, what you might call co-dependency, is an addictive kind of relationship, mistaken notion around who's responsible for how I'm feeling in any given moment and (pause) what governs my behavior [Andrew, early sixties, 25 years of continuous sobriety].

Andrew confirms he is the 'product of a very uncertain emotional home', and that he often misinterprets the behavioral responses of others. These facets of Andrew's pre-anger state confirm and consolidate Andrew's understanding of himself and his behavioural and psychological responses. Andrew gives two examples: one hypothetical, to illustrate his maladaptive interpretation of facial cues, 'if you walked in here with a funny look on your face'; and an explicit example whereby Andrew thinks he could be to blame for a dinner guest's ostensible post-prandial quietness. Deffenbacher's third component is appraisal, simply the threat of something that should not happen, and this is an acute reaction to threats that trespass upon one's values and expectancies in a given domain: an AA meeting. Levels of anger can increase if a

situation is over-appraised and projected negative outcomes are amplified. AA members are inculcated with the belief that attendance at meetings is a primary defense against relapse. Andrew continues:

...in AA when your happiness or your sobriety depends on going to some meetings where, that's one of the things that bothers me. There may be 20 people in that meeting who I really love and respect and can't wait to listen to and there's this one kind of beacon of unhappiness just sitting there with his mental illness stuff and his, whatever it is.

AA members are taught that there is only dysfunctional anger, that it is never a productive force. Step Ten advocates that 'It is a spiritual axiom that every time we are disturbed, no matter what the cause, there is something wrong *with us*' (AAWS, Step 10, 1952:92, emphasis in original). Andrew eventually resolves the issue by speaking about this with other members of AA. Locating the problem within himself, Andrew, rather than use the Twelve Steps, a 'framework for looking at behavior', decides that this issue is related to the concept of co-dependency, and that more therapy is needed to 'unpick' his problem. Broadly, co-dependency is described as a dysfunctional perception of social interaction: feeling worse about yourself following/during social interaction (Stafford, 2001). Novaco (2002) reports that anger can be a resistant affective state to treat in individuals for whom anger has become functional. Further, the author observes that resistance to positive change may not be overt, because anger can be nested within other maladaptive functions and beliefs about one's identity. Andrew specifies co-dependency as an ongoing issue that, in the above example, manifests periodically during or following social interaction. Thus, Andrew's self-diagnosis of co-dependency could be masking anger as the primary affect disorder that ought to be

addressed. Novaco (2002: 42) continues: ‘Anger is often entrenched...and may be derivative of traumatic life history’, in Andrew’s words he is, ‘...a product of a very uncertain, emotional home’.

Smith’s (2007) study of AA reflects the same responses to AA’s norm violations. Drunk and disruptive members are tolerated, to a certain degree, they are not ‘ejected’ from the meetings, but are sometime led away by more experienced members. The use of physical force and/or verbal threats is largely uncommon at AA meetings. This is perhaps surprising, given the strong association between alcohol abuse and violence (White et al, 2012). The combined effects of excessive alcohol and poor affect regulation are associated with poor treatment outcomes. One of the therapeutic goals in AA is successful affect regulation: references to the amelioration of anger and the negative consequences of unsuccessful regulation feature strongly in the AA literature (AAWS, 1952: 37, 48, 59, 67, 90 &103).

6.3.2 Preserving Ideological Purity and Program Fidelity

Another potentially disruptive issue that occurs in AA meetings and provoking strong reactions amongst members of AA are the consequences of ‘fundamentalism’. Fundamentalist and dogmatic approaches to AA’s Twelve Steps and the AA literature in general, stem from either individuals or sub-groups within AA. Given the centrality of AA texts and the frequency of both overt and unconscious references to these texts that feature in every narrative in this study, it is perhaps expected that a degree of

fundamentalism exists amongst some AA members. Phil observes groups and people in AA that are following ‘the steps properly’:

Interviewer: Can you tell me what your relationships are like with people in AA?

Phil: Depends on the people. With my elders and betters in AA, people who’ve taken the steps properly and have been sober a long time, I have very good respect and I listen to them and try – same as I did at the beginning, just try and pick up what they’ve got. Younger people I find are a great inspiration. Time wasters, of which there are many, I don’t waste my time with them.

Interviewer: Can you give me an example? You mentioned doing the steps properly, so for it to be done properly, they must obviously be an opposite of this.

Phil: Yeah, there was a non-god group once in xxxx Northern town once.

Phil: You know, [assumes regional accent] “We don’t have god in AA, there’s no such thing, we don’t believe it. We stay out of wet places, we talk about our drinking problems and we stay sober.” That’s not AA to me and I don’t want anything to do with it. I’m a bit, you hear about AA step Nazis and that, I’m of that ilk. People who try and do the will of a higher power of some variety, doesn’t matter what; someone who’s taken the steps and suffered the pain; people who are prepared to be honest and open. One of the tenets of AA is complete and absolute honesty, isn’t it? When I see someone come in one week and everything’s great, and the next week they’re falling apart, and they’ll talk about it in great detail, and they talk about how they’re using the program to get where they want to be. You hear of people trying to borrow money in AA, I’ve no time for it at all [Phil, early fifties, 20 years of continuous sobriety].

For Phil, his strict adherence to AA’s Twelve Steps and belief in God is a means by which he can assert his identity as a ‘Step Nazi’, as someone who is doing the program ‘properly’. Threatened by the existence of a group of recovering alcoholics that do not necessarily recognize the need to believe in God or the Guidance of a Higher Power,

Phil distances himself. The group to which he refers does appear to be espousing at least two of AA's core recovery practices, staying away from places that serve alcohol and talking about their problems, a necessary function Phil later refers to. Phil explained earlier in the interview how he experienced a profound spiritual awakening:

And I went and sat there [Church], and I felt the presence of Jesus as strongly as anything I've ever felt, and that's where my spiritual awakening occurred.

Phil's conversion to AA's principles and world view is deep and enduring. Greil and Rudy (1983: 16) observe that 'At an ideological level, old-timers try to develop converts commitment to the organizations beliefs and values, specifically the Twelve Steps and Twelve Traditions'. Smith (2007) notes that old-timers, those with many years of continuous sobriety, often have the reputation of 'AA gurus' bestowed upon them. AA's 'flat', non-hierarchical membership structure is threatened by such individuals. Tradition Twelve (AAWS, 1952: 188) warns specifically against such controlling characteristics, and reminds members to place the principles of the AA program and overall ideology before the personalities of other members.

Phil's frustration at members of AA who appear to be less committed to the AA program is born from his own fundamentalist approach to AA.

People who try and do the will of a higher power of some variety, doesn't matter what; someone who's taken the steps and suffered the pain; people who are prepared to be honest and open.

Monroe and Kreidie (2002:21) define behavioural dimensions of fundamentalism that emerge in a response to threats to the 'purity' of ideological beliefs. Amongst these are persons and groups that are 'highly devoted, ready to live an austere life with struggle and sacrifice', much like those individuals who have, 'taken the steps and suffered the pain'. Altemeyer and Hunsberger (2009) argue further, that fundamentalism manifests strongly in those individuals for whom authoritarianism and an unswerving conviction in the existence of God are core beliefs.

Members of this study reported that, periodically, AA was subject to 'infiltration' by either religious organisations, looking to colonise their own organisations, or variants of AA that were described as more fundamentalist, taking a much harder line in terms of 'working the program'.

Jane: At the moment there's a bunch of people running round the fellowship who call themselves, oh god, what is it...um...um...it's the er, the Real AA, it's not the Real AA, I'm thinking of the Real IRA but its similar... [laughs]...yeah. Um, it's something like Rapid Recovery or something like that, I can't remember what they call themselves, but they are characterised by a very literal approach to the Big Book, which involves people getting down on their knees and crying out to their gods to save them and anybody who doesn't do it that way is self-evidently doomed. I really annoy these people because I've been sober for 19 years and I don't appear to do any of this stuff and [laughs]... and it seems to be going alright at the moment but I have never been terribly comfortable with bigots....

Interviewer: Mmm

Jane: Um, and I think, if that's the way that works for them that's absolutely fine, but please don't shove it down my throat any more than I'm than I'm going to shove my atheism down yours. It's, yeah, it's about *living and let living* [Jane, early forties, 20 years of continuous sobriety].

In a further interview, Penny speaks of another splinter or recovery group, for whom a more dogmatic approach to AA and the Twelve Steps supports their beliefs on achieving lasting and meaningful sobriety.

Interviewer: Can you tell me about the primary purpose element you mentioned – what that's meant to AA?

Penny: I think they're a bit fascist approach to it: this is the way to do it, there is only one way – limited interpretation, but I do view it as being dangerous – because to me, when I was ill, I'd have loved someone to say to me, I don't think you're a real alcoholic, and I've listened to some Primary purpose tapes of conventions in Dallas where it originated and I find them scary – I'm so and so and a REAL alcoholic. That, as it says in the book, will *raise the bottom*. I, myself, am a low bottom case, but most people who come into AA are not, they are functioning with kids and jobs.

Interviewer: Do you think that Primary Purpose [movement] would exclude a lot of people?

Penny: Yes, their view is there are problem drinkers, not real alcoholics. I'm not prepared to define what an alcoholic is. I go with the, count yourself in if you want to, there's only *one criteria for membership – if you want to stop drinking*, come along [Penny, mid-fifties, 12 years continued sobriety].

Both Jane and Penny describe those individual members of splinter/sub AA groups as having literal or limited interpretations of the Big Book and the AA program. Of interest, from the data gathered, it appears that both 'sides' take refuge and conviction for their behaviours from the AA literature. The relevant discourse is italicised. Jane refers to one of AA's slogans that adorn the walls of AA meetings, Live and Let Live, as a pragmatic approach to tolerance. Penny further explains that members of the Primary Purpose movement regard 'real alcoholics' as 'low bottom cases', for example

those for whom imprisonment and homelessness have characterised their drinking patterns. Step 1 (AAWS, 1952:23) describes ‘low-bottom cases’, but, as AA gained popularity, ‘Alcoholics who still had their health, their families, their jobs...’ were attracted to the organization. The purpose of Step One is to underscore the ‘unmanageability’ of alcoholic drinking patterns, to attune a person to the concepts of control (or lack, thereof), and the ‘progressive’ nature of alcoholism. Thus in order to remain as inclusive as possible, Step One states, ‘It was obviously necessary to raise the bottom the rest of us had hit to the point where it would hit them’. Thus the ‘net’ is widened and supported by Tradition Three, which Penny paraphrases as a desire to stop drinking. Further, the concluding sentence to Tradition Three (AAWS, 1952: 149, *italics in original*) denotes AA’s fluid arrangements concerning membership: ‘any alcoholic is a member of our society when *he* says so’.

6.3.3 The Limitations of Sponsorship

Smith (2007: 84) characterises the role of a sponsor in AA as one that, ‘...usually involves strong affectional ties’. The sponsee/sponsor dyadic relationship is a normative feature of AA where a sponsor may play a pivotal role in the recovery of an AA member and exert a significant influence in the life of a sponsee. This relationship may endure far beyond early recovery.

One of the key features of success in AA is acquiring and employing a sponsor (Whelan et al, 2008; Kelly et al, 2009). The difficulties and limitations of the sponsor-sponsee relationship are demonstrated in the following examples. In keeping with the focus of

this chapter, the following examples given demonstrate and describe the problem, and the mechanism(s) used for coping. These mechanisms range considerably, from a belief that without a sponsor, relapse is merely a time dependent eventuality, recourse to the AA literature or a more pragmatic strategy that may simply involve allowing the, initially therapeutic dyadic relationship to decay naturally.

Young (2009) describes sponsorship as a ‘protective factor’, lessening the chance of relapse. Little research, thus far, has documented or described any of the negative consequences of such dyadic relationships, the breakdown of which may threaten disengagement with AA. Difficulties with sponsorship range from a difference of opinion (in terms of behaviour), feelings of failure regarding the suicide of a sponsee and rejection by a sponsor/sponsee.

The key thing is sponsorship, meetings, and steps, those are the key things. And I always say, if any of those things are missing, there’s a link missing in my recovery. Because I can remember when I didn’t have a sponsor for twelve months, and I found it really difficult, and I came close to leaving the fellowship and it just became really difficult [Jake, early 40s 17 years of continuous sobriety].

Jake reflects the teachings of AA regarding alcoholism: that without the support of other AA members, in particular that of a sponsor, recovery is at best problematic. Consequently, Jake found a new sponsor with whom he felt comfortable and resumed a cyclical recovery plan, constantly working through the Twelve Steps. Whelan et al (2009) identified the main functions and roles of sponsors. The author reports some sponsors displaying ‘controlling’ characteristics but negative effects remain relatively unexplored.

The sponsor-sponsee relationship may break down due to a simple difference of opinion on issues not relating to AA, or as a part the natural process of relationship decay.

... we realised our lives were going in very different directions and eventually her views on how I should live, it became uncomfortable. We were butting heads a lot, erm,, but I think sponsorship allows for that, it allows somebody to be the right sponsor for you at the right time and you may be sometimes you outgrow sponsors [Jane. Early 40s, 20 years of continuous sobriety].

Brad gives an interesting example of individuals who may have other psychological problems, which make sponsoring problematic.

I had to sack two sponsees because in both instances they had deep psychological and psychiatric problems that were so far beyond my skills and experience that it was obvious that they needed quite specific help. [...] We could talk about his alcoholism until we went blue in the face, because he was an alcoholic, is an alcoholic, but I could never, didn't have the diagnostic skills to separate out his alcoholism and his hypermania. [...] The other one was a guy who suffered from some personality disorders and long term depression [...] I passed him [first sponsee] off onto my sponsor who coped with him not particularly well, and he bounced around between a number of people, and when I went back down South to live, although it was only for eighteen months, he approached me and asked me to be his sponsor again, and I said to him, if it didn't work last time, why do you think it's going to work this time? [...] So, I think sometimes, with sponsorship, it's important to know what you can and can't do.

If they have access to a counselor, psychiatrist, depends on circumstances. If they are getting that help then they can become sponsorable. Frankly, some people are just not going to get it. You can't help everybody save themselves Sometimes it's about your own ego, and that's more to do with your own beliefs about how effective you can be. But it's like it says in *How it Works*: there are those that are *constitutionally incapable*. It's just the way it is [Brad, mid-fifties, 21 years of continuous sobriety, my emphasis].

The co-occurrence of alcoholism and other psychiatric disorders, such as anti-social personality disorder and depressive disorders, is well documented; and these

relationships, depending on the study, demonstrate either high or weak associational strength (Helzer and Pryzbeck, 1988). Nevertheless, the link has been identified. AA members in this study have frequently made references to individuals with other perceived, psychiatric problems. There are three salient points to be explained here in relation to Brad's understanding of 'unsponsorable' individuals: 1), issues of co-morbidity; 2), self-evaluation in terms of 'ego'; and 3), referral to AA's central text. Points 1 and 3 are linked. Brad's attributes his failure in his role as a sponsor to issues of co-morbidity. To neutralise this failure further, thus protecting himself from reproach, Brad quotes a passage from The Big Book (AAWS, 2001: 58, my emphasis), which clearly states: 'Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are *constitutionally incapable* of being honest with themselves'. However, this often-quoted passage does, five sentences further, state that 'There are those, too, who suffer from grave emotional and mental disorders, but many of them do recover if they have the capacity to be honest' (ibid). The second is a reference to the self in terms of ego, and perceived abilities relating to the role of the sponsor. An artifact of active alcoholism, ego distortions manifest as feelings of omnipotence, as Denzin (1987: 25) comments: 'Alcohol creates illusions of power. It fuels feelings of grandiosity'. Brad is referring to the ability to know one's limitations regarding the power to help another alcoholic as a sponsor. The inference here is that persons taking on the role of sponsor for individuals with perceived co-morbidity are doing so because their 'ego' exhibits characteristics of the still drinking alcoholic.

Sam offers another perspective on 'unsponsorable' persons in AA:

I don't think there are unsponsorable people, but here is a lot of poor sponsorship. There are only few with people with a pure AA message. What happens is there is now a therapeutic logic, which is more counselling. AA sponsoring is different. It is just to guide a person through the 164 pages. Sponsors are not qualified to counsel on sex, debt, gambling. It's not life coaching. You can't tell people not be in relationships for the first twelve months, or shouldn't be taking medication, just because they've been sober for a few years. They can't supersede medical knowledge. It's insane thinking. Sometimes AA isn't the place for them. Its not about mental health; it's just about staying sober.

Interviewer: Where do you think this 'therapeutic logic' has come from?

Sam: Therapeutic logic has seeped in from the therapeutic communities that have used the Twelve Step program. It is partly the Hazeldon publications, because they're AA approved publishers, but they also operate residential re-habs, so the extra therapeutic language then merges with the AA meetings when these people join AA in their local communities [Sam, early 30s, 9 years of continuous sobriety].

Sam's account reflects some of the tension that exists in AA. The boundaries between professional counselling and AA sponsoring have become blurred. As part of becoming an active member of AA, newcomers are strongly encouraged to get a sponsor and proceed through the Twelve Steps. Specifically, in Step Four, an individual is asked to consider areas of their lives, other than alcohol, that are problematic: 'When, and how, and in what instances did my selfish pursuit of the sex relation damage other people'; and with regard to debt, 'Did I recklessly borrow money, caring little whether it was repaid or not? (AAWS, 1952: 52, 53). As Sam's transcript and the text from AA's literature demonstrate, the boundary between a sponsor, counsellor or confessor is a contested area in AA, replete with tensions and problems. The AA texts ask a person to reflect on past misconduct, then, in Step Five, to share this information with a sponsor. Inevitably as one confides to a confessor the dynamics of the sponsor-sponsee are cast

as, hierarchical in nature. AA's position on persons seeking help following participation in alcoholism treatment external to AA is clear. Membership is open to any for whom the AA model of recovery is attractive, however as AA states, those new members that participate having recently exited treatment may well, 'reach us in a physically dry condition...But the mental obsession with alcohol may still be there...' (AAWS, 2005: 11). AA claims that government and 'industry' programs refer many alcoholics to the organization for continuing treatment (ibid). Frequently AA members work in formal treatment settings. Smith (2007:115) describes one long-term abstinent AA member becoming president of the board of directors of one rehabilitation corporation involved. It is therefore imaginable that the differing perspectives and treatment modalities become enmeshed.

Suicide attempts feature in Chapter Five, in the narratives of three respondents. The distinction to be made here is that suicide attempts, made before joining AA, helped to consolidate other pressures providing the initial motivation to change. In this example, Elaine provides a moving account of a sponsee that committed suicide, who had been sober 10 years and attended AA meetings frequently.

Well, I failed ultimately this year. XXXX, she, she took her own life and she died and I was with her for 10 years. Sponsored her for 10 years. I didn't know her level of suffering. How could I? Um, [pause] did I fail as a sponsor? Not for me to judge. Ultimately, yeah, but how responsible am I for that? That's, that's a terrible question that I've been tormenting myself with. But, she believed, Jamie, and I know this very well, she believed in the Twelve Steps. She knew it could change her life and she didn't pick a drink up, even to commit suicide, with drugs, with tablets [used to commit suicide], she didn't, not with drink ... [pause] ... she knew it was possible, she saw other people do it. She saw other people doing it. She knew what was possible but she knew what the programme could do for, to people's lives and, my god, did she try. But, her mental health destroyed her. [...] I don't know, I mean, I regret some things and I don't

regret some others that perhaps I should but, [pause] the only way I can sponsor is taking no, taking no credit for someone who doesn't drink and taking no responsibility when someone picks up...[.] I'll take no credit for you staying sober, however long it is, and I'll take no responsibility for if you pick up [AA slang for drinking]. And I've got to keep applying that to XXXX [name of suicide], bless her. Um, you know, there's no credit to anyone's life really other than that she didn't drink for 10 years and I can't be responsible for her getting to the stage mentally where she couldn't, she couldn't hack it. She couldn't carry on any more. So, [pause] yes, I do fail [Elaine, mid-fifties, 20 years of continuous sobriety].

Elaine takes psychological 'refuge' in the principles of AA, thus deflecting a proportion of guilt and emotional pain she feels at the tragic loss of a sponsee. Elaine frames the account using the three following devices learned in AA: (1), AA works -the suicide knew of the transformative effects of AA, and, 'importantly', she died sober; (2), AA cannot 'solve' all problems - some severe and enduring mental health difficulties are beyond AA's curative effects. This is a reference to the book *Alcoholics Anonymous* (AAWS, 2001:58), which regards the chances of those 'who suffer grave emotional and mental disorder' as having slim chances of recovery; Finally, Elaine takes little responsibility for any success or failure she may have had in the recovery of a sponsee. This is a reference to Kurtz's (1979) *Not God* thesis. Kurtz's twofold analysis of 'Not God-ness' revolves around the alcoholic's struggle for control, initially over alcohol intake, and then in recovery learning personal limitations, essentially not believing in God like powers of control. Pertinent to Elaine's account, Not God-ness here illuminates a willingness to accept personal limitation: taking no credit or responsibility for success or failure is registered.

Illustrating an example of homophobic prejudice, Patrick, recounts the experience of being rejected by a sponsor on grounds of sexuality.

Patrick: Um, this guy I mentioned, Um, [sigh] he didn't, he didn't like me being gay for his own personal reasons. Um, [pause], that was a big deal to me at the time, it wouldn't mean much to me now. Um, but so, basically I got stranded, I had no Sponsor. Er, and that was just after a period of weeks and, of course, that, that really affected me because I felt like I'd trusted someone to go through the first couple of Steps and, and, I don't know, I suppose the feeling was just rejection, um, you know, I tried to trust someone so I got pushed away. Er, so it made me reluctant then to ask anyone else. [...]Um, but there was this er, there was this lady called XXXX [name of Sponsor] who [pause], she had a bit of quirkiness but there was something about her, shares that seemed to strike a chord. Er, so after much dillying dallying I did ask her to be my Sponsor, and that worked rather well. We went over the same Steps again. Um, [pause] I, er, [sigh] ... I don't know, er, [pause], I liked an arm's length relationship with Sponsors.

Patrick reflects the need to find a sponsor that would be comfortable with his sexuality, and to progress his recovery through working the Twelve Steps. Patrick's strategy for coping with this threat is to keep his sponsor at arm's length, demonstrating Patrick's understanding of sponsorship as pragmatic and utilitarian. Sponsors and sponsees need not develop a relationship that includes a social dimension. For Patrick it is a relationship based on needs: to be guided through the Twelve Steps. In this instance, Patrick relied on the AA's written advice for sponsees seeking a sponsor with whom he considered compatible (AAWS, 2010). Further, Patrick reports at the time of the interview that he has not used the guidance of a sponsor for the last three or four years of his recovery.

Trust is central to the success of relationships in AA. Violation of trust in AA is prohibited, although there are no formal sanctions. Ryan gives the reverse of the previous examples, as the sponsee 'sacks' the sponsor.

...with first person that sponsored me, very early on in AA, I did step four and five with him, and he repeated a lot of it to people, and that's not me suspecting it, I know he did. He's dead now. But, turning a negative into a positive, I didn't get violent with him, which I wanted to, initially. The fact that I handled it in a decent way, and just sacked him as a sponsor, and got on with my life, and trusted that other people who now knew a hell of a lot about me that I didn't want to share, wouldn't spread it around, and they never did. I never had to ask them, it just was never repeated. And some of the stuff I shared was quite horrific, [...] So that was a bit of a false start. And it was only when, and I tried with other people and I was as honest as I could be, but I always held back the stuff about when I was in prison as a young person, you know, that, I'd locked that away so deep that I didn't even know how to start talking about it, really [Ryan, early 60, 26 years of continuous sobriety].

AA operates a formal request that members practice anonymity, in the form of a verbal reminder read out at the end of every meeting, 'The Yellow Card'. Displayed as part of the AA literature, and read by the meeting secretary, the text states: 'who you see here, what you hear here, when you leave here, let it stay here'. Ryan has divulged personal, sensitive information to someone with whom he had trusted, expecting confidentiality. Anger is generally regarded as a precursor and activator of aggression, of which violent action is a sub-category of aggressive behavioral responses (Chemtob et al, 1997). Ryan's new found supportive, non-aggressive relationships in AA's therapeutic social environment have been forged on the practice of pro-social interpersonal repertoires (Meichenbaum, 2005). Having developed better cognitive and emotional regulation skills in AA, provocation, trust violation, is not met with an aggressive response, even though Ryan 'wanted to'. In terms of self-efficacy, Ryan's better developed self-diagnostic functioning has brought about a positive outcome (Bandura, 1991). Time spent in AA, sober, has afforded Ryan an opportunity to develop a capacity for self-observation. Cataloguing previous behavioural patterns and strategies that have regularly led to negative outcomes, Ryan's intra-personal goal of non-violent responses has been achieved. Ryan's self-diagnostic functioning has improved, resulting in

behavior modification.

Summary

AA members access key resources which support an individual in a time of crisis. The overall aim of this chapter has been to shift the focus from short-term gains suggested in the original model - the 'virtuous cycle' of change - to incorporate analysis of both proximal and distal threats to disengagement from AA and the cognitive-behavioural coping mechanisms used to deal with them as evidenced in the narratives of long-term abstinent members of AA.. Behaviourally, individuals in this study respond to distal threats via recourse to their pro-abstinent support network: friends in AA. Threats of a distal nature are occurrences such as the death of an intimate partner or family member. Cognitively, proximal threats are dealt with 'linguistically', with regard to internal dialogue and 'self-talk'. Reference to the AA discourse such as common recovery couplets: AA 'slogans' (Live and let Live), and reference to AA's core texts, pepper the narratives of individuals as they make sense of and formulate strategic responses to threats.

Further, as argued, the model shifts; it becomes elongated over time to resemble a helix. The purpose of this approach is both analytic and conceptual. At a conceptual level, the purpose of this chapter is to 'test' the model proposed in chapter Six, the 'virtuous cycle', to tease out the strengths and weaknesses of the model. As a corollary of this analysis and approach, we can begin to observe some of the inconsistencies and weaknesses of the AA Twelve Step program in terms of AA's therapeutic practices.

Engagement with AA meetings, and maintaining close friendships amongst AA members, are the primary means by which long-term sobriety is maintained. Specific Steps taken from the Twelve Step programme, although occasionally mentioned overtly as a means of support, are integral to the therapeutic process for long term abstinence. The Twelve Steps, and other examples of the AA literature, can be ‘heard’ and identified as linguistic ‘echoes’ in the respondent’s narratives. These ‘echoes’ are deeply rooted in the maintenance of the self, as a recovering alcoholic in AA. Employing these therapeutic expressions thus helps to re-establish psychological stability and reduce the negative effects of the threat. This is a linguistic strategy for understanding and managing threats to disengagement, whether these threats are proximal or distal in nature, sobriety has been maintained.

In AA success is always measured by one’s ability to do so without having to ‘lift a drink’. AA members interviewed for this study hold negative or adverse life experiences in a relational capacity to the importance/significance of maintaining sobriety. The importance AA places on abstinence are understood to be the ‘best’ indicator of success in AA. Constant awareness of and seeking out one’s ‘character flaws’ are principles that AA suggest might help pre-empt a relapse. The consequences of these practices, and the more permanent changes which have occurred longitudinally, will be studied in the next chapter.

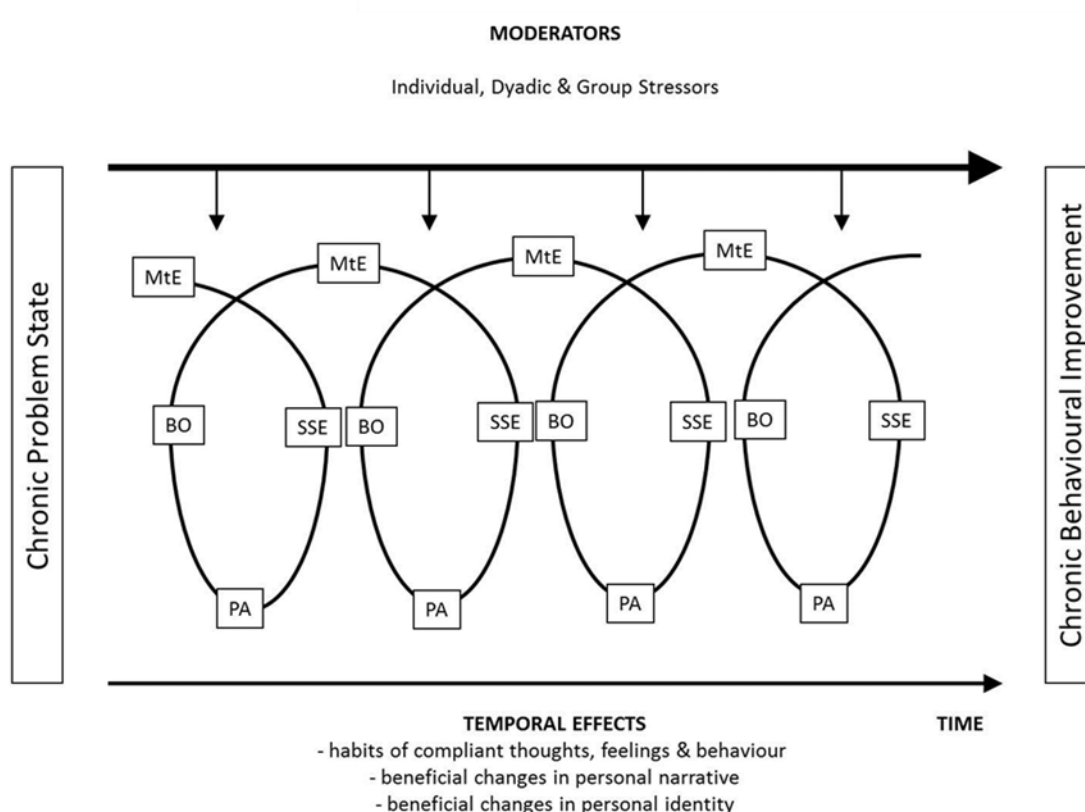
Chapter 7: Pre-Requisites for Sustained Behavioural Change: The Reorientation towards Self-Control

Chapter Five described and analysed the key motivating factors that led an individual to seek help, participation in AA's structured social engagement increased access to and acquisition of social capital. In terms of personal agency, improved self-efficacy enabled individuals to pursue socially approved goals. The presence of identifiable 'progress' helped to maintain the initial motivational momentum to engage, and continue to engage, with AA.

Chapter Six analysed how, for the abstinent members, the model shifted over time from a 'virtuous cycle' of positive changes to an elongated, helix. The key argument made was that, AA members managed threats to disengagement by making use of an established close network of friends and by referring to a supportive cognitive scaffolding of linguistic expressions and associated self-regulatory concepts derived from AA. These are the cultural, linguistic 'echoes' that have become embedded in the narratives of the respondents and are also in evidence in this chapter. Where relevant, the language identified in the narratives of the respondents that is also found in AA's literature has been emphasised. The chapter also described the variety of negative experiences that threatened disengagement from AA, or 'spinning off the helix'. Visually one might imagine the 'stressors', exerting pressure to 'push' the individual off the helix. Adding a temporal dimension to the model, a person travels along the helix towards 'Chronic Behavioural Improvement', the chief goal of recovery. The model

below allows us, to ‘see’ this line of travel, with the associated conceptual components interacting with the identified moderators, and the temporal effects.

Figure 9 - Hypothetical Model of AA-Mediated Behavioural Change: Temporal Components



This chapter assesses the long-term effects of membership of AA among the study cohort. Conceptually, these effects are represented above on the helix as Behavioural outcomes (BO). As beneficial changes in Personal Agency (PA) become fast and stable components of a person’s identity, changes in behaviour are observed. Describing and analysing the complex interplay between Personal Agency and Behavioural Outcomes is the overall focus for this chapter.

One of the aims of this chapter is to explain, using the data, how contrary to Maruna (2001), long-term abstinent members achieve recovery by *accepting* a ‘condemnation script’. Maintaining behavioural change for members of AA means frequent examination of one’s thoughts, and taking responsibility for one’s actions. An individual is encouraged to accept the permanence of their status as an alcoholic. This is achieved via participation in AA’s therapeutic practices and acceptance of basic AA tenets, set out in the Twelve Steps (AAWS, 1952). Cognitive restructuring occurs following adherence to AA’s principles; this is conceived of as the development of internal support. This internal support mechanism encourages ‘habits of abstinence’, the practice of moral reflection. Further, external support mechanisms such as AA’s literature and other group members, facilitate enhanced levels of self-control. Transformations of personal agency, specifically increases in the capacity to exercise and ‘master’ self-control emerges as a core achievement. Bandura’s (1977, 1991 & 2005) self-regulatory mechanisms offer a useful analytic framework to understand how behaviour is shaped. Re-orientating one’s attitude towards self-control is thematically at the core of this chapter.

As a person develops internal and external support mechanisms, a third resource, the acceptance of a Higher Power, supports the successful abstainer. These are the key goals to be achieved that help long term members of AA maintain abstinence and behavioural change, aided by the development of a spiritual dimension. Whether an individual chooses to call this a spiritual dimension or a relationship with a Higher Power, it is a prescribed outcome of working the Twelve Steps, particular the Twelfth Step (AAWS, 1952: 109). There is considerable variation amongst the members of this study in the approach to, understanding a Higher Power. Once acquired, this results in a

greater reflexive capacity and guides action, with a particular focus on the ability to make moral choices. How one develops self-control, while ceding this to a Higher Power is explained as the fundamental ability to accept that one is ‘not God’ (Kurtz, 1979). The Higher Power thus becomes a projection of an individual’s increased capacity for self-control. The conclusion to be drawn from this is, self-control is socially as well as psychologically constructed: it is psycho-social.

7.1 Framing the ‘Recovery Script’ in AA

The trouble with being sober a long time is you start to think you’re alright again, and you’re well again [Richard, late 60s, 30 continuous of sobriety].

Recovery in AA is ‘scripted’ for the individual, no matter how long abstinent an AA member is, there is always the risk of a return to drinking. When a person joins AA, they are inculcated into AA’s theory of alcoholism. This theory holds that alcoholism is a disease, an illness or an allergy that one can never be rid of (AAWS, 2001: 18). AA conceives of abstinence as an ongoing project of self-development. To achieve abstinence, an individual embarks upon a process of cognitive restructuring. This process requires that a person accepts the basic tenets of AA and the wider therapeutic practices, such as the aggregation of a pro-abstinent supportive network. In so doing, habits of moral reflection become embedded cognitive practices. These practices stem from AA overarching theory of the permanence of the alcoholic status of the individual.

And for me, the lesson is that it’s not overnight [sustained positive change], it’s very, very slow, it’s on-going forever as long as I’m alive... [Mary, mid-40, 13 years of continuous sobriety].

Mary's quote articulates AA's perspective on recovery: you can never be cured; sobriety is contingent on continued therapeutic engagement. AA teaches that, 'Our liquor was but a symptom. We had to get down to causes and conditions' (AAWS, 2001: 64). As Denzin (1987) observes, uncovering these causes and reasons for destructive drinking is conceived to help prevent relapse. AA re-frames alcoholism as a problem of existence, the causes for destructive drinking lie in flaws of character. These flaws govern mal-adaptive responses to, and interpretations of events. These defects of character are defined by members of AA and in the literature as stable personality traits (see Step Six & Seven, AAWS, 1952: 64-71). To demonstrate this Lenny's narrative reveals one of his key insights,

The way you are drunk is just an amplification of the way you are, I believe, and I do actually believe that to some extent [Lenny, early 40s, 9 years of continuous sobriety].

Without AA's Twelve Step treatment, cognitive distortions will prevail and result in negative responses to stressful situations. In terms of treatment, AA's Steps are designed to align a person's interpretation of external events with AA's philosophical strategy of responsabilisation. If this is not achieved, then risk of relapse is increased. Step Six (AAWS, 1952: 70) warns the individual to practice moral reflection and attempt to curb one's excessive desires, because, 'Delay may be dangerous and rebellion may be fatal'.

Discussion at AA meetings revolves around dealing with life's problems sober, often in relation to working the Twelve Step program and matters arising from the utilisation of

a specific step, or the program in general. Specifically Step Six asks that with God's help defects of character, or 'emotional deformities', be removed. For example, anger, lust envy, (AAWS, 1952). Humphrey (2004: 38) lists these defects as, 'grandiosity, infantile narcissism and selfishness'. The consequences these untreated 'defects of character' often mean collision with other people. Step Ten encourages, '...unsparing self-survey and criticism', and again, 'It should continue for our lifetime' (AAWS, 1952: 90; AAWS, 2001: 84). The respondents in this study navigate AA's prescribed route to recovery: looking for evidence of alcoholism, through listening to people at meetings and working the Twelve Step Program.

I will never be cured of this illness, but if I do what is suggested, I can have a daily reprieve. I believe I was born an alcoholic – it was just waiting for some point in my life to happen – and I believe I will die an alcoholic, so, to me, the best way of staying sober is still to be involved in AA [Jill mid-fifties, 14 years of continuous sobriety].

Jill's conviction that a complete cure for alcoholism is impossible demonstrates AA's paradox. Defects of character can never be removed completely, AA members are to be content with improvement, rather than complete eradication. The lingering defects of character are evidence that one is an alcoholic, and will therefore have this condition for life. Any statement that proclaims the individual free from emotional distortions/disorders would be tantamount to a 'full recovery'. Logically an individual would then be capable of drinking again, thus a circular tautological situation would occur whereby one could not, according to AA, have been an alcoholic in the first place.

7.1.1 Accepting the ‘Condemnation Script’

Always judging people, always comparing myself to other people, always, it being one of the most crippling things of my life, threading through my whole life. I think [Andrew, early 60s, 25 years of continuous sobriety].

AA members achieve recovery by accepting a ‘condemnation script’. Following Maruna’s (2001) contribution to explaining and analysing the process of desistance, members of AA accept a condemnatory dimension of their lives and motives as a result of working through the Twelve Steps. In contrast to Maruna’s sample of persistent offenders, analysis drawn from the narrative accounts in this study, finds little support for, ‘The condemned person...reserves[ing] plenty of blame for society...’ (Ibid: 75). On the contrary, individuals interviewed use AA’s framework for understanding this script and are encouraged to take responsibility for their actions, locating ‘blame’ within themselves (Borkman, 2009). Defects of character are to be evaluated and efforts towards ameliorating the worst of these effects are strongly encouraged, via internal and external resources of support.

Sarah describes the radical change in her attitude towards sexual relationships once she started to recovery from alcoholism.

Sarah: [...]the only thing that I did, from a moral point of view, is I slept with anybody and everybody, erm. Yeah. I never paid a taxi driver in money. I think I must have had quite a reputation. I also ended up with two Samaritans coming regularly to see me, both of them married, which wasn’t good. It was just what I did, what I did in those days. Hmn, it’s bringing all sorts of stuff back. When I was in XXXX, I was screened, had cervical screening, I had cervical cancer, and at the time I can remember thinking, yep, that’s about right, I deserve that; it felt right, it felt like I should have that, it felt like some sort of punishment for the way that I’d behaved, ‘cause you only get that if

you've slept, well, you do – virgins don't get cancer of the cervix. It felt like that was the right thing to happen, it felt like – yeah, I slept with a lot of married men, yeah.

Interviewer: Hmn, right. OK. And how about those sorts of behaviours now? Now you've been in your recovery.

Sarah: Oh that all stopped, as soon as I went into recovery. It's had, it's had an impact on me, it's left me, well, I don't know if that, well, it is that, but it's also talking to you earlier¹, about the men that I'd had problems with, before I'd even started drinking, and it's left me with this general sense that sex is dirty, sex is, I don't have a very healthy attitude towards sex, really, erm, and, yeah, so as soon as I stopped drinking, that all stopped. But that's a different person, it's a bit like being schizophrenic really; the person I was then and the person I am now are really very different, and I could almost describe myself as a bit prudish now; once I stopped drinking, I became a bit prudish, really, about it all, it was all [laughs] not something nice girls do [Sarah, 60 years old, 26 years of continuous sobriety].

Sarah describes her attitude towards sex as prudish and, although in contrast to previous sexual conduct. The redemptive, fatalistic nature of her response, the sequencing of attitudes and temporal ordering are of importance. Cervical cancer brings about a fatalistic response; perceived retribution for previous sexual conduct is regarded as 'deserved'. This adaptive response to an uncontrollable life situation, finds Sarah 'splitting' herself. Blame for the cancer rests with the actions of a 'guilty/culpable' previous-self. AA and sobriety have had a transformative effect upon her present sense of self, now she is 'a different person'. In Rotenburg's (1987) study of narrative, 'therapeutic-re-biographing' enjoins a person to retrospectively re-construct past negative behaviour and events to suit one's present purposes and goals. For Sarah, the ability to encapsulate an 'older', untreated self in the past, but to allow contamination of her present self by her past actions, gives a coherent sense of oneself. From Sarah's re-

¹ Sarah disclosed that as a pre-pubescent schoolgirl attending a boarding school, she had been sexually abused by a school employee.

biographing process, emerges a conflicted self-schema. Maruna (2001: 86) citing Capsi and Moffit (1995) argues that these self-schemas are stable over time. However, Sarah's attitude is evidence of a stable self-schema towards alcohol but is conflicted towards present sexual conduct. Maruna (2001:87) explains the redemption script as a narrative that emphasises a core 'goodness and conventionality' of the individual. However, in direct contradiction to the 'redemption script' here, Sarah establishes a negative self-identity with regard to sex. Sarah's diametrically opposed attitudes and resulting behaviour towards sexual conduct is shaped by a core belief that, 'sex is dirty'. The acceptance of this 'condemnation script', in one dimension of Sarah's life may be interpreted as having a negative effect: prudishness. However, mechanisms in Sarah's condemnation script have a similarly protective function, shielding the individual from the overwhelming guilt of past negative behaviour (Blagov and Singer, 2004). Sarah has successfully 'split' herself, accepted the condemnatory nature of this element of her identity, but has maintained sobriety and succeeded in improving other areas of psycho-social functioning (see page 144). AA provides the framework from which an individual can interpret and adjust their narratives that fit with the condemnation script. The Steps, particularly Step Six emphasise the central behavioural patterns that are perceived as negative. AA's programme and therapeutic discourse defines these patterns of behaviour as the result of core 'defects of character', associated with AA's theory of alcoholism (AAWS, 1952: 64; AAWS, 2001: 76).

7.1.2 Developing a Reflexive Capacity through Dissonance

I do not need to fear alcohol; I need to fear me, and a return to the way I was. I would like to think, if I'm going to have a drink, I would like to know about it, quite a bit in

advance. And see, head it off at the pass if I can [Terry, early fifties, 6 years of continuous sobriety].

Terry's statement sums the key points made so far. Alcohol, in a physical sense ceases to a problem. The problem lies within the person, being able to predict a relapse is contingent of the development of a reflexive capacity. This is shaped by AA discourse on the nature of alcoholism and is treated via the Twelve Steps. Through self-examination and re-examination one is demonstrating commitment to AA's overall therapeutic philosophy and fidelity to the Twelve Step program. Thus, at times, the recovering alcoholic finds themselves set in a state of dissonance or discomfort (Festinger, 1957). Feeling uncomfortable as a result of engaging in or planning to engage in behaviour that is negative and/or incommensurate with AA's ideology, emerged from the findings described and analysed here.

Here Angela describes this feeling of discomfort,

I always feel uncomfortable when I'm doing something that I shouldn't really be doing [Angela, late 60, 20 years of continuous sobriety].

Elliot and Divine (1994: 382) define cognitive dissonance as an arousal component of dissonance, and that, 'dissonance is experienced as psychological discomfort'. Alleviation of cognitive dissonance is motivational in nature. Thus AA's perpetual cycle of recovery is maintained, as members are made continually aware that alcoholism is an illness, a malaise of self: 'emotional deformities'.

Patrick describes practicing Step Seven, and the permanence of his character defects,

Um, I just, I'm using the present tense there, that's because I still have them, and Step 7 is about trying to reduce or diminish them [Patrick, early 40s, 11 years of continuous sobriety].

These emotional deformities or character defects remain with the individual, the amelioration of which is achieved through working the Twelve Steps. One needs to be watchful, because, '...when we are disturbed, no matter what the cause, there is something wrong with us' (AAWS, 1952: 92). Through working the Twelve Steps, AA members become attuned to their 'character defects' and are inculcated with the belief that a developing a relationship with a Higher Power will provide a therapeutic alliance that will guide future behaviour.

7.2 Spirituality and Control

'The alcoholic at certain times has no effective mental defence against the first drink. [...] His defence must come from a Higher Power (AAWS, 2001:43).

Developing and accepting a Higher Power, becomes a formal, prerequisite for recovery. This process occurs as a corollary of developing internal resources that derive from interaction with external supports. The Higher Power or spiritual dimension becomes a third form of support.

AA's critics have contended that the Twelve Steps and the organisation are religious, overly-coercive and cult-like (Bufe, 1991; Peele, 1992). For Valverde (1998) AA avoids

being categorised as a religion, by foregoing any attempt to universalise its ideology and practices beyond its members. In part, the problem of studying AA's spiritual dimension emanates from the Twelve Steps as members are encouraged to develop their own understanding of a High Power,

Some people have the proper God, some people have Jesus, some people have a tree, it's just whatever you um, you believe is out there [Patrick, early 40s, 11 years continuous sobriety].

Swora (2004) notes the 'frustration' of some behavioural psychologists (Snow et al, 1994) in trying to interpret and assess the effects of AA's spiritual approach, particularly for long term members. For AA members, in this study the spiritual/religious dimensions of the Twelve Step program has proved problematic, but over time, an understanding of a Higher Power or spirituality reflects an external source of strength. For some members of AA, belief in a Higher Power is brought about by experiencing 'coincidences' that have led to finding AA and recovery. Swora (2004: 203) argued that, 'For many AA members, nothing in the world happens arbitrarily or by mistake; there are no coincidences in God's world. Many members believe that what happens in their lives is the direct result of the action of their Higher Power'.

Loz illustrates how this process has led him to believe in a Higher Power,

..I believe that the basis of my higher power comes from, that was a sign [sets of coincidences], I know it sounds a bit weird but, that was a sign saying 'look what happened to you'. Um, so that's sort of {Steps}2 and 3 came to believe and I do believe there's someone out there looking after me 'cos some of the scrapes I got into, some of the situations I got into through drink, I should have been dead, but I'm not. So, that just

proves to me that there is a higher power and I've just learnt not to question things like this and um, just do it it's part of me AA training... [Loz, mid-thirties, 8 years of continuous sobriety].

From Loz's account, it appears that despite one's past wrong doing and character flaws are not an overwhelming bar to the care and protection that a Higher Power has provided. Bars to spirituality stem from personal struggles to control one's alcohol consumption and environment. Humphreys (2004) explains, the founders of AA believed that alcoholics had to relinquish any thought that they were 'masters of their universe'.

Analysing Brad's narrative exposes just how far AA's approach to self-governance moves well beyond merely avoiding alcohol. Valverde (1998: 125) argues that within the context of AA, self-control operates as a hybrid state between the clinical and ethical, lending itself more readily towards ethical, spiritual practices and beliefs. Brad makes clear the limits of one's personal agency in terms of control and reflexivity,

Well, the key part to it is identity, so if you know that you are not God and that there is a God, that then starts to introduce the most important boundary in your life, because you then, you have to work through this, you then become better at understanding what stuff is down to you and it's in the serenity prayer actually, you'll focus on those things that are your responsibility, you'll let go the things that are not your responsibility, and over a period of time as a result of spiritual development you'll get some insight into, it's called *wisdom in the serenity prayer*, what's your stuff and what's not your stuff. So, for instance, I don't watch the news or read a newspaper, because as an alcoholic, all that does is, you internalise all sorts of shit about the banking system, you internalise all sorts of shit about politics, as if it's anything to do with you. Now, you can be politically aware and you can develop a series of beliefs around that and that's fine, but if it starts to affect how you behave and how you think about yourself in a negative way than it's of no value to you because, at the end of the day, politics and the banking

system are a train running off on their own particular course. You can stand up in front of that with your hands up as much as you like and all that's going to get you is run down by the train. That's not to say that you should absolve responsibility. There are circumstances in which you can make a difference, and that's where the insight comes, where you get a sense of, well, I could make a difference to this, or I could stand up and say something that would matter but that's where the humility thing comes in. A lot of alcoholics have a problem with pride and emotional boundaries [Brad, mid-fifties, 21 years of continuous sobriety].

Brad's account of behavioural control makes reference to two key texts, one explicit, The Serenity Prayer, and the other is an implicit reference to Ernie Kurtz's, *Not-God* (1979). The serenity prayer reads,

“God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and wisdom to know the difference” (AAWS, 2005).

Brad overtly refers to the Serenity Prayer while explaining how his understanding of a Higher Power has helped and helps guide action. The sentiments expressed in Brad's statement and the Serenity Prayer relate to control. According to Brad, alcoholics have problems with boundaries, the ability to correctly assess under what circumstances they might affect an outcome. Brad is implying that alcoholics have a predisposition to incorrectly judge personal efficacy, and have problems separating social and political problems from their inner emotional selves. Accordingly, after a period of time in AA, the 'wisdom' to differentiate circumstance where one may affect change, comes from learning one does not-possess God-like powers of control.

This long quote is typical of Brad's intellectual understanding of the Twelve Steps and the long term effects that AA's philosophy of control, reflexivity and responsibility have had. The first part of Brad's account deals with his understanding of the reality of existence, as a recovering alcoholic and, control. The second is an enhanced reflexive capacity and, the third part is about taking responsibility. Lastly Brad describes the conceptual effects of trying to re-attain futile god-like powers of control in terms of putting oneself in front of a moving train.

Unlimited beliefs in control have stemmed from, paradoxically, the, 'self-hatred over his *failure to control* his drinking' (Kurtz, 1979: 105 my emphasis). Kurtz's argument is a complex formulation of reflexivity and control. It is an argument worth re-iterating and distilling here, precisely because, many of the alcoholics believe this to be fundamental to their recovery and these beliefs are embedded in their narratives.

In AA's theory of the alcohol-control nexus and Kurtz's (1979: 208) analysis, three key ideas emerge, one's conception of self, living in reality, and control. First, alcoholism is 'a misunderstanding and denial of the spiritual' - thus the alcoholic is at the centre of the universe: self-centred. Therefore the recovering alcoholic must learn that,

...you know that you are not God and that there is a God...[Brad, mid-fifties, 21 years of continuous sobriety].

Second, AA and Kurtz propose that the alcoholic knows that fulfilment and happiness are spiritual quests. In order to receive, or experience fulfilment one must live as fully human being, in reality. However, living in, reality does not deliver complete control over moods and feelings neither does reality bestow infinite happiness upon a person. Alcoholics know this because they feel the shifts in emotional experiences that external reality imposes on them.

Here Lenny quote illustrates points two and three, living in reality and control,

...on the times when I've got a little bit close –[...] like a thought'll come through my head, what if you did just have one [drink], something's going on in my life that I'm not happy about, and it's usually, for me that stray from the path of the spiritual to the path of the material [Lenny, early 40s, 9 years of continuous sobriety].

Demonstrating the third and final concept, control, Lenny articulates the nature of the alcoholic, that when he feels he is losing control, the 'answer' to problem is a material strategy, to drink. As Kurtz argues, this is the attempt wrest control of the spiritual by means of the material: adding alcohol is the apparently only available option to the alcoholics' existential conundrum. This results in addiction, as striving for absolute, infinite control develops dependence. The alcoholic is thus caught, as drinking more delivers less fulfilment.

Having established the perpetual state of the alcoholic, one that can be characterised as accepting a 'condemnation script', a firm belief in the necessity of a Higher Power for guidance, the following extract from Sam's narrative demonstrates how one maintains

control, yet simultaneously ceding (or crediting) this to a Higher Power. Sam describes a situation where he was presented with an opportunity to be unfaithful,

But I wouldn't, I couldn't do it to her [wife]. It would sever my spiritual being, if you like, my conscious contact – my connection to god is broken if I conduct myself in that way, I'd be half dead. It's kind of like alcohol, in a way, it's there, there's always that possibility that you could do, but it's not something I could ever imagine myself doing [Sam, early 30s, 9 years of continuous sobriety].

The prospect of losing self-control, for Sam, bares a heavy weight. With overt religious connotations, Sam regards the act of being unfaithful as potentially tantamount to a return to drinking alcohol. Breaking an established connection with God, is a perilous proposition, self-control becomes a primarily ethical and moral endeavour (Valverde, 1999, Valverde and White-Mair, 1999).

Thus AA, teaches that one must relinquish control. Giving one's will up to a Higher Power has provided a protective and guiding source of support that is permanently available. This is a benevolent force that operates in the lives of AA members interviewed for this study. Mary's explanation demonstrates a more liberal, collectivist sentiment regarding her belief and reliance on a Higher Power. Importantly, Mary describes how her own internal support mechanism developed following interaction with external sources of support for example the Steps and the AA group. The result was a concept of spirituality as a third resource that could be drawn upon during personally troubling times,

The spiritual element was hugely important for me; not in a religious way [...] I mean in a sense of community. In a sense of that collection of people creating that higher power, knowing that I could go to a meeting, whenever I needed to, knowing that I could pick up that phone, and having that faith and trust in the group, the sponsors, the book, [...] it held me, it held me when I just felt totally out of control, and my world was falling apart, it was the one thing that was steady that was there [Mary, mid-40, 13 years of continuous sobriety].

For others, AA's ability to liberalise, secularise and individualise the notion of a Higher Power, has allowed many techniques to flourish that compel the individual to attain *some* notion of a Higher Power. Elaine explains one such technique,

I had serious, serious misgivings about the Twelve Steps, simply around God and I tried the Good Orderly Direction and I tried Group of Drunks saying that would for a for a while and I and I'd try an AA group and that would work [Elaine, mid-fifties, 20 years of continuous sobriety].

Believing in the AA group or simple linguistic techniques such as think of God in the context of AA as a Group of Drunks provides a flexibility to name this source of strength. Valverde (1998) argues that AA's approach is akin to new age spirituality, where the consumer or AA member is free to choose and deploy their own conceptions, in often contradictory ways. It is these contradictory and myriad ways of accepting this guiding influence that do not lend them easily to categorizing each example into either external or internal locus of control models (Humphreys, 2003). What is apparent though, is that each member aligns themselves with AA's overall philosophy that in order to cease drinking and conform to a more moral existence, one must have a Higher Power in one's life.

7.3 Behavioural Change: From Condemnation to Stable, Long-Term Sobriety

‘Must AA’s spend most of their waking hours drearily rehashing sins of omission or commission? Well, hardly.’ (AAWS, 1952:91).

This section addresses the marked transformations in pro-social attitudes towards alcohol and offending/personally troubling behaviour amongst the study cohort. Having accepted one’s perpetual state as an alcoholic, members of this study demonstrate behavioural change across a wide variety of psychological and social domains. Interviews revealed that the internalised effects of the ‘condemnation script’ do not predict a decreased sense of personal agency or psycho-social functioning: quite the opposite. Analysis so far in this chapter may have led the reader to suspect that individuals are ensnared in a cycle of self-examination, the effects of which may curtail certain behaviours, such as socialising in public spaces where alcohol is served. Perhaps counter intuitively, some members of this study report keeping alcohol in their homes and with the exception of two persons, all of the respondents desisted permanently from any form of criminal behaviour, as well as drinking. They do not understand themselves as victims of society but have, nevertheless overcome a bleak prognosis.

Well, I think there are two parts to recovery from alcoholism. The first part is not drinking, and the second part is staying stopped [Richard, late 60s, 30 continuous sobriety].

On first reading, Richard’s comment on what recovery means to a member of AA appears glib. In AA, abstinence is all; it is *the* key marker of success and is celebrated and revered (Denzin, 1987; Smith, 2007). With such a high premium placed on

abstinence, the following section documents a range of behavioural strategies, from extreme vigilance regarding food ingredients to drinking low alcohol beverages. Members of AA with considerable lengths of continuous sobriety are respected and their counsel often sought. However, as Michael stated, just ‘not drinking’ is not enough.

Cessation from drinking is but the first step away from a highly strained, abnormal condition (AAWS, 2001: 122).

This quote, taken from AA’s basic text states the organisational understanding of recovery, abstinence must come first. Destructive drinking and recovery from the concomitant effects, there of; have social, psychological and temporal dimensions. AA’s definition of the problem of alcoholism continues and expands, to incorporate other people, ‘The entire family is, to some extent ill’ (ibid), ill-health, financial misadventures, and criminality are co-opted into the overall problem to be ‘treated’: the individual’s distorted cognitions and attempts to wrest control of their lives (AAWS, 1952). AA’s literature and therapeutic mechanisms offer a ‘complete’ recovery from all such matters (AAWS, 2001).

7.3.1 ‘Altered Attitudes’ to Alcohol

One of AA’s slogans encourages members to think of the AA acronym standing for ‘Altered Attitudes’ (Vallverde and White-Mair, 1999). These slogans are designed to help with daily living; others include ‘Easy Does It, Keep It Simple and One Day at a Time’ (Borkman, 2006). This generalised and simplistic approach towards changing

behaviour and thinking is adopted by AA members, as one way of understanding the effects of the Twelve Steps, in terms of developing self-control. The result is a shift in perception, specifically how one understands oneself in relation to alcohol.

There are two mechanisms evident that demonstrate how a long-term abstinent member of AA, manages alcohol in their daily lives. First, agency and control are structured through AA's discourse, using the 'linguistic echoes'. Second, Bandura's (1977, 1991 & 2005) social learning model sheds light on the self-regulatory capacity of individuals in this cohort. Practising self-regulation confers upon the person, hitherto unknown reflexive capacity.

7.3.2 Self-Regulation through AA Discourse: The Use of 'Linguistic Echoes'

Almost all of the participants interviewed described similar attitudes to alcohol at those expressed in AA's literature. This is not surprising and is predicted in the AA's literature, the colloquially known section in the Big Book, 'the promises' (AAWS, 2001: 83-84), and in Step Twelve (AAWS, 1952: 109-132). There is a striking similarity in the language used by the respondents while describing their attitudes to alcohol. To illustrate how tightly bound to AA's prognosis of this newfound attitude to alcohol, the first quote comes from AA's key text, *Alcoholics Anonymous*,

We will seldom be interested in liquor.[...]. We are not fighting it, neither are we avoiding temptation. We feel as though we had been placed in a position of neutrality-safe and protected (AAWS, 2001:85).

Brad outlines his psychological attitude to alcohol and the prerequisite, ‘mental state’ needed to maintain sobriety.

But you’ve also got to get yourself into a mental state, where having a drink is not a priority and, in fact, you can become indifferent to alcohol [Brad, mid-fifties, 21yrs of continuous sobriety].

There is a marked similarity between Brad’s understanding of maintaining abstinence and that demonstrated by the above quote from AA literature.

Jill’s account of her changed attitude towards alcohol demonstrates the embeddedness of AA’s discourse with regard to her relationship and attitude to alcohol,

I do keep alcohol in the house because I have friends who come for supper and who like to have a drink, and there’s a bottle of wine in the fridge –I’m not even interested – it doesn’t – I’m not afraid of alcohol. I don’t think this is probably going to make sense; I’m not afraid of having alcohol in the house because, just because I don’t drink it, doesn’t mean that other people can’t drink it. The fact that it’s here doesn’t pose a problem to me; my *obsession* and my *compulsion* to drink alcohol has totally gone. Whether that’s a result of my having worked the steps, I don’t know; whether it’s the result of a spiritual awakening, I don’t know, I don’t need to know. [...] the bottle of wine in the fridge that’s been sitting there, that will sit there for months and will continue to sit there for months [Jill, mid-fifties, 14year of continuous sobriety].

Jill talks of the ‘obsession’ and ‘compulsion’ to drink alcohol being removed. Steps 1, 2, 3, 4, 6, 7, and 12; explicitly describe one of the chief characteristics of alcoholism as an ‘obsession’. For example, Step One (AAWS, 1952: 24&22) speaks of a ‘mental’ and

‘merciless obsession for destructive drinking’, and that there is, ‘...no such thing as the personal conquest of this compulsion...’ Step Two (AAWS, 1952: 32) teaches that, ‘...God could enter us and expel the obsession’ and Step Twelve (AAWS, 1952: 107), ‘...we were unable to be rid of the alcohol obsession...’ No fewer than 19 instances can be found in AA’s core texts the Big Book (2001) and the Twelve Steps and Twelve Traditions (AAWS, 1952), where alcohol and the solution to the problem of alcoholism is described as an ‘obsession’.

There are normal drinkers out there who can drink alcohol and there’s me who can’t and I’m quite happy to sit with a mineral water or an orange juice and watch other people drink. It doesn’t bother me. It, it’s really a non-event because what other people drink is none of my business and I don’t have an envious relationship with that. I’m not even particularly conscious of what people are drinking most of the time. What matters in what I’m drinking and the reason for being in the pub in the first place, which for me, it’s a social thing[...]Um, if I was going because I thought that I might get a vicarious thrill by being around people who were drinking a lot of booze then I’d start worrying there’d be something going on with me. Um, but I’m also quite comfortable these days with the non-alcoholic drinks. Um, and I will quite happily drink things that are zero alcohol, beers or wines. To be honest, not quite happily, ‘cos most of them taste like shit but there are one or two German ones that I’m comfortable with. It was never about the taste for me and sometimes I like a soft drink that isn’t sweet.

Interviewer: Right.

Jane: That’s not something I share widely in AA because I know I would get shot down and that’s probably a bit of cowardice but...

Interviewer: Right.

Jane: But it does have to be zero alcohol. [Jane, 21years of continuous sobriety].

First Jane demonstrates the necessity to separate herself from ‘normal drinker’, establishing herself as someone who simply ‘can’t’ drink alcohol. Second, Jane offers an almost exact replication of the behavioural outcomes, with regard to socialising with friends in places where alcohol is served, as found in the book *Alcoholics Anonymous*;

So our rule is not to avoid a place where there is drinking, *if we have a legitimate reason for being there..* [...] Therefore, ask yourself on each occasion, “Have I any good social, business, or personal reason for going to this place? Or am I expecting to steal a little vicarious pleasure from the atmosphere...” (AAWS, 2001: 101. Emphasis in original).

Jane presents a unique example. While adhering to AA’s perspective on socialising in environments where alcohol is served, Jane speaks of drinking zero percent alcohol products that appear to taste and look similar to the more usual alcoholic beers and wines served. Jane’s reluctance to speak about this behaviour in AA meetings is notable. Drinking zero-alcohol products is strongly discouraged in AA, as it is perceived as a (possible) first step towards drinking alcohol. Jane offers the explanation that drinking alcohol, was never about the taste...’. The implication being that it was in pursuit of the effects of alcohol that motivated her drinking. Jane’s experience appears at the farthest end of the alcohol- AA spectrum, in terms of ingestion and what would be deemed unacceptable (generally) and acceptable behaviour.

7.3.3 Structuring Agency through Cognitive Self-Regulatory Mechanisms.

Sarah’s response reflects an almost effortless-forgetful attitude, towards alcohol. However, Sarah and Andrew’s account seem slightly at odds with AA’s prediction that

recovery will yield a definite state of safety and neutrality where alcohol is concerned (AAWS, 2001:85).

I think for quite a few years in recovery, I don't know, I was going to say that I was scared of it, but I'm not sure that's even true. I have a healthy respect for it. I don't have, because, obviously, I'm married to an alcoholic [recovering, also in AA], we don't have alcohol in the house because there's no reason to have it in. When my sister comes over from Sweden, we have wine in, but when she leaves, it goes. I'm not scared of it, but I – don't really think about it too much, to be honest. I don't go to pubs, but only because I've no reason to. If somebody, if friends invited me to a pub, I would go and sit in a pub, but I probably wouldn't stay very long 'cause I'd get bored. Er. I, I, it doesn't feature in my life; it's just not a thing I think about [Sarah, late fifties, 26 years of continuous sobriety].

Following Bandura (1977) the perceived level of difficulty in achieving goals (sustaining sobriety over the long-term), changes. Progress towards attainment shifts along a positive linear trajectory: put more simply, these are the habits of abstinence. Here Sarah demonstrates one of Bandura's (ibid) key mechanisms of self-regulatory control. Future goal attainment is predicated upon a high level of perceived self-efficacy. Over time, Sarah has learned to incorporate alcohol, at a minimal level, into her life. Sarah considers being married to an alcoholic a protective factor, and that alcohol in the household stays in close proximity for a definite reason (her sister's enjoyment) and for a limited time. Knowledge of the risk that alcohol poses in social settings shapes Sarah's response in terms of limiting the time spent in locations where alcohol consumption is an expected routine activity.

Andrew gives an interesting example of a cognitive skill taught in AA: ‘running the tape forward’.

You know, I can sit in Pizza Express and watch someone having a cold beer or go to Henley and see someone having a glass of Pimms, or the tennis or, and my salivatories will salivate and I think “Oh god, that looks nice” but I don’t want it (clicks fingers), I don’t even have to, you know, XXX [another AA member] used to talk about looking at the skull and crossbones on the bottle or ‘running the tape forward’ or any of that shit. I don’t need to do that, you know. I remember the night in Bow Street nick. It’s just there, the two things go side by side [Andrew, early 60s, 25years].

AA members are asked to think of a time and or a situation when they have started drinking and it has ended problematically: for Andrew, in ‘Bow Street nick’. This simple exercise, ‘playing the tape forward’ [imaginary CCTV footage], serves to remind members that all drinking ends negatively. Andrew states he doesn’t use this method, but quite contradictorily, goes on to explain that a conjured image of incarceration is all that is required to dispel the idea of taking a drink.

Intention to control future actions and the concomitant outcomes is based on a cognitive ability to represent the future consequences (Bandura, 1977 & 1991). Generation of relapse ideation, under hypothetical social contexts that present a level of risk, provides the motivation for courses of action. Anticipating future consequences becomes an embedded thinking process. Given the centrality of abstinence and the apparent physiological response to a perceived set of environmental circumstances that trigger craving, this method of relapse prevention is informative. As a consequence of long-term membership in AA, highly developed affect-control strategies are implemented.

Almost all of the respondents speak of alcohol from a position of safety and ‘neutrality’, while also being largely un-fearful of alcohol in close personal proximity, but behavioural and cognitive strategies differ. Each respondent demonstrates a marked shift in attitude towards alcohol that in spite of the variation in control responses and strategies has resulted in a long term continuous abstinence.

With the exception of Step One (AAWS, 1952:21), where alcohol and loss of control while drinking are specifically addressed, each of the remaining 11 Steps are orientated towards behaviour and cognitive-emotional modification in other domains: ‘So our troubles, we think, are basically of our own making. They arise out of ourselves...’ (AAWS, 2001: 62). Problems other than those directly associated with the consequences of excessive drinking, the long-term changes personally troubling behaviour and how those changes are achieved direct the focus for the remaining analysis of this chapter.

7.3.4 Attitudes to Criminality and Moral Transgressions

Drinking and driving was a big one for me, I used to do it a lot, every day really [Sarah, 60, 26 years of continuous sobriety].

With one exception, all of the individuals in this study admitted to drinking and driving on many occasions. The following section details some of the crimes/criminal activity and other moral transgressions that characterises events and conditions under which, according to AA, alcoholism flourishes (AAWS, 2001). Examples of criminality begin this section, which then focuses on narratives of attitude changes towards moral

decision making. Only one participant was prepared admit to participating in (occasional) criminal activity, tax evasion, post- AA engagement. The long-term changes in behaviour are attributed to ‘working the program’. All previous crimes are held, as evidence of past ‘alcoholic’ behaviour and as a result of being sober, the respondents have desisted.

It’s interesting really, that when you look at the dishonesty of an alcoholic; it’s low key, it’s dishonesty by lying about how much you’ve had to drink, it’s about stealing drink from other people, abusing people’s hospitality, you know, and that sort of low level theft, of crime and money and opportunity, you steal money from your employer, at least I did because I travelled a lot, and I put a lot of my drinking on my expenses [Brad, mid-fifties, 21 years of continuous sobriety].

Brad gives an account of criminal and morally transgressive behaviours that are consistent with the AA literature, specifically those noted in Step Four (AAWS, 1952:443). However, the variety of criminal behaviours admitted to, pre-AA engagement, in this study ranges from shoplifting, domestic and other type of violent behaviour, fraud and manslaughter.

Lenny’s interview is a frank and unguarded account in its entirety, a ‘moralistic confessional’ (Maruna, 2001: 124). Lenny’s account presents three points for further analysis. First, the therapeutic mechanism, second a level of reflexivity or deep insight into his own personality and third, the result, a ‘hyper-moral’.

Lenny: Some of the shitty things that I’ve done in my life, I cleared out in my Steps Four and Five.

Interviewer: Can you tell me about a few of them?

Lenny: There were violence, towards men and women, there were cheating, I've slept with women into triple figures and since being fourteen years old, until recently, I'd only spent two months on my own without being with a partner, a permanent partner, and I'd cheated. I'd got girls pregnant, and, I wouldn't say force them to have a termination but I put pressure on them to have a termination. I stole, I lied, I stabbed people in the back to get on, I wasn't a good friend, I wasn't good to my family, [...]

Interviewer: OK. So, in terms of offending behaviour; has it stopped?

Lenny: Yes. For two reasons: I'd like to say I've stopped committing offences because I'm sober, but that's not true. The way you are drunk is just an amplification of the way you are, I believe, and I do actually believe that to some extent. [...] But I think, through the Steps, I've learnt a lot about consequences, and taking responsibility for the consequences of my actions, and what'll hurt and what'll offend other people, so in terms of offending like that. Even now, if I end up talking for a minute on my mobile phone, while I'm driving in the car, which I sometimes still do, I feel guilty about it, and I haven't felt guilty, I didn't give a shit about it, about offending when I was a police man, all I gave a shit about was getting caught, and having to deal with the consequences. Now it's different [...] it's brought to it a new morality that I didn't believe I had before that sits actually really comfortably with me, [...] [Lenny, early 40s, 9 years of continuous sobriety].

For Lenny the therapeutic value of working through Steps Four and Five are clear. This process has allowed him to come to terms with his past behaviour, but have also provided a framework for understanding his own personality. Personality traits for Lenny are stable overtime and are consistent with AA's theory of the 'alcoholic personality'. Insights into his personality provide an opportunity to develop agency through generative action. Following Macadams and St. Aubin's (1992: 1004) interrelated features of generativity, cultural demand and inner desire, analysis reveals positive long-term changes in psychosocial development. Lenny evidences AA's theory of progression in recovery, a reflexive capacity which concomitantly guides future behaviour, markers of 'getting well' in AA.

Richard's explanation helps to shed-light of the culturally demanded expectations of practicing the Twelve Steps and the results,

...but if you do the twelve steps in a proper way, it will take those out, that sort of stuff out of you [criminal conduct and immoral behaviour] [Richard, late 60s, 30 continuous sobriety].

Integration of 'cultural demand' (working the Twelve Steps) and 'inner desire' are expressed in Lenny's generative goal (inner desire[s]) to take responsibility and learn the consequences of negative behaviour. McCadams and St Aubin (1992:1006), state further that an increase in generative patterns of behaviour and thought become rooted in one's life story. This 'generativity script' is a narration of a person's planned, future course of positive action, integrating an individual's reconstructed personal history into the framework of AA's theory of change. This self-awareness, or reflexive capacity, promotes self-examination and motivates continued efforts towards generative goals.

Lenny's 'hyper-morality' - in his own words a 'new' morality - is a change in attitude to the extent that speaking on his mobile phone while driving, is now undesirable. However, this stops short of Maruna's (2001: 123) 'aggressive piety', it is Lenny's feelings towards his own actions, rather than other people's transgressions he has a new moralistic attitude toward. For Lenny and Richard, the Twelve Steps are the primary change mechanism that has brought a new understanding of responsibility and the consequences of problematic behaviour.

Richard's attitude towards crime -in this instance, tax evasion - bears a closer resemblance to an 'aggressive piety'.

I mean, I don't do it, that's fine, and I don't indulge in tax evasion either. I find it abhorrent, I don't see why people should do that, but I didn't used to think like that, years gone by, before I came to AA [Richard, late 60s, 30 continuous sobriety].

Richard reflects on past attitudes towards tax evasion that are contradictory to his present views. AA for many of the respondents is the pivotal, life changing event that structures the past and the future. Specifically, all other problematic behaviour, previously associated with excessive drinking becomes relational to one's current attitudes. Thus the 'archetypal' past self (Thune, 1977) becomes subsumed into the AA's communal discourse. These examples help the new member psychologically to break from their past problematic behaviours, allowing new forms of behaviour and thinking to emerge as recovery progresses.

These examples illustrate the range of crimes committed and the variation of other problematic areas of behaviour that members of this cohort have experienced and changed. For most individuals, criminal and other morally transgressive or personally troubling activity previously engaged in stops immediately after joining AA, and maintaining sobriety. Coming to terms with previous deviant actions, is dealt with via the Steps, particularly Step Four. The rationale for Step Four, and Step Eight, is that one makes a list of persons harmed, and then makes amends. These Steps lessen the risks of 'feeling' the effects of future negative consequences. There are two interlinking concepts, consequences and negative feelings, these concepts are referenced many times, by respondents in this study, in relation to criminal and problematic behaviour patterns.

Phil explains the, relationship between acting in immoral and criminal ways and the feelings associated with such action,

I find that people who've been in AA a long time, those who seem to be following the program, tend not to bother with it too much. It, it tends to be the newcomers who are doing that stuff, and they either leave, which is what the majority do, or they just gradually stop doing it. [...] If you're going to stay sober it's just got to stop, but there's no time limit to it, but again, I don't do it for moral reasons, it's just uncomfortable.

Interviewer: Right. It makes you feel uncomfortable.

Phil : Yeah. Which I can't afford to do [Phil, early 50s, 20 years of continuous sobriety].

The motivation for avoiding future engagement with problematic behaviour is the prospect of 'risky' consequences. Many of the respondents, believed in a certainty that indulging in such behaviour would promote negative conceptions of ones' self.

Angela explains further how this process can leave one vulnerable to relapse,

I think it's because I'll know that I'll feel horrible about it afterwards [...] if I feel bad and I don't like it there's a serious chance I might try and take something to make myself feel better and then you, you're in the circle again [...] you know, make me turn to alcohol and pills [Angela, late 60s, 20 years of continuous sobriety].

Almost non-of the respondents appeared willing to speak about any present criminal or morally questionable behaviour they were still engaged in. There were two exceptions

to this. In both examples, justifications and neutralisation techniques are evident in these accounts. Loz describes tax evasion post-AA involvement.

I've been a plasterer while I've been in AA, so I've done work for plastering and got paid cash in hand and not thought anything about it 'cos it's not really hurting anybody else, it's not like stealing sort of robbery where you physically take someone else's money out of their handbag um[...] but you could say I would steal off the government, what they're owed but they never had it in the first place, so I don't see that as stealing [Loz, 34 years old, 8 years of continuous sobriety].

Loz draws clear boundaries around acceptable and unacceptable forms of stealing. Following Skyes and Matza's (1957), moral neutralisation theory, Mathew describes these boundaries in terms of acceptable and unacceptable victimisation. First, reflecting the wider norms of society, stealing from a person is proscribed, but in defence of positive self-image, Loz asserts that this form of criminal is unlikely to cause physical harm. Second, a more potent neutralisation follows a simple logic: how can it (money owed in tax) be stolen, if they (government) never had it in the first place. Denial of injury, one of the five techniques of neutralisation is evidenced and used effectively in Mathew's account. In this instance, the abstracted nature of government, an unseen collective, allows a distance between the victim and the act (Maruna and Copes, 2005).

Jill provides an account of her relationship with a married man,

Infidelity is probably a bit of an issue now, not because of – because xxxx [husband] died this year – the man that is part of my life is married but his wife has got Alzheimer's, and it started off as a very friendship orientated – it's somebody I've known for donkey's years, he contacted me because he was having difficulty coping [...] I know I'm probably doing wrong, but, it works for both of us and he – I understand where he's at because I've been through the same thing. Morally, I'm still

doing something wrong, but I don't have a major issue about it [Jill mid-fifties, 14 years continuous sobriety].

As McCarthy and Stewart (1998) propose, offenders involved in low, intermittent criminal behaviour, share the dominant value system. While Jill's behaviour is not criminal, the neutralisation process is shared with the author's framework, and Hirschi (1969), that an individual has to ameliorate the negative effects that personally troubling behaviour causes via a 'hardening process'. This process is necessary as Jill acknowledges a wider societal perspective that would view her behaviour as morally wrong. Maruna and Copes (2005:223) describe an, 'appeal to higher loyalties'. The ability to neutralise the external morally proscribed behaviour of adultery, in favour of supporting a person in a similar situation, provides a footing from which all criticism of such actions can be held in abeyance. The conditions under which the relationship occurs, mediates any negative effects. The perceived positive effects, in terms of reciprocal emotional support, justify the continuation of Jill's relationship.

The individual learns in AA that indulging in morally transgressive or criminal behaviour will have negative consequences. Negative affect, or 'feeling bad/uncomfortable' is the beginning of the relapse process. Overwhelmingly, AA members in this study reported desistance from criminal activity at the point of joining AA, but desistance is not the primary goal, it becomes incidental a tactic to avoid relapse. This is apparent in the narratives given; persons reflect upon their old lives and modes of behaviour as pre-AA. In terms of problematic behaviour, the same narrative mechanism is observed. Narratives are cleaved; the point of incision marks the separation of the old from the new, sober, AA-informed method of living. The long

term effects of regular participation in AA and practice of the Twelve Steps results in continual observation of one's own thoughts and behaviour patterns. This becomes an embedded reflexive practice. Reflexivity is shaped by AA's discourse, the organisations theory of alcoholism and the identification of certain personality traits that are evidence of an 'alcoholic personality' (AAWS, 2001). AA's literature teaches that these are stable characteristics that may never be eradicated; they are 'character defects'. Committing to AA's therapeutic practices, specifically the acceptance of the AA's 'recovery script', habits of moral reflection and incorporation of a spiritual/Higher Power, into one's life, are the pre-requisites for the recovering AA member to maintain long-term behaviour change.

Summary

Overall, findings indicate that members of this study have followed AA's normative 'pathway' of recovery employed strategies to stay engaged in the recovery process and have experienced marked shifts in self-control. AA provides the framework or 'recovery script' which one must accept. Embedded within this, there is evidence of a 'condemnation script', but this is more emancipating than stifling. Acceptance of this essential condition promotes the habit of moral reflection. Employing this key internal resource in partnership with external sources of support, the written material such as the Twelve Steps, and the AA group, one maintains control. Further, as recovery progresses, AA members, of necessity, are strongly encouraged to engage in spiritual beliefs, specifically that of a Higher Power. This Higher Power, becomes a third form of support, it is the projection of one's increased powers of self-control arrived at through utilisation of internal and external support mechanisms. The individual cedes, or credits

their sobriety and new found powers of self-control to this notion of a Higher Power. Thus, AA's diagnosis of alcoholism as a 'spiritual, mental and physical' condition, needing a 'spiritual' (Higher Power), 'mental' (internal: increased reflexivity) and 'physical' (Twelve Step, Sponsor, AA meetings), treatment, are demonstrated here. How one arrives at this relationship, and accepts this, is performed in a multiplicity of ways. The variation in spiritual beliefs, whether one chooses a 'tree' or an anthropomorphic conception of God, does not matter. It is the acceptance that one *must* have this dimension in one's life that is of import.

Demonstrable behavioural change is empirically evidenced. Attitudes to alcohol shift considerably throughout the long-term course of recovery. AA members appear to be indifferent towards alcohol, but do employ deliberate behavioural and cognitive strategies to deal with social occasions where alcohol is served. Criminality and continuing engagement in other problematic behaviours either stops abruptly at the point of committing one's self to the AA program or, over a period of time, such behaviour, leaves the individual in a state of incongruence with AA's moral philosophy. In this sense, the goal of long term recovery surpasses merely not drinking; it is to achieve a wholly more ambitious goal, to attain an inner peace (Valverde, White-Mair, 1999). Inner peace comes from having a highly developed sense of reflexivity, and sustained engagement in AA's therapeutic practices: 'We will comprehend the word serenity and we will know peace' (AAWS, 2001; 83&85).

Chapters, Five, Six and Seven provide analysis that supports the hypothetical model of AA-mediated behavioural changes. Stability in the model is retained, as the effects on a

person's identity and behaviour is mediated by AA engagement conceptualised by the integral components, MtE, SSE, PA, the findings are the Behavioural Outcomes (BO). The stability of the model was deductively arrived at, as questions 'tested' the model, as they related to the integral components. New findings emerged inductively, as the temporal dimensions of the recovery process were explored. These were, acceptance of AA's recovery script, use of linguistic echoes and a developed capacity for self-reflection and self-control. These new findings require changes to the hypothetical model, illustrated and described at the beginning of Chapter Four. Chapters Six and Seven, have the models placed at the beginning to remind the reader what the analytic focus will be and how this impacts on the models. Empirically derived changes in Chapter Eight and are presented as an original contribution to the field of study regarding AA's therapeutic process.

In simple terms, these chapters demonstrate how one engages with AA, what activities are associated with engagement and what the effects are. Evidence drawn from the data, describe how, in relation to AA's discourse, how one attains and maintains sobriety under stress. The task remains, to discuss in detail, the relative strengths and weaknesses of the model. Further, the limitations of using a purposive sample in determining effectiveness and the new findings- the model of change is not a process model for *all* persons for whom AA has had some either positive or negative affect. In addition, and in light of the most salient findings, the implications for policy and a future research agenda will be addressed.

Chapter 8: Discussion

8.1 Introduction

The evidence presented in this thesis suggests that successful engagement with AA improves a person's psychosocial functioning across many of the domains that represent recovery. This is a 'story' or a 'journey' of change. Each of the respondents has given invaluable insights into their inner life - their own personal stories of change and recovery- and their relation to the outer world of life-events and the therapeutic practices of AA. Respondents in this study had been continuously sober for between five and thirty years. Specifically, questions were asked relating to how AA supported successful cessation from negative drinking patterns. Reflecting a secondary set of interests, questions were asked of the cohort, how AA may have impacted on desistence and other personally troubling/morally transgressive behaviour. To achieve these aims, 20 semi-structured interviews were conducted with long-term abstinent members of AA.

The literature assessed AA's therapeutic mechanisms this review identified three key concepts. These concepts represented necessary conditions, sufficient enough for these respondents to maintain long-term abstinence. This conceptual framework was then used for analysis. Related literatures on these concepts, motivation to engage, (MtE), structured social engagement, (SSE), and personal agency (PA). An ideal model or a 'virtuous cycle' of change was constructed comprising of these three over-arching conceptual components. As all the respondents were sober for many years, it became necessary to draw this model out over time, to demonstrate the temporal effects.

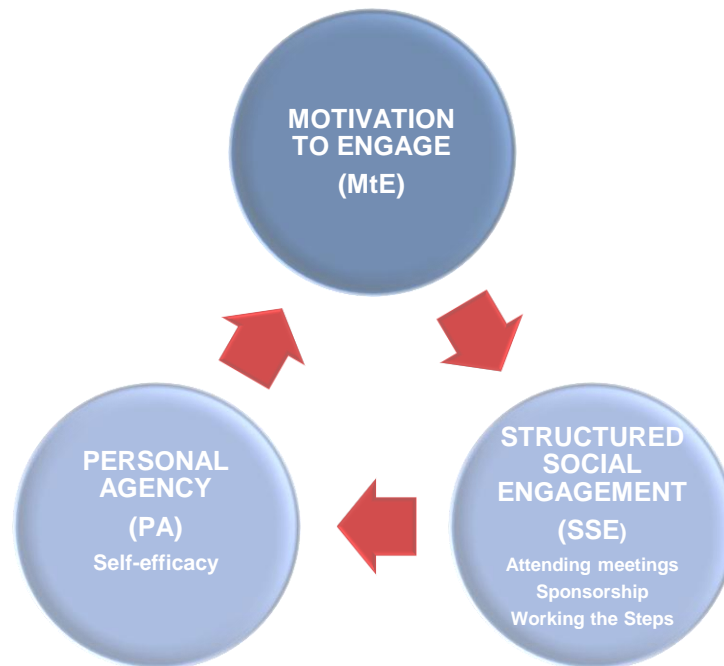
Visually, this became an elongated ‘helix’ representing recovery journey in AA, and the circumstances that threatening disengagement or spinning off the ‘helix’.

This chapter is structured into three parts. The first assesses the acute ‘ideal-typical’ model of change developed from a synthesis of the research literature. The second discusses empirical findings in relation to the chronic helix model of AA- mediated change. The ‘end-point’, changes to the hypothetical model following data analysis, represents an original development in the study of AA and its therapeutic mechanisms and is significant contribution in this field of study. Third, the limitations of the study and policy implications are discussed with examples of overlap and intersection. A future research agenda is then outlined that will further inform policy, theory and practice.

The conclusion to be drawn is clear: for this cohort recovery from alcoholism starts with abstinence. From that point on, further, pro-social goals can be achieved, across a range of domains. Overall, for this cohort, AA has ‘worked’ and continues to ‘work’.

8.1.1 Assessing the Acute ‘Ideal-Typical’ Model

Figure 10



The first part of this discussion reflects on the evidence collected from the interviews that support the three-part component model composing the ‘virtuous cycle’ of change. The first concept of motivation can be understood as pressure or pressures to change. This is presented by the concept Motivation to Engage (MtE). These motivations or pressures emanate from differing spheres inhabited by the individual, both psychological and environmental. For members of this study, pressure from families exerted a strong influence. These experiences ranged from threats to remove children into statutory care; and in addition, new findings revealed that self-motivation was key to engaging with AA. Extending further Seddon’s (2007) argument, that external pressure becomes subjectively experienced as an internal pressure, psychological models of change were assessed. At the psychological level, the decision to change coincided with what one respondent labelled ‘that golden moment’. Armitage and Conors (2009) define this as the ‘decisional balance’; that is the balance becomes ripe

for tipping as the subjective understanding of pressure renders the individual less resilient and amenable to processing salient information.

The second component of the ‘virtuous cycle’ model for change, structured social engagement (SSE), revealed that individuals encountered acceptance and support in AA meetings, offering a therapeutic and easily accessible environment to hitherto chaotic lifestyles. The outstanding finding here is that new forms of communication are discovered upon entering AA. The ‘scaffolding’ of recovery is learned through the language of shared meaning and experience. An individual becomes exposed to these ‘linguistic echoes’ through participation in AA’s therapeutic practices: attending AA meetings and reading AA literature.

Relationships amongst AA members are characterised as ‘deeper’ than with non-members, giving one the confidence to disclose one’s ‘darkest secrets’. Sharing these experiences erodes the social isolation of the alcoholic (Allen et al, 1981), and recovery is facilitated through functionally supportive relationships. As a ‘non-tangible good’ (ibid), human capital is passed from person to person, in AA meetings and via the sponsor-sponsee dyadic relationship. AA’s formal activities include sponsoring newer members. Following Adler and Kwon’s (2002) argument that the substance of social capital exists in the goodwill of persons, one particular AA member demonstrated a willingness to employ new AA members.

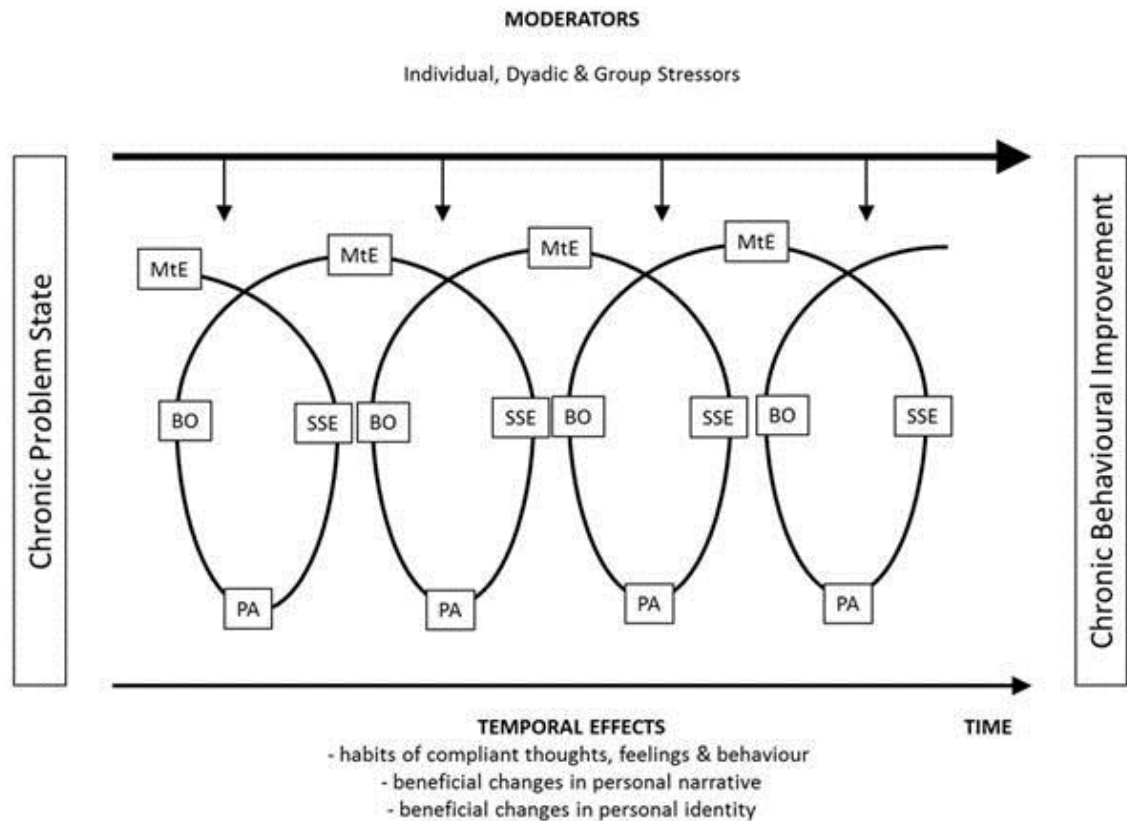
Personal agency (PA), the last component in the ‘virtuous cycle’ of change, was understood in terms of self-efficacy. Improvements to psycho-social functioning

emerged following participation in AA's structured social engagement. Making use of Bandura et al's (2001) social cognitive theory, recovery began to be understood in terms no longer associated with just staying sober. For many individuals, examples of self-efficacy included an emphasis on achieving other pro-social goals. Education featured as a key indicator of self-efficacy, lending further weight to Kaden and Cooney's (2005) suggestion that effective relapse avoidance strategies ought to feature forms of generative action.

The 'virtuous cycle' or ideal model of change model is supported by evidence found. Sustaining abstinence and one's capacity to maintain engagement with AA therapeutic mechanisms, often under stressful conditions, sheds new light on coping mechanisms deployed by members of this study.

8.2 Threats to Disengagement

Figure 11 Hypothetical Model of AA-Mediated Behavioural Change: Temporal Components



It is important to stress that this model is an a priori, hypothesised model of change. Analytically, this model provided a 'tool' to test, deductively, the findings in Chapters Six and Seven. A detailed account of model-development has been discussed in Chapter Four, but perhaps it is helpful to describe, briefly, the function(s) of this model, and its purpose in this section and 8.3. As Figure 9 illustrates, moderators, individual, dyadic and groups stressors are descriptions of situations and contexts which may threaten disengagement from AA. Maintaining abstinence is dependant on the strength of AA's mediational effects and activities. So, the level or magnitude of the moderators (threats) is mediated by the relative strength an individual reports in their understanding and commitment to AA's therapeutic practices, represented by MtE, SSE and PA. The

mediators explain the relationship, how engagement mediates the negative moderating effects of the stressors; thus one either maintains sobriety or ‘spins off’ the helix and risks relapse. Maintaining a positive line of travel towards Chronic Behavioural Improvement, has been evidenced in the component Behavioural Outcomes (BO): ‘staying on’ rather than being ‘pushed off’, the helix.

Conceptually, recovery is understood as an elongated process, as the respondents had between five and thirty years of continuous abstinence, the ideal model now resembles a helix. The helix helps to explain how threats to disengagement from AA’s therapeutic practices are experienced. Two broad categories of threat were identified: proximal and distal threats. The former type of threat was dealt with subjectively, as one uses one’s psychological resources, adapted from and developed from AA’s therapeutic practices. AA members found solutions to the latter, distal threats, via recourse to AA’s literature and from a pro-abstinent support network. Threats of a distal nature are those expected to occur over the life course.

8.2.1 Managing Distal Threats

Making use of AA’s geographic spread, members experiencing extreme emotional discomfort were able to access AA meetings in hitherto unknown environments. AA meetings, times and venues are updated online and published in AA’s ‘Where to find’ handbook, which is updated yearly. Larimer et al (1999) argued that the ability to anticipate, or effectively re-act during emotionally troubling times is fundamental to relapse prevention. The most striking example of managing distal threats was recounted

by one of the cohort who had recently been bereaved. Having previously been the victim of rape and suffering the loss of a first spouse, this respondent found himself psychologically vulnerable to relapse. Phoning another member of AA and immediately attending an AA meeting, this respondent's behavioural response was successful and pragmatic, stating that the magnitude of grief experienced remains the same, whether one is or is not a recovering alcoholic. The consequence identified was the possibility of using grief 'as an excuse to lift a drink'. This example underscores a further argument: the functionality of AA's 'recovery script'. The respondent in question had over 15 years of continuous sobriety, before finding himself with a drink in his hand. In AA the individual is inculcated with the belief of permanent vulnerability: one is never 'cured' of alcoholism. This belief being perceived as functional rather than negative or deterministic. Accepting the permanence of the alcoholic condition, is one of AA's central beliefs and it is re-iterated in AA meetings and is embedded in AA's key literatures (AAWS, 2001; AAWS, 1952).

In most cases, the responses to distal threats were predicted accurately from a close analysis of AA's core texts, and from the findings that emanated from the literature review. Uncovering the AA's recovery script represented new findings. Threats to disengagement, from proximal sources, had hitherto not been reported in the academic literature, and neither were they specifically addressed in any of AA's literature.

8.2.2 Managing Proximal Threats

Members of this study managed proximal threats to disengagement by drawing on their internal, psychological resources. Issues of fundamentalism appeared at the group and individual level; although a distinction should be made: collectively, recourse is often sought to the Twelve Traditions (AAWS, 1952) as a means of maintaining AA inclusive membership arrangements and to resolves conflicts. AA's literature warns against exclusionary practices and beliefs, as the non-hierarchical nature of the organisation becomes threatened by individuals and splinter groups evidencing fundamentalist 'styles' of recovery.

Individually, proximal threats are experienced subjectively and from differing perspectives. For one particular member of the cohort, a self-confessed 'Step Nazi', who interpreted the AA texts literally, there were certain groups and individuals *not* practicing AA's recovery philosophy 'properly'. This perception was reiterated by a number of AA members. Monroe and Kreidie (2002) defined the dimensions of fundamentalism as a behavioural response that emerges when threats to the 'purity' of ideological belief systems occur. Other forms of fundamentalism exist within AA, as respondents reported periodical 'infiltration' of mainstream AA by fundamentalists, for whom a retreat to literal interpretations of AA's key texts protects to the 'purity' of AA's approach.

Anger features prominently in AA's discourse, as a negative affective state to be managed and avoided. AA's philosophy encourages members to address issues relating

to anger and to build a capacity for effective self-regulation through working the Twelve Step Program (AAWS, 1952: 90). Misinterpretation of social cues for one member of the study cohort demonstrated a level of empirical congruence with Novaco's (2002) model of anger. Following Novaco's model, anger for one participant appeared to be a functional reaction to perceived bullying by another AA member. However, anger according to the author 'may be derivative of a traumatic life history' (Novaco, 2002: 42). Defenbacher (2011) noted that the rules for appropriate responses are coded early in childhood, according to one's cultural and familial background. Many of the respondents spoke openly about coming from dysfunctional familial backgrounds. The resulting psychological discomfort becomes functional for individuals as a motivational 'spur' for self-appraisal. AA teaches that all forms of anger are negative responses (AAWS, 1952: 92), and that there is no room for 'justifiable anger' in AA's therapeutic framework. AA members are inculcated with the belief that mismanagement of emotional disturbances may lead to relapse. The 'problem' exists within the individual and further Steps need to be taken as a corrective measure.

Sponsorship is the only prescribed relationship in AA's texts; it is a normative feature of AA. The role a sponsor may take in an individual's recovery is significant, defined as necessary by AA (AAWS, 2001; 1952), and considered a protective factor reducing the likelihood of relapse (Young, 2012). This formal dyadic relationship is un-supervised, and members cited problems from the perspective of a sponsor and a sponsee. Reasons for this relationship decay ranged from ending the relationship on grounds of sexuality: one sponsor could not 'cope' with another member's homosexuality and perceived levels of co-morbid psychological problems, rendering persons 'unsponsorable'. AA

members are free to enter into and exit the sponsor/sponsee relationship voluntarily, and are under no obligation to offer an explanation following termination of this arrangement.

The boundaries between AA sponsorship and therapeutic communities which also use of the Twelve Steps had become blurred with a 'therapeutic logic'. Individuals leaving therapeutic communities and residential care and rehabilitation care are strongly encouraged to join AA groups in their respective communities. It was suggested that a person leaving treatment had brought with them an expectation, and this was reflected in sponsor's roles becoming more analogous to that of a counsellor. AA's guidance on sponsorship (AAWS, 2010) report's that government and the treatment industry commonly refer persons to AA for continuing treatment. AA claims that, while individuals exiting treatment may be 'physically dry', a reference to being without a drink but not 'sober', they may still suffer from the mental obsession with alcohol. This consolidates AA's theory of alcoholism and its permanence.

Respondents in this study were long-term abstinent members of AA, for whom coping mechanisms were deeply embedded behavioural and cognitive responses. Threats to disengagement from AA's therapeutic practices have been conceptualised as emanating from distal and proximal sources. The key argument made here is that AA members make use of AA's literature and cognitive strategies developed. Perhaps a clearer conclusion on managing threats to disengagement ought to be left to one of the respondents. This quote from Ryan sums up the purpose of attending AA, the value of

embedding AA's principles at a cognitive level and the behavioural responses that maintain sobriety:

There's no reason for me to lift a drink, just ten thousand excuses. I try to remember that, and going to the meetings and talking to people certainly helps [Ryan, early 60, 26 years of continuous sobriety].

8.3 New Perspectives and New Knowledge

This study is the first qualitative study conducted in the UK into AA's beliefs, practices and effects since David Rudy's (1980) study of relapse, or 'slipping' in AA parlance. Gabhainn's (2003) cross-sectional study design, had hitherto been the only study into AA membership in the UK since 1979 (see Gabhainn, 2003: 59). Studies that have focused exclusively on AA in the UK are scarce. This study, in addition to demonstrating and discussing hitherto unexplored aspects of AA, offers a new empirically validated and revised working model of AA mediated change.

Section 8.2 described the moderating effects of individual, dyadic and group stressors, and how engagement with AA's mediational components -MtE, SSE and PA - provided a protective set of psychological and environmental defence responses to the risk of disengagement. Here, further changes to the model are discussed and integrated. Behavioural Outcomes (BO) - sustained behaviour change over time - was discussed in Chapter Seven; and it is to these temporal effects that the analysis turns, in order to assess the model and make the necessary adjustments. These are outlined as accepting the 'condemnation script', developing a capacity for self-reflection and self-control, and the use of 'linguistic echoes': phrases used in the 'recovery script' are prerequisites for

behavioural change. These components are treated as revisions to the temporal effects-
parctices that emerged inductively following data collection and analysis.

8.3.1 Changes to the Model: AA's Mediated Effects

Figure 12

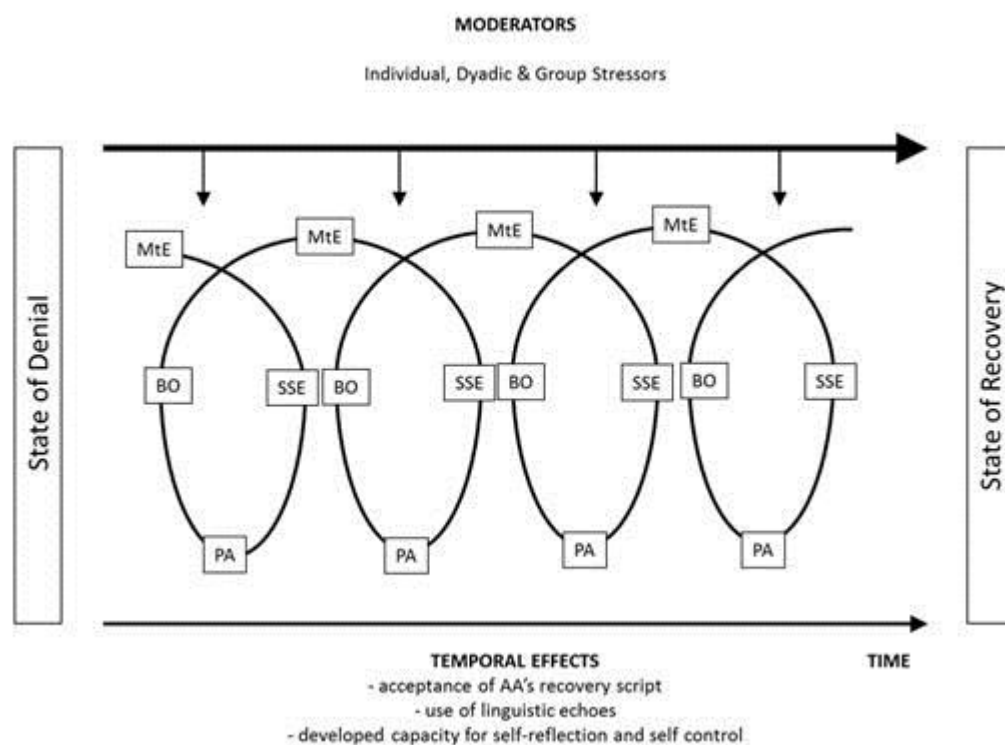


Figure 10 above represents changes made to the original hypothetical model of AA-mediated behavioural change in light of the field data. The 'book-ends' of the model, reflect the trajecotry of recovery for this cohort- from a Sate of Denial to a State of Recovery. The temporal effects are now acceptance of AA's recovery script, use of linguistic echoes and more highly developed capacity for self-reflection and self-control. Participation in AA's therapeutic practices mediates or explains how the individual starts from a state of denial, moving towards behavioural improvement. The

helix is labelled so as to demonstrate each conceptual component, and the analysis accompanying these concepts was addressed in Chapter Five, Motivation to Engage (MtE), Structured Social Engagement (SSE) and Personal Agency (PA). The moderators have been discussed across the three analytic chapters. Specifically, Chapter Six dealt with individual, dyadic and groups stressors. These were the threats to disengagement from AA, and the variation in individual and group responses to these stressors that maintained engagement.

The empirical evidence and a close reading of AA's literature demonstrates and explains how and why these effects occur. AA's therapeutic practices predicts behavioural change. The temporal dimension of this model was investigated by interviewing persons for whom membership to AA had been a central activity for a number of years.

8.3.2 Accepting the 'condemnation script'

The arguments made so far clearly show that on entering AA, one begins the recovery process begins from an unacknowledged/unmanaged chronic problem state. Thereafter, following AA's principles and therapeutic practices, a person acknowledges and manages that chronic state. The unique finding from this study is that a key facilitator in this process is derived by learning AA is a 'recovery script'. In brief, this is supplied in AA's literature, and forms a key discursive feature orally transmitted in AA meetings. As a person becomes attuned to and frequently exposed to these forms of discourse,

AA's philosophy of recovery, theory of alcoholism and overall ideology are a potent and persuasive mix.

One of the most striking finding from this study was that abstinent members accepted a 'condemnation script'. This supported a coherent sense of self, facilitating cessation from negative patterns of drinking, criminal and personally troubling behaviour. This is contrary to Shadd Maruna's (2001) argument that the 'redemption script', one that focuses upon a core 'goodness and conventionality of the narrator', is deemed necessary (Maruna's expression) to recovery. 'Redemption scripts' require that a person 'rewrite a shameful past', paving the way for a 'productive and worthy future' (ibdi: 87). Evidence gathered for this study clearly demonstrates individuals taking responsibility for past wrong-doing, participating in generative modes of behaviour while remaining abstinent and, overall relatively crime free.

For Maruna (2001:75), persistent offenders accept a 'condemnation script' that allows a person to be absolved from a degree of responsibility, based on the belief that 'their life-scripts' are written in early life. Blame for any negative behavior or psychologically and emotionally disturbing past events is apportioned to society. Expressing similar 'turning points' to Maruna's (2001) 'condemned persister', one respondent described similar sexual abuse in early childhood. Key features from Maruna's study of condemnation scripts and empirical evidence from this study are congruent. Maruna's 'thief' accepts this identity: 'just a thief -no more, no less', much in the same manner to which Sarah accepted her diagnosis of cervical cancer: 'I deserve that [...] virgins don't get cancer of the cervix. It felt like that was the right thing to happen'. Similarly, in Maruna's study,

and for the respondents in this study, the recovery ‘script’, either condemnatory or redemptive, offers a level of protection from previous shameful events. A coherent sense of self is achieved, just as Sarah quarantines an ‘older’ untreated self in the past. Other evidence was found that supported the ‘condemnation script’, as other respondents suggested that ‘I need to fear me, and a return to way I was’, and that ‘always judging people [...] [is] one of the most crippling things of my life’.

8.3.3 Developing a Capacity for Self-Reflection

Reading from the condemnation script, a recovering alcoholic in AA becomes skilled in assessing their emotional and mental states. This reflexive capacity allows a person a degree of predictive ability in terms of relapse prevention. As Terry asserted, he needs to ‘fear himself’ and the return to old patterns of behavior, following the Twelve Step program, finds a person in a state of cognitive dissonance (Festinger, 1957). Through self-examination, employing the Twelve Steps with the aid of a sponsor and moral reflection, cognitive distortions are revealed. These distortions are associated with older forms of behaviour, in which the individual may further indulge with or without alcohol. Engaging in activities incommensurate with AA’s philosophy elicits feelings of ‘discomfort’, thus placing the individual at risk of relapse. Avoiding negative affect is contingent on internal support mechanisms, moral reflection and external resources, other recovering alcoholics and AA’s literature. Significantly, the difference for those interviewed in this study was that, following acceptance of the ‘condemnation script’ or ‘recovery script’, cessation from negative drinking patterns and the amelioration of personally troubling behaviour was maintained.

For AA members, a clear rupture in behaviour is achieved the moment a person achieves stable abstinence. Negative past experiences, various acts of criminality and morally transgressive behaviour are associated with the drinking, previous self. These experiences are reframed as a result of engagement in AA's therapeutic practices. Once internalised, this understanding of the self, facilitates behavioural change, as the successful abstainer develops self-control, based on social support - contrary to Maruna's (2001) findings which condemn the person to perpetual failure.

8.3.4 Developing Control: Prerequisites for Behavioural Change

Maintaining control and translating that control into behavioural change, specifically regarding attitudes towards alcohol, criminality and personally troubling behaviour, were the focus of Chapter Seven. Assessing the long-term effects for AA members in this study demonstrated how the acceptance of the 'condemnation script' supported in the initial stages of recovery, was a necessary pre-requisite for maintaining abstinence. The basic tenets set out in AA's core texts (AAWS, 2001 & 1952), in addition to participation in AA's therapeutic practices, develop cognitive restructuring. As an internal support, 'habits of abstinence' and moral reflection become an embedded practice for each individual, and is a prescribed recovery technique in AA. Re-orientating one's self towards self-control is thematically at the core of the analysis, which explains the development of internal and external supports. Shifts in attitudes regarding criminal and personally troubling forms of behaviour evidence how support is used to effect behavioral change. The data and subsequent analysis does not find that AA has any direct effect on criminality/desistence, rather these effects are incidental.

The problematic to be resolved is - how is self-control developed and maintained while simultaneously ceding this to the notion of a Higher Power?

AA frames alcoholism as a problem of existence. The 'causes and conditions' lie in character flaws within the recovering alcoholic individual (AAWS, 2001: 64). These govern maladaptive responses to events and circumstances the alcoholic finds themselves in during the course of social interaction. From the narrative accounts given, respondents' defects of character are perceived as stable and enduring. As one interviewee described his personality, 'the way you are drunk is just an amplification of the way you are'.

The problem for the recovering alcoholic is one of control. Kurtz (1979) explains the argument; alcoholics are caught in an existential conundrum, forever trying to exert control over their environment. Failure leads to more drinking, as efforts to control the outcomes of social interactions, in order to achieve an inner peace and happiness, become increasingly less successful. This, Kurtz argues, is the chief character flaw of the alcoholic: trying to achieve 'God-like' powers of control, not just over alcohol intake but of their own environment. The individual has to accept 'not being God', and recognise their character flaws in the pursuit of this endeavour.

For AA, the removal or amelioration of the worst effects of these character flaws or defects, can only be facilitated by abstinence and help from a Higher Power. Step Ten (AAWS, 1952) introduces the recovering alcoholic to the practice of 'unsparing self-survey'. This is the formalised practice of moral reflection, the development of a

reflexive capacity that, once firmly embedded as a cognitive skill, becomes a ‘habit of abstinence’. Lingering defects of character are evidence of person’s alcoholism; they may hope for improvement in such areas, rather than eradication. The recovering alcoholic in AA simultaneously achieves self-control by using cognitive skills, moral refection and external forms of support. Key to success comes from a Higher Power, a third resource that is a projection of powers of self-control. The conclusion to be drawn is that self-control is socially as well as psychologically contracted; it is psych-social.

8.3.5 The Use of ‘Linguistic Echoes’: Phrases Used in the ‘Recovery Script’

Thematically, mastering techniques of self-control have been at the heart of the analysis, across the three analytic chapters (5, 6, &7). Individuals interviewed for this study used key expressions or linguistic devices found in the AA literature, when narrating their life stories and experiences. These ‘linguistic echoes’ recurred in the respondents’ transcripts with extraordinary ubiquity, and they have been explored across all three analytic chapters. Where possible, these examples were made by italicising key words and phrases. This represents another new finding, and an interesting addition to Borkman’s (1976) analysis of shared experience, conveyed in mutual-help groups as ‘experiential knowledge’. The argument made supports Borkman’s (ibid: 446) notion that this form of knowledge is acquired following direct experience with alcoholism. This knowledge represents a therapeutic ‘source of truth’ for recovering alcoholics to be shared. This source of information is validated by a collective experience representing broad, shared themes that characterise the shared problem. Marked similarities between the respondents’ narratives and phrases identified in AA’s texts demonstrated how

respondents structured their understanding of themselves in relation to alcoholism. These were the ‘linguistic echoes’ used as a support resource.

AA has a mediational effect by exposing the individual to a recovery script. The vehicle for embedding the recovery script is the ‘linguistic echoes’, the therapeutic expressions learned via participation in AA. As the findings and discussion have detailed, AA’s mechanisms and therapeutic practices confers upon the individual a belief in a ‘core-badness’, or in AA parlance a set of ‘character defects’. As Humphreys (2004: 38), asserts, ‘...one is an alcoholic, there is no such thing as a cured, ex-alcoholic’. Once these defects and permanent problem state have become acknowledged the individual experiences behavioural change.

The overall trajectory of behavioural change points towards positive outcomes, specifically abstinence. There remain fundamental complexities and unanswered questions which underscore the problems and limitations of this study, and which will help to highlight further areas of AA on which to concentrate research.

8.4 Implications: Alcohol-Drug Treatment Policy, Recovery and the Criminal Justice System

AA is not allied with any sect, denomination, politics, organisation or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes... (AAWS, 2014).

Rarely have we seen a person fail who has thoroughly followed our path (AAWS, 2001: 58 my emphasis)

These statements outline AA’s position, in every sphere of social and political discourse, which thus maintains AA’s position of complete neutrality. Regarding the Twelve Steps

and recovery, AA is unchanging, the Steps and associated principles of recovery must be followed. AA's therapeutic approach is inclusive all socio-demographic variations found in those seeking help from alcoholism: one size fit's all. The discussion turns to AA's principles of recovery and how this approach intersects with UK drug policy, specifically with regard to the 'recovery agenda' - *A Vision of Recovery* (UK Drug Policy Commission, 2008), *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life* (HM Government, 2010) and *Putting Full Recovery First* (HM Government, 2012). AA's position on recovery is clear: abstinence is all, without cessation from negative drinking patterns no recovery can be achieved.

8.4.1 Recovery: a sprawling agenda and contested goals

The concept of recovery is not new (Berridge, 2012). Rather, the concept is subject to varying degrees of support, and is currently associated with government strategies and the burgeoning recovery movement (White, 2006; Borkman, 2009). Examples include *Wired In* ([www.recoverystories](http://www.recoverystories.com) 2014), an online channel devoted to recovery stories, and the UK Recovery Federation, an advisory group which promotes diverse pathways to recovery. The *A Vision of Recovery* (UKPDC, 2008) document outlines the polarisation in the approach to treatment, abstinence and maintenance. Further, key features of recovery were identified with the intention of bridging the polarised definition of recovery. These were to be taken forward and implemented in the treatment of drug and alcohol dependent persons. The document recognises the need for an all-inclusive definition of recovery. Abstinence is juxtaposed with support for 'moderate use....(...an occasional alcoholic drink)' (ibid: 5, parentheses in original). Thus the tensions remain, as this further legitimises relapse as a common feature to be

expected in the recovery process. This position stands in contradiction to AA's philosophy of recovery. Abstinence must be achieved before recovery may begin. Many times, respondents in this study reported that, first, the achievement of abstinence is a discrete, recognised and pivotal moment that is celebrated by AA members (Denzin, 1987; Robertson, 1988; Smith, 2007). Other research supports abstinence as a desired treatment goal amongst the drug using population. McKeganey et al (2004: 423) surveyed over 1,000 drug users attending treatment, of whom 56% reported that abstinence was the preferred outcome, as opposed to 7% seeking a reduction in their usage. Neale et al's (2011: 190) qualitative study confirmed that users desired a drug free-life: 'It's got to be abstinence' remarked one respondent.

Key elements that also signify recovery were involvement in family life, and entry/re-entry into the work place. As the document *Putting Full Recovery First* (HM Government, 2012) argues, the notion of recovery constitutes more than an alcohol/drug free life. Work and employment for those in recovery became a priority for the present UK Coalition Government. Ideologically, work features strongly in the current political discourse; the current rhetoric places drugs and alcohol dependency at the centre of social 'problems'. In 2010 Maria Miller, Minister for Disabled People, reported that '80% of problem drug users are estimated to receive benefits ... they need to overcome their dependency and get back to work'. The current government's promotion of recovery- orientated goals, beyond abstinence, is commensurate with AA's philosophy of recovery and has been empirically evidenced. AA literature advocates supporting other members find work, 'try to help him about finding a job' (AAWS, 2001: 96). In addition to this role, one of the interviewees, Terry, actively sought new AA members, whom he judged were effectively working the Twelve Step Program, and offered employment to them.

8.4.2 AA, Alcohol and Offending

In terms of offending, alcohol misuse has remained a permanent feature in public, policy and criminal justice discourses (Fitzpatrick, 2011). Regarding desistance, findings support the argument that once stable abstinence has been successfully achieved, criminal and morally transgressive behaviour become problematic to be resolved via recourse to the 12 Step Program. In terms of desistance, the study cannot claim that 'AA causes desistance'. Rather, continuing involvement in criminal activity or other morally transgressive ways, are re-framed in AA's discourse as risk inducing behaviors that may precipitate a return to destructive drinking. Continuing to behave in such a manner is not commensurate with AA's overall ideology. The avoidance of such behaviors are treated as relapse prevention measures.

The single undeniable desistance outcome found amongst this cohort was that abstinence precluded further drink and driving. With one exception, all the members of this study admitted to having driven a vehicle while over the prescribed legal blood alcohol limit. One respondent, most memorably, recounted how every panel on her car was dented as a result of drink-driving:

Drinking and driving was a big one for me, I used to do it a lot, every day really [Sarah, 60, 26 years of continuous sobriety].

Other forms of criminal behaviour that AA members admitted to participating in, pre-AA engagement, ranged from violent behaviour towards spouses and others, fraud, tax-evasions and manslaughter caused by drinking and driving. While it may sound glib to state the obvious fact, that the instance of drinking and driving is non-existent amongst

an abstinent cohort, the fact that one member spoke openly about the effects drink-driving – manslaughter- serves as a poignant reminder of the positive influence AA has made on this cohort.

In recent years (AAWS, 2011) AA has begun to work more closely with the Probation Service (PO). Prison Liaison Officers (PLOs) have a handbook that suggests that co-operation with the PO and the Criminal Justice System will help reduce alcohol-related offending. Further, the handbook asserts that offenders attending AA ‘have often changed the direction and quality of their lives’ (AAWS, 2011: Chapter 3, no page number given). This direction of AA activities moves beyond the intention to merely pass on information about AA, the Twelve Steps and where one might find and access AA meetings. This is at odds with AA’s preamble (AAWS, 1947), which asserts that ‘AA is not allied with any sect, denomination, politics or institution’.

AA’s official website (www.alcoholics-anonymous.org.uk) reports that the Trustees of AA met with National Offender Management Service on 27 September 2013. The one page article says nothing of AA’s involvement; neither states why the Trustees are attending. Importantly, as reported on the AA web-page, the new incentivised Payment by Results strategy is set to feature strongly in rehabilitation of low-medium risk offenders. Just how far AA is willing to become associated with government agencies remains to be seen, but poses further empirical questions, that might explore AA’s future role in the Criminal Justice System. Stemming directly from abstinence, findings articulated here support the government’s implied perspective that cessation precedes recovery. In terms of direct policy involvement, AA as an organisation would have no

part in the public/political debate on abstinence versus reduced/controlled consumption. This section has demonstrated where AA's therapeutic practices and the concomitant empirical findings are intersecting with policy. However, as discussed earlier, there is some evidence that AA may be about to break with this position as it engages with the Criminal Justice System. The findings presented here regarding the transformative effects conferred upon an individual, particularly in terms of desistence, will be of significant interest to policy makers.

8.5 The Limitations of the Thesis and the Future Research Agenda

From a small scale, qualitative study, the findings are based on data generated from 20 in-depth interviews. The participants were recruited via the use of a gatekeeper; sampling was therefore opportunistic. The cohort selected was biased towards a socially stable abstinent sample of AA members, the majority of whom are in full-time employment. The empirical questions necessitated that the individual had experience of AA membership and was familiar with AA's Twelve Steps. By virtue of this latter fact, persons must have also experience(ed) sponsorship. This research was conducted with specific focus of targeting persons for whom abstinence was stable, and readily identified themselves as members of AA. The findings are limited to individuals for whom regular attendance and sponsorship have featured in their recovery, and not the views of perhaps abstinent members, for whom sponsorship and the utilisation of AA's Twelve Steps have not played a prominent role.

8.5.1 The Limitations of the Data

The notion of generalisation is a goal of research usually associated with the positivist epistemological approach. Harnessing the methodologies of the natural sciences, in search of an ‘objective’, ‘knowable’ ‘truth’ about a social phenomenon, has hampered previous research on AA (Borkman, 2009; Slaymaker and Sheehan, 2009). Therefore, the unit of interest that concerned this researcher was the individual’s lived experience. This focus allowed for the interpretation of the way experiences were told, the language used and primacy was given to certain key events that shaped a person’s understanding of themselves (Bryman, 2001). Individuals perceive past events with an imperfect insight, as Gadd (2002) argues, following Bourdieu’s (2000) assertions that narratives are motivated by the respondent to produce meaning, via offering coherent and consistent sense of relationships and events. Recounting past events in such a way ‘attributes excessive coherence’ (Gadd, 2002: 383). Research that is heavily dependent on memory recollection, encounters problems pertaining to ‘truth’, which are highlighted in narrative accounts (Strauss and Corbin, 1990). The ‘subjective truth’ elicited from the respondents must therefore be recognised as valid; but the role of the researcher is to locate this experience within the structure and discourse available to the subject. This appears to be most certainly the case with the respondents interviewed for this study. However, the case to be argued is not the pursuit of ‘truth’; rather it is to understand the mechanism by which individuals construct or –reconstruct their sense of self, which is presently orientated towards maintaining recovery. The framework provided by AA allows this construction to take place.

AA's basic text, Alcoholics Anonymous, and the first 164 pages, have not been altered in any way since first publication (1939/2001). Also, the Twelve Stapes and Twelve Traditions (AAWS, 1952) have also remained unchanged over the last five decades. In terms of transferability, the theoretical/conceptual framework which helped conceive of the putative model of change described was driven by extant literature. Within this framework, this study could be transferred to other similar settings (Silverman, 1998). In addition, AA's texts were consulted in great detail. A level of triangulation can therefore be argued to exist that further augments the credibility of the study.

It must be acknowledged that the sample drawn from AA has had an impact on the data. Therefore, in an effort not to over-state that this is a process model for all people for whom membership to AA has/is beneficial, a discussion on the limitations the findings from this sample is necessary. Bury (2001) noted that investigating illness, persons interviewed may want to shape their narratives to 'fit' an audience. To propose to the listener, a version of events and coping strategies that make the person suffering from an illness, or alcoholism is recovering more efficiently than is the case. I had no way of knowing that the person was in actual fact sober for the stated length of time.

A purposive sampling strategy was used in conjunction with the help of a gate-keeper. The majority of the cohort sampled were white and well educated, either retired from or having professional jobs, this demographic has previously suggested to represent persons with a greater likelihood of joining AA (Terra, 2007). Miles and Huberman (1994), use the term *elite bias*, which considers a subject more capable of articulating perhaps 'richer' experiential accounts, make the researcher vulnerable to overweighting

this data when drawing conclusions. In terms of ‘plotting’ the recovery journey members of the cohort who have been educated to degree level, may have invested different pro-social goals and objectives, than less well educated members of AA. For example, the model’s integral components illustrate Personal Agency (PA), and changes in self-efficacy to be associated with maintaining abstinence. As discussed in Chapter Four, sampling individuals from different socio-economic backgrounds may evidence differences in A, investment in pro-social goals and B, temporally speaking, changes over time may not evidence the use of ‘linguistic echoes’ as a cognitive structuring device. Reasons for this may range from differing learning styles, or perhaps less of a focus on reading AA’s literature.

This thesis offers a theory of how an individual is motivated to maintain sobriety, while employing AA and its therapeutic practices as a structure of support and motivation. Accounts provided here offer an insight into the experience of sobriety in AA; but this is not an all-encompassing explanation that stretches to explaining other Twelve Step organisations, such as Overeaters Anonymous, for example. Hence, while members of this study may well have engineered and incorporated the identity of a recovering alcoholic, and limited the stigmatising effects by virtue of long-term abstinence and membership to AA, the concealment or distortion of other events may have occurred this therefore negates the credibility of one’s ability to ‘work’ the program, both to the interviewer or a wider AA audience. However, as one progresses, sobriety or an individual’s behavior are neither monitored or subject to official control or censure, it is left to the individual’s subjective judgment to determine success.

8.5.2 AA: Un-Monitored and Un-Regulated

Paul Bebbington (1976: 572) remarked upon AA's 'unusual characteristics' which made its effectiveness particularly difficult to study in terms of effectiveness, primarily on methodological grounds. Humphreys proposes that addicted individuals and society in general have a right to know whether self-help groups are effective. Researchers and evaluators, according to Humphreys (2004), have perhaps a moral obligation to determine the efficacy of such groups. Perhaps the most persuasive argument is to be made when one considers the breadth of AA's geographical spread, across 50 countries, and the size of the membership, 2 million members (AAWS, 2001; Humphreys, 2004, Smith, 2007, Strobbe, 2009). The findings reported here suggest that, on occasion, some of AA's practices may run counter to the intended goal of supporting and encouraging persons towards long-term abstinence.

Through adherence to AA's Twelve Traditions (AAWS, 1952), the organisation has maintained complete autonomy. Demanding no contractual agreement or membership fees, seeking neither licensure or accreditation, and a codified refusal to accept external funding from any government or private source, AA remains autonomous. AA's therapeutic practices are adopted by lay persons, for whom neither mentoring nor supervision feature as an organisational formality. Members cannot report another member to a hierarchical body for mal-practice or for other disciplinary issues. Censure is informal and indeed a rare occurrence. It is largely left to one's own conscience and personal interpretation of the Twelve Step program, or the group conscience, for example Tradition Four (AAWS, 1952), attempt to resolve individual or internecine struggles/dilemmas.

8.5.4 Further Empirical Questions

Emerging from this research further concepts and practices that have attracted little or no attention of researchers thus far, warrant further investigation. First, AA's Twelve Traditions can be interpreted as organisation policies. As previously noted, Tradition Three regarding membership and Tradition Four, regarding AA's finances, have shed some light on the function of the Twelve Traditions. Towards the end of an interview, I asked a 'throwaway question' on the Traditions. The reply came, 'The Steps are there to stops us killing ourselves, and Traditions are there to stop us killing each other'. Pushing further, the respondent elaborated by explaining that the Traditions were discussed at 'inter-group', 'region' and at 'conference level'. There exists in AA a clear organisational structure. This functions to maintain the operation of the Fellowship of AA according to its principles. Further, the respondent then spoke briefly about a 'career' in AA. One is elected to the position of Group Service Representative (GSR), then from inter-group (a collective of local GSRs) a person proceeds to be its representative at Conference level. A study of these operating policies and the organisational structure of AA may go some way to explaining AA's longevity (Gross, 2010).

AA's insistence of maintaining political neutrality appears to be eroding, and suggests that they may be co-opted into the criminal justice system. In addition to the unique insights demonstrated in this thesis, further research into AA's governance policies (The Twelve Traditions) would aid a further understanding and could produce a credible model for the formation of other recovery focused organisations.

A prospective study of AA would help answer some of the following questions, and investigate the themes introduced in this study but without a full analysis. Following Maruna's (2001) notion of the 'condemnation script', or AA's recovery script, some individuals may balk at AA's instance of 'powerlessness' and 'unmanageability', much less accept 'character defects', particularly if one has come from an abusive or dysfunctional family background. One of the key questions to be asked and determined must be - for whom does AA not 'work'? The objective would be to reveal some of AA's exclusionary elements. AA' members' levels of happiness poses an interesting and under- researched theme in AA. This is particularly apposite in consideration of the condemnation/recovery script thesis. The practice of moral reflection and self-searching might engender an almost paranoid disposition to social interaction amongst some AA/prospective AA members.

The effects of age are least understood in the empirical findings presented. A study is needed determine whether age and stage in life are interacting with AA related practices to produce beneficial outcomes. From this study, the youngest participant was in his early 30s, the oldest was in his late 60s, with nine and thirty years of continuous sobriety, respectively. To discover the positive interactional effects of an individual investing in and maintaining stable social bonds, whether informally, such as finding a life partner, or more formal, finding stable employment, would add to and enhance the study of desistance (See Sampson and Laub, 1993, 1998, 2006,: Rhodes, 2008). By further elucidating AA's mechanisms for positive change, elements of AA's therapeutic practices may be adapted to help structure rehabilitation efforts in the Probation Service.

8.5 Conclusion

This study has demonstrated how an individual moves from a chronic problem state to maintaining abstinence. In addition to demonstrating under what circumstances a person enters AA and achieves sobriety, this thesis has illustrated how, thereafter, members of this cohort used AA's recovery philosophy when threats to disengagement had been encountered. The limitations of using a small sample have been noted and suggestions made on how this has impacted on the data collected and the concomitant effects on the model, for example the use of 'linguistic echoes', may not be a temporally related change for all members of AA. Incidental to engagement with AA, AA members described how once inculcated in AA's therapeutic discourse, began working the 12 Step Program, continuing with criminal and other morally transgressive behavior, became incommensurate with AA's philosophy on recovery. AA's impact on criminal and other personally/morally transgressive behaviors has been an increased capacity for self-reflection and self-control. The data does not support an overarching theory that AA engagement predicts desistence. So far as the data does support this, drinking and driving, by virtue of abstinence, is one concrete conclusion that can be made.

This thesis further contends that members use a set of key phrases found in AA's literature. These form a scaffold of 'linguistic echoes' that help an individual understand their unacknowledged problem state, and additionally explain how the person embeds this use of language, forming a new sense of self. The data presented here also challenges Maruna's (2001) notion of a 'condemnation script' as a deterministic narrative that, once accepted, limits behaviour change. Building the argument, this study illustrates how, starting at Step One (AAWS, 1952), a person is inculcated with limiting

beliefs regarding one's own self-efficacy, in relation to alcohol and the general 'unmanageability' of one's life. The term 'recovery script' was felt to better reflect the functionality of these phenomena as pre-requisites for the successful abstainer.

The empirically derived model demonstrates overall positive changes for this sample and is an original contribution towards further understanding AA's mechanisms of change. To help understand the process of behavior change an original model was constructed, tested and then revised in light of the data. This model represents an original contribution to the literature on AA, and expands our knowledge AA's beneficial effects. Three key concepts were identified: Motivation, Structured Social Engagement and Personal Agency. Using these three conceptual components as an analytic framework theories relating to these were used during the analysis of the data. Support for the 'virtuous cycle' of behaviour change, the simple two-dimensional model, was illustrated in the findings. The data at this point revealed some of the benefits of membership to AA, particularly in relation to social capital, such as employment opportunities. At the psychological level, increased levels of personal agency were clearly demonstrated, as members of this cohort described a return to education and the pursuit of other socially valued goals.

Problems associated with maintaining sobriety were also considered. These threats to disengagement from AA's therapeutic practices emanated from two broad spheres: distal and proximal. Although no clear, absolute line of distinction was made, AA members largely dealt with these threats differentially. Findings in this study demonstrated that for distal threats, such as the death of a loved one, recourse to AA's

pro-abstinent supportive network was crucial. Proximal threats emanating from within AA are novel findings and shed new light on the nature of AA. Problems relating to the sponsor/sponsee, dyadic relationship, and perceived threats to ideological purity and fidelity to AA's philosophy were reported. Individuals were found to use psychological resources developed as function of 'working the program'.

AA, it has thus been argued, supports behaviour change across variety of domains, not just cessation of problematic drinking patterns. Tentative claims towards AA's ability to support other social and psychological needs expressed by the respondents in this study have been made. Friendship and trust amongst other members of AA, often following long periods of social isolation. For those members of AA interviewed, AA has 'worked'. However the problem of alcohol dependence is conceptualized, AA's methods and philosophy can and do provide an all-encompassing recovery structure for sufficiently motivated individuals.

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Appendices

Appendix A

Informed Consent Form: Research into Alcoholics Anonymous

Participant ID Number for this research:

Name of Researcher:

- | | | | |
|---|--------------------------|----------------|-----------|
| 1. I confirm that I have read and understand the information sheet dated(version) for the above research and have had the opportunity to think about the information and ask questions. | <input type="checkbox"/> | <i>Initial</i> | <i>in</i> |
| | | <i>box</i> | |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my treatment or legal rights being affected. | <input type="checkbox"/> | <i>Initial</i> | <i>in</i> |
| | | <i>box</i> | |
| 3. I agree to the audio taping of my interview with the researcher | <input type="checkbox"/> | <i>Initial</i> | <i>in</i> |
| | | <i>box</i> | |
| 4. I agree to take part in this research. | <input type="checkbox"/> | <i>Initial</i> | <i>in</i> |
| | | <i>box</i> | |

	__ / __ / __	
Name of Participant	Date	Signature

Name of Researcher

Date

Signature

Appendix B: Interview Topic Guide Membership to Alcoholics Anonymous

Opening Questions and Question on AA

Can you describe your experience of joining AA?

Once you had joined AA, what other activities with other members did you participate in, other than attending meetings?

What other benefits have you been exposed to by being a member of Alcoholics Anonymous, other than the support to stay sober? For example either helping someone to a job/being helped into a job, relationships etc

Can you describe why it is important to attend meetings?

How free do you feel you are from alcohol dependence?

Sponsorship

What has been your experience of sponsorship?

How did your sponsor show you how to start working the 12 Step Program?

Can you describe how each step was worked and what benefits you have gained from this process?

The 12 Steps and their effects on behaviours other than drinking

Can you describe what other problematic behaviours in your life that working the 12 Step Program has helped with?

Can you tell me what your attitude towards alcohol is?

What behaviour that would be classified as criminal did you participate in?

How did being a member of Alcoholics Anonymous help you come to terms with this?

Appendix C

Participation Information Statement (Interviews)

You are being asked to take part in a research project conducted by James G Irving (BaHons, MRes), an Associate Lecturer and PhD candidate at the School of Law, University of Manchester. The purpose of this study is investigating the experiences of people who are members of Alcoholics Anonymous and who have been through the 12 Step Program.

You have been approached by another member of Alcoholics Anonymous because you fulfil the selection criteria, principally because you have more than two years continuous sobriety and have been through each of the 12 Steps with the aid of a sponsor. You are one of 20 to 30 other members of Alcoholics Anonymous who have been approached to participate in this study, it is hoped around 20 members will agree to be part of this study.

Your participation in the research study will be limited to an interview conducted by James where you will be asked questions about your experience membership in Alcoholics Anonymous. The interview will follow some topics and themes, for example, you will be asked questions about why you attend meetings of Alcoholics Anonymous, how you have been taught to understand and use each of the 12 Steps and how these Steps have helped you manage/overcome other problems in life including your experience with criminal activities such as drinking and driving. You can choose to end the interview at any time without giving a reason.

During the interview it is possible that you may experience some discomfort if you are recounting some distressing experiences. It is therefore advisable that you have a mobile phone to hand so that you could easily contact your Sponsor or other person that can provide advice and support to yourself should you become upset during the interview. The research will also have a mobile phone that can be used in the event of such a situation.

The interview will be recorded on a digital recording device and then backed up as an MP3 file onto a password-protected, non-networked computer. Access to this digital file will be limited to James. The recorded interview will then be fully transcribed into text format and the original audio file will be destroyed. Every effort will be made to maintain your confidentiality through the anonymisation of the data during the process of transcription. For example, you will not be referred to directly by name in the research findings and will instead be referred to by an initial or pseudonym. No individuals in this project will be identified in any report or publication about this study.

Your participation in the research study is entirely voluntary and your consent to take part can be withdrawn at any point, including after the interview has taken place, without having to give a reason. A written summary of results will be made available to you following completion of the study. If there are questions and/or additional concerns, you may contact me via email james.irving@postgrad.manchester.ac.uk or by telephone 07540895999 or my PhD supervisors Jon Shute and Professor Toby Seddon at the School of Law, University of Manchester, Oxford Road, Manchester, M13 9PL.

I have read the information provided above. I have had the opportunity to ask, and have had answered, all my questions about this study. I voluntarily agree to participate in this study. I understand that I will receive a copy of this form after it has been signed if I want one.

Signature of Research Participant

Date

Printed Name of Research Participant

Signature of Person Obtaining Consent

Date

Printed Name of Person Obtaining Consent