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The Twelve-Step Recovery Model of AA: A Voluntary Mutual Help Association

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Abstract: Alcoholism treatment has evolved to mean professionalized, scientifically based rehabilitation. Alcoholics Anonymous (AA) is not a treatment method; it is far better understood as a Twelve-Step Recovery Program within a voluntary self-help/mutual aid organization of self-defined alcoholics.

The Twelve-Step Recovery Model is elaborated in three sections, patterned on the AA logo (a triangle within a circle): The triangle's legs represent recovery, service, and unity; the circle represents the reinforcing effect of the three legs upon each other as well as the "technology" of the sharing circle and the fellowship. The first leg of the triangle, *recovery*, refers to the journey of individuals to abstinence and a new "way of living." The second leg, *service,* refers to helping other alcoholics which also connects the participants into a fellowship. The third leg, *unity,* refers to the fellowship of recovering alcoholics, their groups, and organizations. The distinctive AA organizational structure of an inverted pyramid is one in which the members in autonomous local groups direct input to the national service bodies creating a democratic, egalitarian organization maximizing recovery. Analysts describe the AA recovery program as complex, implicitly grounded in sound psychological principles, and more sophisticated than is typically understood. AA provides a nonmedicalized and anonymous "way of living" in the community and should probably be referred to as the Twelve-Step/Twelve Tradition Recovery Model in order to clearly differentiate it from professionally based twelve-step treatments. There are additional self-help/mutual aid groups for alcoholics who prefer philosophies other than AA.

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M. Galanter, L.A. Kaskutas (eds.), *Recent Developments in Alcoholism*,
DOI: 10.1007/978-0-387-77725-2_2,

Alcoholism treatment has evolved to mean professionalized, scientifically, and theory-based forms of rehabilitation. Alcoholics Anonymous (AA), however, is not a treatment method and is far better understood as a Twelve-Step Recovery Program within a voluntary self-help/mutual aid organization of self-defined alcoholics. Recent interpretations of psychiatrists, psychologists, anthropologists, and psychoanalysts who have thoroughly analyzed the twelve-step program show that the AA recovery program is complex, implicitly grounded in sound psychological principles, and more sophisticated than is typically understood.

The twelve-step recovery model of AA is elaborated in three sections, patterned on the AA logo (a triangle within a circle): The triangle's legs represent recovery, service, and unity. The first leg, *recovery*, refers to the journey of individual alcoholics from the cessation of drinking to the adoption of a new "design for living" which includes the meetings, the experientially based narrative approach to gaining knowledge and understanding, working the twelve steps, sponsorship, and doing service. The second leg, *service,* refers to helping other alcoholics (twelfth step work) which not only aids the individual, but also connects the members and attendees into a fellowship—simultaneously providing volunteer effort to keep groups and the organization operating. The third leg, *unity,* refers to the fellowship of recovering alcoholics, their groups, and the larger state, regional, national organizations. The distinctive AA organizational structure of an inverted pyramid in which the members in autonomous local groups direct the organization through their self-financing and policy input to the national level of "servant" service bodies results in a democratic organization in which egalitarian relationships between recovering peers maximize recovery. The group and organizational relationships posited as twelve traditions (12 & 12, 1974) and twelve concepts (12 Concepts for World Service, 1986) are integral parts of the Twelve-Step Recovery Model and the three legs (individual recovery, service, and unity) reinforce one another. This is quite similar to the idea of a "therapeutic community" in which the total environment is shaped to enhance recovery and growth. This chapter concludes with a restatement and the implications of the twelve-step model being a prototype of voluntary self-help/mutual aid, rather than a treatment approach as understood in professional alcoholism treatment circles today. There is an increasing development of professionally based twelve-step treatments (Humphreys, 2003) and AA should probably be referred to as the Twelve-Step/ Twelve Tradition Recovery Model in order to clearly differentiate it from professionally based treatments that rely on a twelve-step approach.

1. Essentials of Self-Help/Mutual Aid

Self-help/mutual aid groups, as defined here and by many social science researchers, are self-governing groups of members who possess a common health concern and provide emotional support and aid; membership is

essentially cost-free and experiential knowledge is highly valued (Surgeon General's Workshop on Self-Help and Public Health, 1988). Self-help groups, mutual help groups, and mutual aid self-help (MASH) are other terms used to delineate contemporary self-help/mutual aid of which AA is regarded as the prototype. I will use self-help/mutual aid and mutual help interchangeably.

"Self-help/mutual aid" is used to connote and signify the complexity, if not the paradox, that these groups and organizations represent. Frank Riessman, a major contributor to self-help/mutual aid theory, research, and policy for 30 years states that *self-help* refers to the internal resources mobilized by the encouragement, hope, and support received from mutual aid and to the self-responsibility an individual assumes for resolving his/her issues within the context of mutual aid (Riessman & Carroll, 1995). *Mutual aid* connotes the distinctive relationships and help found among those who have similar experiences with an illness or condition in such groups. Twelve-step groups, like other mutual help organizations, are problem-solving groups whose attendees develop experientially based information and understanding rather than from professional knowledge, hearsay, or conventional wisdom (Borkman, 1999). In the voluntary self-help/mutual aid context, the relationships among experiential peers are egalitarian instead of the hierarchical relationship of the superordinate professional and subordinate patient/client; help is freely given as a gift (Medvene, 1984), not a commodity; and help is reciprocal (i.e., the "helper therapy" principle; Riessman, 1965). One party to the relationship may be more seasoned and further along in recovery, but he/she can only gain influence, not a different status, as a result.

Self-help/mutual aid is not a panacea and appeals to a small minority of people with a common problem regardless of whether it is a group for people with arthritis, prostate cancer, schizophrenia, Parkinson's disease, alcoholism, or parents whose children have cancer (Kurtz, 1997).

2. Methodologies and Frameworks of Social Science

Social science organizational analysis distinguishes between the *ideal* and *actual* practices in an ongoing organization (see Kitchin, 2002). The analysis of AA as *ideal* would be *textual* AA, that is, AA as written in its official literature and certain highly respected texts. The major texts are Alcoholics Anonymous (1976), known as the Big Book, The Twelve Steps and Twelve Traditions (12 & 12, 1974), Alcoholics Anonymous Coming of Age (AACA, 1957), the Grapevine magazine, and respected histories such as *Not God* (Kurtz, 1979). See White and Kurtz (this volume) for a full description of major texts.

The analysis of *actual* practices and beliefs is empirically based through in-depth qualitative observation, interviewing, ethnography, field research (Agar, 1986; Gubrium, 1988), and "naturalistic inquiry" (Lincoln & Denzin, 2003). Given the nature of voluntary associations and mutual help groups one knows that *actual* living groups vary in small or large but unknown ways (relatively

few groups have been researched and documented) from the *ideal*. Diversity among AA groups is also highly likely because so much of the activity, transmission of beliefs and ideas, is oral rather than through the use of the literature (Makela et al., 1996).

The positivistic research of the medical scientist and epidemiologist that presumes there is a single knowable reality and uses well-developed methods of experimentation, reliable and validly established measuring instruments, and sample surveys with well-developed statistical techniques is inappropriate and limited for the study and understanding of AA in its very diverse cultural, social, and economic situations. Since ideal/textual AA expects each member to self-diagnose their drinking problem, to develop a relationship with a God or higher power of their understanding, to interpret their life story within AA's narrative framework, and to evolve their own recovery program in consultation with their sponsor, higher power, and friends, the individuality and lack of uniformity requires that in-depth field research or ethnography be used to study and understand the nuances and diversity. As a result, current AA researchers who are medical scientists and social scientists whose secular frameworks cannot easily accommodate nonscientific paradigms often parody, trivialize, or stigmatize AA.

Arminen (1998, 16–21) argues that two root metaphors have characterized analysts' descriptions of AA: (1) a religious *sect* with individuals undergoing a conversion process which can be traced to a sympathetic psychiatrist Tiebout (1944) influential at AA's founding; or (2) a *voluntary association* which can be traced to the sociologist Robert F. Bales (1944). While analysts can find evidence in support of either point of view, I selected the voluntary association root metaphor partly because it is compatible with my sociological training, but also for the following reasons: Textual AA says it is a spiritual, not a religious, organization (44 Questions, 1952); members are encouraged textually and in practice to interpret the higher power individualistically on their own terms; AA has diffused to a number of non-Protestant countries and is utilized by agnostics and atheists (Makela, 1993; Tonigan, Miller, & Schermer, 2002) making the religious connotations of *sect* limiting and problematic. The voluntary association metaphor fits best with and is informed by the research on self-help/mutual aid (of which AA is an examplar) and other Third Sector research on voluntary associations.

The study of voluntary associations, grassroots groups, NGOs (nongovernmental organizations), mutual help groups, and other forms of voluntary action is maturing into an interdisciplinary research area known as the *Independent Sector* or the *Third Sector*—government being the first sector, private for-profit business being the second, and the family and informal friends and neighbors being the fourth (Van Til, 2000). The essential concept is that each sector has distinctive practices, forms of organization, values, laws and regulations, financing arrangements, policies, and culture that characterize and distinguish it.

Thus, AA is regarded here as a voluntary mutual help organization. The referent is the organization—from the point of view of AA as an organization, participating in its activities or membership is voluntary. There are no application forms, admission committees, tests of alcohol dependence or other membership criteria, or contractual or fiduciary relationships between the organization and the member. Even more radically, membership is self-defined: You are a member if you say you are and the minimal criterion is "a desire to stop drinking (alcohol)" (12 & 12, 1974, 143). The self-defined members choose which meetings to attend at what intervals and how much contact with what depth to have with other members. There is no mechanism in the organizational principles for terminating membership or rejecting deviant groups. From the point of view of potential attendees, participation may not be voluntary: An increasing number of people with DUIs are court ordered to AA or jail and many people attend because of social pressure or threats from spouses/partners, bosses, physicians, friends to do something about their drinking. *Actual* living AA groups may dispel disruptive drunk attendees or treat newcomers in such a way that they feel unwelcome. *Actual* AA groups often have norms and practices recommending that their members follow certain patterns of attendance and service.

In writing this chapter, I have the objectives of (1) reflecting the interpretations and findings from recent research and analysis of AA which reveals *actual practice*, not just *ideal* text and marking difference between ideal/textual and actual/practiced; and (2) contextualizing and informing the writing from the concepts and findings on self-help/mutual aid which is consistent with the thesis that AA is best understood as a voluntary mutual help organization (Makela et al., 1996; Humphreys, 2004; Kurtz, 1997; Borkman, 1999). I mostly use the term higher power rather than God in respect of their own designations of being spiritual not religious and to acknowledge that AA has evolved beyond its Christian roots.

3. Recovery

Recovery is a special term used in AA (and now the larger recovery movement of other twelve-step groups [White, 2006]) to connote the process by which alcoholics become abstinent and undergo the self-help/mutual aid journey to heal the self, relations with others, one's higher power, and the larger world. Recovery includes the belief system and program of action, groups and their meetings, the Twelve Steps, and helping others within the context of a network of recovering peers. Recovery is a personalized and self-paced journey that is undertaken interdependently with one's alcoholic peers and follows recognizable general stages. Recovery as self-help means that an individual (textually/ideally) decides on how many and what meetings to attend; how, when, and with what guidance he or she does the twelve steps; whether or not one has a relationship with a sponsor or is a sponsor; how spirituality and higher power are interpreted; what and how much service to give to others; and

with whom one interacts at meetings or other places. Recovery as mutual aid indicates that the journey is not done alone but is undertaken with experiential peers and one's higher power who reciprocally assist and support the individual especially when requested. *Actual* recovery means that an individual's choices of meetings, working the twelve steps, sponsorship, view of spirituality and higher power, and service, are shaped and influenced by the practices of the groups, sponsor, and friends with whom the individual identifies and interacts.

3.1. Basic Beliefs About Alcoholism

AA's pamphlet *44 Questions* (1952, 7) describes the organization's definition of alcoholism as "an illness, a progressive illness, which can never be cured but which, like some other diseases, can be arrested." Although some drinkers think they are morally weak or mentally unbalanced, the view in AA is "that alcoholics are sick people who can recover if they will follow a simple program" (1952, 7). Once a person has become alcoholic, "free will is not involved, because the sufferer has lost the power of choice over alcohol. . .." What is important is to face the facts of the illness and use the help that is offered. Alcoholism is defined as a spiritual, mental, and physical illness and recovery requires healing all aspects of the illness. Abstinence from alcohol in and of itself is regarded as "being dry" and is insufficient because alcoholism is but a "symptom" of underlying character defects.

3.2. Becoming Abstinent

Recovery in AA is implicitly viewed in terms of an indeterminate number of phases or stages, at a minimum beginning, middle recovery, and oldtimer. Professionals such as Brown, a psychotherapist who worked with recovering alcoholics from AA, formalized a developmental model of four phases: drinking, transition, early recovery, and ongoing recovery. Others have models of change, such as DiClemente's (1993) transtheoretical approach, with five stages.

The transition (Brown, 1985, 1995) or beginning phase involves stopping drinking and giving up the illusion that one can control his/her drinking. In AA it is "hitting bottom"—surrendering or admitting defeat in self-controlling one's drinking. Brown and other treatment professionals refer to it as giving up "denial."

Newcomers are usually given extra attention and help as it is recognized that stopping drinking and accepting basic ideas of loss of self-control and the need to rely on an external power to stop drinking is difficult. A radical change of thinking is necessary; one cannot control one's drinking and the chaotic life that one has created is the result of abusing alcohol; and the key to restoration is not drinking (or using other drugs) and relinquishing control to an external power of one's choice. This transformation of belief is further discussed in Section 3.3.

Seasoned members give simple instructions to newcomers: go to meetings, don't drink, stay away from "slippery" places, say your prayers (i.e., ask for help from an external higher power). Alibrandi (1978), an anthropologist, asked a sample of established AA members to sort suggestions that would be given to newcomers versus those to be given to people in the program a month, 6 months, and so forth. She found that only a few simple suggestions are made to newcomers. Newcomers who want to make drastic changes to their job, family, or the like are cautioned to wait until they are more stable in their abstinence. More complex suggestions about working the twelve steps or making major life changes are made for members through the transition phase and into early recovery. Winegar, Stephens, and Varney's (1987) provocative analysis of alcoholic defense mechanisms shows how AA's actions toward newcomers confront their denial about drinking but let the newcomers maintain denial about other problems, which is therapeutically beneficial. They conclude that AA practices are complementary to their professional therapy—alcoholic defenses are selectively dealt with (denial is challenged to confront loss of control and the need to stop drinking) but denial and rationalization are retained in a positive manner at a time when realistically confronting other problems would send the alcoholic back to drinking. Steigerwald and Stone (1999) examined their cognitive restructuring theory in relation to the twelve steps and various AA practices such as meeting, using, and being a sponsor; and they found that the AA's twelve steps can lead to restructured thoughts, and "AA meetings. . .provide an atmosphere in which cognitive restructuring can take place" (Steigerwald & Stone, 1999, 323) and recommended further empirical research on the issue.

3.3. Identity Changes: From Drinking Nonalcoholic to Recovering Alcoholic

The drinking newcomer to AA, suffering from increasingly onerous and unacceptable effects of drinking, faces a belief system that is difficult for many to accept: Abstinence from alcohol is the first and necessary step toward recovery. The paradox of how to stop drinking for any length of time is to surrender control over your drinking. You must admit your powerlessness to control your drinking (Step 1) and develop a belief that a power outside yourself greater than alcohol can aid you in not drinking—by the early 1950s, the AA group was frequently mentioned as the higher power (12 & 12, 1974).

"The acceptance of loss of control and [assuming] the identity as an alcoholic form the core of the continuum of recovery" states Brown (1985, 11), a psychotherapist who has worked with alcoholics. AA regards the alcoholic not simply as a person who drinks too much alcohol but as a person whose human frailties are extreme—a self-centered and willful way of living that causes self-defeating unmanageability.

Social science analysts (Denzin, 1997; Pollner & Stein, 2001) have interpreted the AA process as involving two identity changes: (1) from the drinking

nonalcoholic to the alcoholic and (2) the recovering alcoholic who is not drinking and is facing his/her shame and remorse over past actions and repairing the damage and developing a spiritual and alternative way to live.

Original AA literature talks about a conversion process (Thiebout, 1944) of surrendering control to a higher power as a spiritual awakening and an identity change. Newcomers and critics often misunderstand the meaning of the self-labeling "alcoholic" as they interpret it with the conventional connotations of the drunken and stigmatized person who is out of control causing misery and havoc to himself/herself and others. But within the fellowship among seasoned members, the alcoholic identity is not regarded negatively but positively; it represents the shift from trying to control one's drinking to the positive alcoholic identity which offers hope for developing a constructive and useful life and for being "happy, joyous, and free" (AA, 1976). Newcomers to AA often describe their drinking to seasoned members and ask their opinion as to whether or not they are alcoholic. Veteran members and textual AA tell them that they have to decide for themselves; self-diagnosis is an important part of an individual developing his/her alcoholic identity.

The identity changes evolve within the context of AA meetings where members hear each others' personal narratives; when they identify with them, they gain experiential understanding of the alcoholic self from which they can reinterpret their past and develop their story. Personal stories follow the format suggested by the Big Book (AA, 1976, 58): "Our stories disclose in a general way what we used to be like [when drinking], what happened, and what we are like now." The drinking alcoholic self is "self-will run riot" who *engaged* in shameful, destructive, if not outrageous actions, whereas, recovering members manifest hope and the promise of living differently. Instead of a "drinking nonalcoholic" who denies the havoc that was associated with his/her drinking, a newcomer alcoholic can assume an alcoholic identity because he/she is among peers who have done similar things and because it contains a promise of being able to live differently.

Bruner (1990) contrasts the logico-scientific mode of cognitive functioning or thought with the narrative or story mode. Each is distinctive in its ordering of knowledge and irreducible to the other. The logico-scientific is excellent for testing hypotheses, sound empirical analysis, and developing universal statements. In contrast, the narrative mode which mutual help uses is good for gripping stories, histories, human intention, action and meaning, and identity construction. Social science researchers studying mutual help are increasingly turning to the narrative mode of analysis along with many other fields (Riessman, 1993; Mattingly & Garro, 2000). AA especially focuses on the narrative mode of communication: its oral tradition, the importance of people telling their stories, reshaping their identity based on recasting their life story (Cain, 1991), the talk in meetings being from one's own experience, and the significance of friendship in and around meetings.

Social scientists explain how the identity change occurs within the context of AA. Doubling back on the self is one mechanism: An individual examines himself/herself, listens to his/her self-talk and locates himself/herself within a structure of experience in which he/she is both object and subject to himself/herself. Doubling is especially practiced with self-deprecating humor and laughter which are potent resources for reinterpreting one's behavior and self (Pollner & Stein, 2001, 48)

Pollner and Stein (2001) posit that the abstinent AA member who accepts the *alcoholic identity* has a second identity, the *recovering alcoholic self*. Pollner and Stein (2001, 47))

> In uttering the well known phrase "I am an alcoholic" and thus acknowledging an uncontrolled inner force, the rudiments of the recovering self are given voice: the recovering self is other than, and aware of, the alcoholic self as a potent and insidious source of trouble. In this sense, the alcoholic and recovering selves are twin born.

The recovering alcoholic self is portrayed in AA texts as learning to be constructive and usefully whole to serve others and, upon working the steps 4–9, to become "happy, joyous, and free" (AA, 1976) [The steps 4–12 are described in Section 3.4.]

Social identity theory (Forsyth, 2006) maintains that identity is socially bestowed, socially sustained, and socially transformed. People sustain and change their identity in interaction with others. Barrows (1980), a sociologist naïve about alcoholism recovery but sophisticated about group therapy, captured this process in situ while observing for several months at a social model recovery home whose staff were recovering alcoholics and practicing the AA Twelve-Step Recovery Program. Residents talked about the consequences of their drinking, their plans, and goals for the future. Barrows often heard the same person tell slightly different stories about the same event, reflecting changes in their self-images (Barrows, 1980, 6):

> At one group session, one resident expressed disappointment with himself because. . .he had gotten angry at another resident who had been ranting at the morning meeting. Other residents who had witnessed the incident reassured him. They thought that he had been quite assertive; they had experienced similar feelings but only he had expressed them. On two subsequent occasions, I heard this individual recounting the same incident. Each time he had a more positive image of himself. Initially he indicated he had been disappointed and upset; later, he realized that he had experienced and expressed his anger in a nondestructive manner; that is, he had not gotten drunk!

Barrows' analysis (1980, 8) is that the resident initially showed his self-identity as an unworthy person who could not control his feelings. His peers did not validate his view of himself but countered with positive reactions that he had assertively and appropriately expressed his anger. The resident upon further

reflection and introspection modified his self-image. His new interpretation or story was then validated by his peers when it was recounted which helped him maintain the slightly different view of himself. "Further repeating the account of the incident and the subsequent validation sustained the self image and integrated the self-image into the person's identity" (Barrows, 1980, 8–9). What Barrows did not notice was that in the resident's final story he had been helped to link his assertive anger behavior to not drinking. The fact that the process occurred in a stable environment where the residents saw the incident that provoked his anger, that they felt the same way, and were there to validate him as he reflected and retold his story is important. Strangers to the incident would be unlikely to be socially validating in the same way. These social processes are facilitated when people are familiar with each other over a period of time which is an implicit reason that newcomers are advised to have a home group where people know them. Another reason for attending the same meetings is that as the member observes others over time he/she sees changes in their behavior and attitudes thereby confirming the effectiveness of the program in changing individuals.

3.4. Practicing the Program

Becoming abstinent is necessary but insufficient to maintain sobriety. Sobriety is viewed as a complex process not only of being abstinent but also of practicing the program to quell the very character defects that are causing one's self-centeredness and incapacity to live harmoniously with other people (AA, 1976). Practicing the program then involves going to meetings, helping other alcoholics, "working" the steps, using the tools in daily living, and asking for help and guidance from one's sponsor and from other seasoned members. Makela et al. (1996, Chap. 12) found in their study of eight societies that within and between societies there was extensive variability in how the program was *actually* practiced.

3.4.1. Designing and Building Sobriety

"A Member's eye view of Alcoholics Anonymous" (1970), a talk by a 16 years' sober AA member to a university class, became a General Service Conference-approved pamphlet. The writer compared recovery to building a house.

"The house that AA helps a man build for himself is different for each occupant because each occupant is his own architect. . .. What is really important is that AA has more than demonstrated that the house it builds can accommodate the rebel as well as the conformist, the radical as well as the conservative, the agnostic as well as the believer. The absence of formalized dogma, the lack of rules and commandments, the nonspecific nature of its definitions and the flexibility of its framework—all the things we have thus far considered contribute to this incredible and happy end" (1970, 20–21).

The house as the "design for living" is one's core place, safe from the elements, where one sleeps, eats, and plays but from which one ventures forth to one's job, family activities, friends and leisure time pursuits, and community activities. In AA the house is a metaphor for a new "design for living" that constitutes recovery, viewed as ongoing and potentially life long. In contrast, in professional treatment, the agency and professional staff are the architects who, more or less, consult the client/patient in the design but, having only a week to 28 days of treatment, designing and building a house are beyond their scope.

Within AA the newly abstinent alcoholic is not necessarily viewed as a competent architect but as a willful adult (with free will) who will make his/her own choices and decisions unless tamed by the first three steps and a willingness to listen to suggestions from seasoned members and a sponsor.

3.4.2. Practical Tools for Everyday Living

The program uniquely combines the once-in-a-lifetime experience of total identity change (see Section 3.3) with practical tools for dealing with the everyday *minutae* of life (Valverde & White-Mair, 1999). Action and practice is emphasized, not theory or abstractions. Valverde and White-Mair wrote that "the unity of AA is to be found in its techniques much more than its theories of alcoholism or views about God" (Valverde & White-Mair, 1999, 407). Among the practical tools are the slogans or aphorisms that are often pasted on walls at AA meetings: One day at a time; HALT; Easy does it but do it; Utilize, don't analyze; Progress, not perfection; Makela et al. (1996, 121) found 250 such sayings. To the novice or fact-free critic, they may seem vacuous or inane, but the slogans represent and signify various aspects of the practical philosophy to guide everyday behavior. "One day at a time", for example, is used to motivate (just do not drink today), to help equalize newcomers with old timers (we are equally vulnerable to taking a drink today), and to forgive relapses (irrespective of yesterday, you can be sober today) (Valverde & White-Mair, 1999).

The focus is on the individual examining his/her own motives, behavior, and feelings (especially through working the steps) combined with the prohibition of criticizing or judging others in meetings (i.e., no cross-talk in meetings). AA views human beings as essentially limited and fallible who can achieve wholeness through their interdependence with others (Kurtz, 1982). The attitude of "progress not perfection" creates permissive learning environments where seasoned members and newcomers alike can try out new behaviors and ways of being without being harshly judged (Zohar & Borkman, 1997).

3.4.3. Sponsorship and Guidance

A sponsor, a seasoned member having maintained sobriety and worked the steps for some time, acts as a guide to a newcomer or to someone with less experience in staying sober and working the AA program. The guide's knowledge rests on his/her experiential understanding of how to apply the program to drinking and living problems (Borkman, 1999; Pollner & Stein, 1996). One

learns methods of work, virtues, and experiential wisdom from role models—serenity, fortitude, or humility can only be learned experientially, not instilled by written dogma. The fact that learning is primarily based on role modeling and experience rather than didactic instruction adds to the variability in how the twelve steps, "sacred" texts, aphorisms, and virtues are interpreted. Members discuss with their sponsors private and secret material that would be embarrassing or inappropriate to discuss in meetings (Makela et al., 1996, 193)

There is extensive variability in the extent to which attendees have sponsors. Some use a sponsor for the fifth step primarily. Many people have sponsors in the beginning but later rely on their AA friends as confidants. Many members learn, primarily, from listening at meetings or talking to respected members before or after meetings.

3.4.4. Working the Steps

There is a saying that the person you are will drink again (12 & 12, 1974). Unless an alcoholic becomes less self-centered, less willful, and more concerned with others, his/her character traits will result in him/her picking up a drink. The answer is to practice the program, especially to "work the steps." The first three steps involved in becoming abstinent through relinquishing self-will to a self-defined higher power were discussed in Section 3.2. Steps 4–9 deal with character change—dealing with one's shame and remorse for the havoc caused by drinking, the wrongs done to others, one's awful secrets, prideful self-centered behavior that alienates one from others, and the like. Each person has his/her own list.

The psychoanalysts Khantzian and Mack (1994, 85–86) say:

> A contemporary psychodynamic understanding of alcoholism suggests there are degrees of vulnerability in self-regulation involving self-governance, feeling life (affect), and self-care that are involved in the predisposition to become and remain dependent on alcohol. AA succeeds in reversing this dependency by effectively challenging alcoholics to see that they disguise and deny their self-regulation vulnerabilities. Implicitly, if not explicitly, AA employs group processes to highlight and then modify the vulnerabilities that plague the lives of alcoholics. The focus of AA on the loss of control over alcohol and the insistence on maintaining identity of the suffering individual as an alcoholic (i.e., it is always that one is "recovering," never "recovered") is a useful if not essential treatment device. It permits alcoholics to acknowledge and transform vulnerabilities in self-regulation.

Steps 4–9 describe a general process, spiritual in nature, that can be interpreted in various ways. Step 4 pertains to identifying one's shortcomings that have interfered in one's life, Step 5 admitting them to another person and one's higher power, undergoing a process of being willing to give up the character defects (Step 6) and humbly asking one's higher power to remove them (Step 7). Having become aware of his/her defects and taken responsibility for them, Steps 8 and 9 focus on repairing one's relationships with others. In Step 8 one

identifies the harm one's drinking has caused other individuals and in Step 9, the individual attempts to repair the harm unless to do so would cause more harm. Stolen money is to be reimbursed. Lies are to be righted. Members often find that they first need to forgive the other for the harm done to them since in many relationships harm was mutual.

Upon completing the first 9 steps, a series of promises are listed in the Big Book (AA, 1976, 83–84) which are often posted on a wall. Among others, these include freedom from self-centeredness, self-pity, and fear of economic insecurity, serenity, a new happiness, concern for others, no regret of the past, and "No matter how far down the scale we have gone, we will see how our experience can benefit others" (AA, 1976, 84).

Steps 10–12 are often referred to as the maintenance steps. Step 10 is to do a daily inventory, to identify the mistakes one made, and become willing to admit and to correct them. The emphasis is on taking responsibility for one's actions. Step 11 is a meditation and prayer step in order to maintain "conscious contact" with the higher power of his/her understanding and is viewed as important in maintaining a spiritual rather than a materialistic perspective. "The joy of living is the theme of AA's Twelfth Step, and action is its key word" (12 & 12, 1974, 109). Step 12 reads "Having had a spiritual experience as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs" (12 & 12, 1974, 109). The spiritual experience includes abstinence and freedom from obsession about drinking or compulsion to drink. In addition, having worked the 11 steps gives the recovering alcoholic an understanding of how one's willful and selfish demands to have one's desires satisfied irrespective of other people has contributed to unsatisfactory relationships and lifestyle; a knowledge of the principles inherent in the steps for maintaining abstinence and dealing with other living problems; and the importance of doing twelfth step work to "carry this message to alcoholics."

Helping other alcoholics is the "helper therapy" principle (Riessman, 1965), the idea that helping others benefits the helper, not just the recipient. Carrying the message is viewed as helping alcoholics in any and all aspects of the program, which is viewed as spiritual—the individual getting beyond his/her self-centeredness to be concerned for the other. Empirical studies of outcomes of degrees of AA involvement indicate that among those with similar lengths of time in AA, sponsors are more likely to maintain sobriety than non-sponsors (see section on effectiveness and outcome research in this volume).

Khantzian and Mack (1994) interpreting the steps and program from within their psychoanalytic framework find that the steps address core issues:

> The spiritual and religious elements in AA act as an important counterforce to the egoistic aspects of chronic drinking by directly confronting the denial, rationalizations, and allusion of control that support the persistence of alcoholic behavior. Through its appeal to a higher power, AA's insistence on humility acts as an anodyne to the self-serving grandiosity and the wallowing self-pity of the alcoholic. . .. Step 3 and the remaining steps in the 12-step

> tradition of AA help the alcoholic move from a self-centered posture to a more mature one by helping the individual give up the overly prominent, grandiose parts of the self. The self-examination involved in taking "a moral inventory" (step 4), "making amends" (step 9), and "carrying the message to others" (step 12) are steps that inspire and instill a real concern for others and an increasing capacity for mature altruism. This effect of AA is genuine and lasting (i.e., for those who embrace it) and suggests that AA may produce permanent structural change, a result that has clinical and conceptual significance for psychoanalytic theory and practice.
>
> (Khantzian & Mack, 1994, 78–79)

3.5. Long-Term Recovery

Long-term recovery has been of little research interest (De Soto, O'Donnell, & De Soto, 1989). Previous researchers lumped together people sober for weeks or months with those sober several years and found no difference in symptomology, but De Soto et al. (1989) in their 4-year follow up of 249 AA members in the Baltimore, MD area found reduced symptoms, better work and family history, and diminished risk of relapse among those sober 5 years or more.

The noteworthy exception to short-term follow ups is Vaillant (1995) 50-year longitudinal study that followed a community sample of working class Core city men and of upper middle class College men, observing who developed alcoholism, who had treatment and went to AA with what results. Vaillant warns about the methodological errors of making generalizations about AA from studying clinic treatment samples and then observing over 6 months or a year who has AA involvement. With his Community sample, he found that alcohol abusers in both groups were more likely to get sober in AA than in professional treatment (Vaillant, 1995, 388). Similarly, a third sample of 100 alcohol clinic attendees who were followed for 8 years were more likely to get sober through AA but this would not have been observed in the short run (Vaillant, 1995, 257). He saw extensive variety in the kinds of involvement in the larger Core city sample who became sober through AA: Some went to AA initially for a few weeks, then stopped going; others went for a few years, then stopped attending while "for others AA became a part of their stable life structure" (Vaillant, 1995, 257).

Vaillant (1995) categorized the Core city men who were continuously abstinent three or more years as "securely abstinent." Although the "securely abstinent" were initially as symptomatic and antisocial as the "progressive alcoholics," they were less likely to die and more likely to enjoy their lives in the long run. Vaillant concludes "Given adequate time to rebuild their lives, abstinent alcoholics resemble the general population far more than they resemble actively drinking alcoholics or nonalcoholics with personality disorders" (Vaillant, 1995, 270).

When the research predominantly focuses on clinic samples followed for 6 months or a year, a focus on longer term recovery disappears. What happens to the abstinent recovering alcoholic long term? Research on mutual help organizations shows that nonmedicalized and normal lifestyles within the mutual

help organization are created (Borkman, 1999). The community psychologist Rappaport (1993) characterized established mutual help organizations as having a "normative narrative community" or an organizational wide story that is an alternative to professionalized views of illness and disease. For example, GROW, a twelve-step mutual help organization for people with mental illness experiences, has a "caring and sharing" community narrative in which committed members are unlikely to be rehospitalized in mental hospitals and they drop their identities as ex-mental patients even as they continue their psychiatric medication. AA's paradoxical stance of referring to alcoholism as an illness and within the medical purview but the "treatment" being sociological and psychological is being noted by social scientists (Valverde & White-Mair, 1999): A fellow recovering alcoholic is best suited to help a newcomer get sober; live within the community anonymously to the outside world but identify as a recovering alcoholic within the AA fellowship; and engage in work, family life, and community activities as a conventional member of society. AA members may be totally involved in AA but lead community lives as ordinary citizens. Viewing AA as treatment or analogous to treatment (as the scientists do who are primarily concerned with AA's effectiveness with drinking outcomes) obscures and distorts AA as a "normative narrative community" that provides a nonmedicalized and conventional way of living in the community for its members.

4. Service

Service is the second leg of the triangle in the AA logo. Service is defined very broadly to include taking a turn at a meeting, sharing with others before, during, or after meetings, sponsoring, assisting with maintenance of a group or the larger organization or twelfth step work. Service can be making coffee and folding chairs at a meeting (even newcomers are encouraged to do this type of service), listening to a fellow member, helping a newcomer, opening a meeting or being its treasurer, taking a meeting to a jail, hospital, or other institution, or making twelve-step calls—typically made to someone actively drinking who is in trouble. (With the development of so many professionalized treatment centers, twelve-step calls have been considerably reduced.)

The service of helping others is freely given—a gift, not an economic exchange (Medvene, 1984). The gift comes without money, contracts, or any explicit incentives involved. The help given is personalized, spontaneous, and often available seven days a week, around the clock (Medvene, 1984; Makela et al., 1996). In AA the incentive to give is mixed—giving to others helps the giver stay sober because the giver gets beyond his/her self-centeredness to focus on someone else. Giving to other alcoholics simultaneously furthers the single purpose of AA—to stay sober and help other alcoholics achieve sobriety. Thus, the AA program explicitly recognizes the significance of the "helper therapy principle" although not by name. There are some initial limited empirical tests which are verifying the usefulness of the "helper therapy" principle.

Project MATCH (Pagano, Friend, Tonigan, & Stout, 2004), a longitudinal prospective study of three alcoholism treatments had a total of 1,501 patients with complete data at baseline and 3 months follow up at the end of treatment. A 13-item AA involvement scale measured working of the program. Helping others was indicated by whether or not in the last 90 days they had been a sponsor or they indicated they had completed Step 12. There was a correlation between number of AA meetings attended and helping others. Relapse in the 12 months following treatment occurred for 75% of the sample: those helping other alcoholics were less likely to relapse (60%) than those who did NOT help their peers (78%).

Zemore and Kaskutas (2004) looked at the relationship between AA involvement and kinds of helping. A scale of Recovery Helping measured the amount of time spent the day before with such items as sharing experience being clean and sober, giving moral support and encouragement, and explaining the program. Community Helping measured conventional volunteer activities (see Thoits & Hewitt, 2001). The sample (N = 200) was from AA meetings (60%), but also included some from Women in Sobriety, and treatment programs. Looking at the sample from AA, they had higher rates of Recovery Helping and AA involvement. AA involvement and working the twelve steps was positively associated with Recovery Helping. Longer sobriety for the entire sample was associated with more Community Helping and negatively with Recovery Helping.

Third Sector studies of volunteer membership and volunteer work find a bidirectional relationship: that volunteers are self-selected among those with resources and physical and mental well-being but social causation also operates—that engaging in volunteer work enhances their well-being (Thoits & Hewitt, 2001). Could similar findings be true of alcoholics? The Zemore and Kaskutas (2004) findings of longer sobriety associated with more Community Helping needs to be further explored. Which recovering alcoholics leave AA and which ones stay—does their previous volunteer activity predict their reaction to AA? Gottlieb and Peters (1991) found that the Canadians who belonged to mutual help groups (including AA) were indistinguishable from the Canadians who belonged to other voluntary associations. Does an alcoholic's previous volunteering experience predict who helps their peers and who does not? This Third Sector tradition of studying the impact of volunteering could fruitfully be applied to AA and enlarge our understanding.

Help giving as a gift relationship rather than as an economic transaction means (Medvene, 1984)

> Its essence is the motivation to be responsive to the others' needs and to reciprocate in a spirit of generosity and spontaneity, expecting that others will do the same. Unlike economic transactions, people tend not to keep score and there is an assumption that over the long run the pattern of giving and receiving will be mutually satisfying. . .
>
> (Medvene, 1984, 15–16)

Such gift giving and reciprocal relationships contribute to the solidarity and unity of groups. Studies of social support and of mutual help groups (Uehara, 1995; Medvene, 1984) find that many follow moral norms of reciprocity found in society at large and believe that they should give back, if not to their immediate benefactor, to some generalized other in the future (Medvene, 1984). How norms of reciprocity might relate to patterns of service in AA has not been studied—are recovering alcoholics who believe in the norm of reciprocity more likely to do service in return for the help they received as newcomers and help they continue to receive? How does the presence or absence of friendship networks in AA relate to an individual's reciprocity and to service done?

From a Third Sector perspective, service work in AA and other mutual help groups is volunteering (Borkman, 1999). Third Sector research regards membership organizations like AA as only helping their members, rather than contributing to public service by helping others outside its organization. However, we must ask: How many thousands are mandated by courts to attend AA for drunk driving offenses? How many others with drinking problems go to AA members for help, whether or not they become members of the organization? In national surveys of volunteers, AA members' contributions (or other mutual help groups) are not counted. AA (at no cost to the tax payer) now aids more alcoholics per year than the professionally based treatment programs that cost millions of dollars (Miller & McGrady, 1993). Furthermore, the criminal justice system refers many DUIs to AA or jail with little concern about the impact of coerced clientele being sent to a voluntary association (Makela et al., 1996). In interviewing AA members over the years, I have heard of many cases of members assisting newcomers and other AA members by giving them a place to sleep on their sofa for a few weeks in order to avoid homelessness, free legal assistance, jobs to earn money such as painting or cleaning, work in their businesses, and the like. I know of no research that has shown interest in the kinds of material aid that AA members give others that act as a safety net or how AA members as a whole contribute to the public good without cost to the tax payers.

AA has also been the model and inspiration for other twelve-step groups (see Laudet's chapter in this volume), for social model recovery programs and sober living houses (see Polcin and Borkman chapter in this volume), and for many aspects of professional substance abuse treatment (see Slaymaker's chapter in this volume).

5. Unity

Unity is the third leg of the triangle. *Unity* is the first organizational principle known as the Traditions: Tradition 1 states "Our common welfare should come first; personal recovery depends upon AA unity." "Without unity, AA dies. . . .The group must survive or the individual will not" (12 & 12, 1974, 10). Unity also refers to the *fellowship*, the network of relationships among

members and attendees, their groups and organizations, families, and friends. The unity or cohesion of the diverse meetings, groups, fellowship, and larger organization are knit together by common principles and beliefs. The Twelve Traditions and the Twelve Concepts are the organizational principles for the groups and their relationship with members, the larger organization, and the outside world.

Khantzian and Mack (1994) think that AA's group focus of meetings, fellowship, and relationships is extremely important and adds to its effectiveness in helping alcoholics become abstinent and psychologically more mature. They say:

> Alcoholics Anonymous is effective because it appreciates that the underpinnings of self are connected with social structures and institutions. Self-governance comprises a set of functions that derives from the individual's participation in a variety of group and institutional activities and affiliations. Alcoholics Anonymous helps alcoholic individuals to achieve sobriety by providing a network of stable individual and group relationships which powerfully impact on the governance of drinking behavior
>
> (Khantzian & Mack 1994, 76).

5.1. Groups and Their Meetings

An AA group has a name, meets in a specific (rented) location, elects members to fill its various positions on a rotating basis, hosts meetings, and takes responsibility for refreshments, financial matters, affiliating with the larger AA organization, and may host other events such as social activities or take meetings to jails, hospitals, or other institutions. Any and all members can initiate a new group; there is a saying that all it takes to start a new group is two drunks with a resentment and a coffee pot (12 & 12, 1974). There are no franchises or territories. Members learn how to run a group and conduct meetings by observing and participating in groups and meetings.

5.1.1. Meetings

Meetings are the primary place where the ritualized aspects of AA are practiced, where members learn the belief system, observe how seasoned members behave, learn how to tell their stories, and through listening, observing, and taking their turn talking, gain new identities, and the "experience, strength, and hope" to resolve their drinking and living problems. Current research is revealing much greater diversity in meetings than researchers have previously presumed and many early generalizations based on tiny samples of culturally similar meetings need to be discarded.

There are various kinds of meetings, the most important distinction being between open and closed meetings. Closed meetings are for those who self-identify as an AA member while open meetings welcome AA members, their families and friends, or any interested person (such as a college student doing a paper on AA). There are speaker meetings where several people will tell

longer drunk-a-logs and discussion meetings or literature meetings in which a major text (such as AA [1976] or 12 & 12 [1974]) is read and used as the basis of a discussion. Special populations, such as women's meetings, gays and lesbians, young people, lawyers, and so forth, develop meetings but these meetings are expected to admit any AA member who shows up. Histories are beginning to be written of the struggles within AA that stigmatized statuses, such as gays and lesbians, have faced in hiding/revealing their situation and their challenges of starting specialized meetings (see Borden, 2007). Reading Borden's history as a sociologist, my impression is that the attitudes toward gays and lesbians in the larger society very much influenced the reactions of AA members in different locales, although AA groups were often somewhat more tolerant than the surrounding cultural milieu.

Major commonalities among meetings include: opening rituals, announcements, discussion, money collection, serving of refreshments, and closing rituals although the order of items varies from place to place (Makela et al., 1996). The main part of the meeting is the discussion during which attendees talk in turn. Makela et al. (1996, 138) found that the major difference between conversation and talk in an AA meeting is that turns of talk are preallocated. The Chair has the right to talk first and to comment after each person speaks. Meetings usually have their own customs for turn taking. Small meetings often speak in order of seating. In larger meetings a variety of customs may prevail: The Chair may select the next speaker or choose among volunteers who raise their hands or the current speaker may select the next speaker. Individuals do not speak or reply to the next or to the last speaker as in ordinary conversation (Makela et al., 1996, 139). Unlike group therapy, passing one's turn and not speaking is accepted.

Ten customs for discourse in AA meetings were identified from research in Finland; these also apply to AA meetings in the United States and other countries:

1. Do not interrupt the person speaking.
2. Speak about your own experiences.
3. Speak as honestly as you can.
4. Do not speak about other people's private affairs.
5. Do not profess religious doctrines or lecture about scientific theories.
6. You may speak about your personal problems in applying the program but do not attempt to refute the program.
7. Do not openly confront or challenge previous turns of talk.
8. Do not give direct advice to other members of AA.
9. Do not present causal explanations of the behavior of other AA members.
10. Do not present psychological interpretations of the behavior of other AA members. (Makela et al., 1996, 140–141)

These customs of discourse, especially the second one of talking personally from your own experience, create discourse in which disagreements and

hostilities are unlikely to surface within the meeting. Disagreements and hostilities can and do surface between individuals before and after meetings or online (Kitchin, 2002). Therapists are often concerned that there is no trained facilitator to negotiate conversation in an AA meeting (or other mutual help meetings) but the rules of discourse in twelve-step meetings create settings which preclude the kinds of eruptions that therapists fear might happen.

In the United States, other customs on discourse include minimizing details of one's socioeconomic standing, area of residence, or occupation that would set you apart from others (Robertson, 1988).

5.2. Fellowship

Fellowship refers to the network of relationships among AA attendees, members, families, and friends. Egalitarian relationships between experiential peers were recognized as critical by the co-founders of AA (Borkman, 2006) and are necessary to the "sharing circle" of mutual help (Borkman, 1999); the co-founders' insistence on maintaining egalitarian and nonhierarchical relationships not just in the "sharing circle" of a meeting but also throughout the entire organization is a major contribution to the theory and practice of mutual help. The egalitarian and nonhierarchical relationships were also regarded as important to counteract the alcoholic's character defects of self-centeredness and demands for more than his/her share of power, prestige, sex, or money (12 & 12, 1974).

Some AA attendees think that their sobriety is based on their friendships rather than working the steps. Others work the steps and AA members become their major friendship networks. As Maxwell described, talking to fellow members before and after meetings is as significant as the meetings per se. He writes: "Thus, within local groups, there are dyads, triads, and circles of very close relationships. Generally, it is within these intimate clusters that the most uninhibited and meaningful interactions take place, in an atmosphere of caring and mutual trust" (Maxwell, 1984, 10).

Little recent empirical research was found on actual friendship networks of recovering AA members. An exception is Humphreys and Noke (1997) who studied male veterans' friendship patterns 1 year after discharge from treatment (among those who had not previously had twelve-step involvement). Almost half (49%) of the final sample of 2,337 were African-Americans, the others mostly non-Hispanic Caucasians (45.2%). They examined twelve-step involvement in AA, NA, or CA and its predictiveness in close friendships with twelve-step attendees. AA, NA, or CA involvement predicted for both African-Americans and Caucasians larger friendship networks, with more close friends of more frequent contact. However, as expected by researchers who study the diversity and idiosyncrasy of AA, a few with mutual help involvement had *no* twelve-step friendship network.

5.3. Principles of Organization: Traditions and Concepts

AA is unusual as an organization in that it began as and continues to have a democratic, egalitarian, and nonbureaucratic structure that is self-financed by its members, 72 years after its founding (Borkman, 2006, 2007). AA describes its organizational structure as an inverted pyramid in which the unincorporated local groups set policy through their representatives at a conference for the national-level service bodies—the General Service Board (12 Concepts for World Service, 1986). This essentially tri-partite structure is unincorporated with only the national-level service units being legally incorporated. AA has no government in the sense that there is a body that can make and implement binding rules and has sanctioning power against those who break the rules. Instead of a government, order and coherence organizationally are maintained through twelve "traditions" (12 & 12, 1974) which are principles of group functioning and twelve "concepts" (12 Concepts for World Service, 1986) which are principles for the relationship between the individual and the organization or between organizational units. The binding power of the principles appears to be cultural (Hall, 1987) and is learned, primarily, from the motivated and direct personal experience of members and by oral transmission and, secondarily, from AA literature. The approval of two-thirds of all AA groups internationally would be required to institute any major changes to the steps, traditions, or the literature.

Founded in 1935, AA has grown to over two million members in over 180 countries. It is an alternative organization, eschewing money, property, prestige, professionalization, and bureaucratic organization (Borkman, 2006; Room, 1993). AA describes itself as a spiritual (but not religious) organization. AA has but one primary goal (Tradition 5); there are no secondary goals of advocacy, reform, or education.

AA operates with a philosophy and accompanying practices that minimize the need for money. It owns no real estate, operates no treatment centers, hospitals, clubs, or any entity other than its local groups and related service entities. Organizational service units obtain monies to operate from the contributions of local groups and by selling AA literature and tapes.

Groups are relatively autonomous within the "traditions" and many local issues are decided within each group. The second level of organization is a system of elected or volunteering delegates from local groups who participate in district and area committees; they select an area (state) level delegate who attends the yearly policy-making body, the General Service Conference, hereafter *Conference*. They rely on AA Traditions and the money from AA groups for their authority over the umbrella organization, the General Service *Board*. The *Conference* charter is not a legal document but clearly states the scope and limits of the policy-making *Conference***.** Paraphrasing a long quote, the *Conference* shall observe the spirit of AA. Traditions in all its proceedings and never become the seat of perilous wealth or power; that none of the members shall ever be placed in a position of unqualified authority over any other; that all decisions

shall be reached by discussion, vote, and hopefully substantial unanimity; that its actions should never be personally punitive nor incite public controversy; and, like the Society of Alcoholics Anonymous which it serves, always remain democratic in thought and action (AA Service Manual, 2006–2007, 62).

The third level, the General Service Board, is the legally incorporated 501C3 organizational body that directs two incorporated national-level entities: the World Service Office and the Grapevine. The World Service Office publishes and distributes AA literature and tapes, maintains the copyrights, logos, and domain names of the organization, answers queries, and serves the member groups. The Grapevine is the member-supported magazine that features member's recovery stories.

The General Service Board and other formalized service bodies cannot dictate or sanction AA groups or members (Tradition 9). AA on all levels—General Service Board in NYC, policy-making Conference, and local groups—"...has no opinion on outside issues; hence the AA name ought never be drawn into public controversy" (12 & 12, 1974, 12). The heart of the twelve traditions is to subordinate personal objectives to the common good (12 & 12, 1974, 13). Tradition 12 states "Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities." The spiritual is defined here again as focusing on service to alcoholics and the group instead of personal desires for prestige, power, or wealth.

Given the autonomy of local groups combined with a large organization that has no governance, sociologically, one would expect deviant groups that violate the twelve steps and/or the twelve traditions to evolve. As an example, a recent article in Newsweek (Summers, 2007) alleged a group named Midtown in Washington, DC, violates a number of traditions and behaves like a cult in restricting newcomers to associating with the Midtown group members only. Sexual impropriety and other violations of AA norms were also alleged. But, deviance is newsworthy and the professional who wants to refer a client can easily avoid such groups by becoming acquainted with members from a group: as with professional treatments, quality varies.

6. Conclusion

AA is a voluntary mutual help association that functions very differently than professionally based treatment or twelve-step treatment. A fundamental difference is its base of experiential knowledge rather than scientific or professional knowledge (Borkman, 1999). Recovery, service, and unity represent the key facets of the Twelve-Step/ Twelve Tradition Recovery Model. *Recovery*—an individual's journey as an architect constructing a house with one's assisting peers symbolizing a new, more productive, and meaningful way of living; *Service*—an individual reciprocates for the help received as a newcomer learning to become abstinent by helping others, contributing to group functioning, and becoming a sponsor, thereby manifesting the "helper therapy"

principle; *Unity*—the fellowship of self-examining recovering alcoholics framed by democratic and egalitarian meetings of groups who support their "servant" organization. The AA logo's circle contains and reinforces the three elements: *recovery* is service and the unity of fellowship which shapes and energizes the organization; *service* rests on healthy recovery and promotes fellowship which fuels the organizational functioning; *unity* is the special relationships of peers who underwent similar miseries with alcohol and who share similar benefits of abstinence and valued experience working for a *single purpose* in an egalitarian organization.

It is time to update our views of AA. "In fact, the assertion that 12 step programs for substance abusers are a white, middle class phenomenon may say more about where researchers and clinicians focus their attention than it does about biases within the AA or NA organizations" (Humphreys, Mavis, & Stoffelmayr, 1994, 178). Makela reports that long-term AA has been found since the 1990s in "all wealthy non-communist, non-Islamic countries and some industrialized Asian countries" (1993, 228), that females are over-represented in AA in comparison with their proportion in treatment facilities or national surveys of heavy drinking in countries for which there are data (Mexico, US and Finland) (1993, 228–229); agnostics and atheists may not be as attracted to AA as the nominally religious but benefit from it equally (Tonigan et al., 2002). Chenhall's (2007) recent study of aboriginal Australians, who attribute their alcoholism in part to the consequences of the oppression of European colonization, details how they have adapted AA to reclaim their cultural heritage and aboriginal spirituality. The extreme demographic diversity, the differing opinions and interpretations of spirituality and working the steps, the varying quality and integrity of meetings and groups, and the attendees, ranging from the skeptical and minimally involved to the zealous converts, would seemingly result in total anarchy and it is not surprising that some label AA as a minimalist organization (Seabright & Delacroix, 1996). However, as an organizational analyst looking at the totality of AA and recognizing historically that for more than 70 years the organization has maintained its democratic nonbureaucratic structure while dramatically expanding beyond its Protestant Christian white male beginnings, we categorize it as a learning organization (Zohar and Borkman, 1997). The genius of AA is its adaptability.

Ernie Kurtz said in 1982 that it was (past) time to take AA seriously intellectually. This is finally happening:

- A major national NIAAA research study chose twelve-step facilitation (TSF) as one of the three "treatment" conditions for its controlled trial known as Project MATCH (Pagano et al., 2004).
- The idea of recovery, a concept borrowed from AA and its offshoots, is being applied to mental health, a field having more mutual help groups than professional and government treatment agencies (Goldstrom et al., 2006). The National Institute of Mental Health has

funded eight states to transform their public mental health systems to be conducive to *recovery* of the person with mental health problems.

- Psychiatrists, psychoanalysts, social workers, sociologists, and organizational analysts are studying AA in relation to their theories and knowledge but *not* from a doctrinaire perspective and concluding

    - "The remarkable success of AA, which we have argued is to be attributed to its skills in combining technologies for governing the self with techniques for running democratic organizations, raises a serious challenge to the conventional thesis about the domination of 'experts' over everyday life in the late twentieth century" (Valverde & White-Mair, 1999, 407).
    - Organizationally there is an isomorphic relationship between AA's ideology and structure unlike many modern organizations (Seabright & Delacroix, 1996).
    - Khantzian and Mack (1994, 68) conclude: "...beyond achieving abstinence and providing support, AA is effective because it is a sophisticated psychological treatment whose members have learned to manage effectively and/or transform the psychological and behavioral vulnerabilities associated with alcoholism."

In addition to accolades to AA, its limitations must be addressed. AA, like all mutual help organizations, appeals to only a minority of potential members for a variety of reasons. A recent and reasoned article (Walters, 2002) suggested twelve reasons why alternatives to AA are needed (spirituality, view that recovery is life long, abstinence rather than social drinking, and its other beliefs and practices that are abhorrent to some). But mutual help groups for alcoholics who do not like AA already exist, including Moderation Management for those who are not alcoholic, Rational Recovery, Women for Sobriety, Secular Organizations for Sobriety, and Laudet's chapter in this volume describes Christian-based twelve-step groups who find AA not religious enough. The American Self-Help Clearinghouse's web site (http://mentalhelp.net/selfhelp) can help with those and other mutual help groups.

The twelve-step recovery model of AA within a mutual help organization provides a nonmedicalized and anonymous "way of living" in the community that is significantly different from the medicalized alcoholism treatment as measured in scientific research studies.

References

12 & 12. (*Twelve Steps and Twelve Traditions*) (1974). New York: Alcoholics Anonymous World Services, Inc.

12 Concepts for World Service (illustrated) (1986). New York, NY: Alcoholics Anonymous World Services, Inc.

44 Questions (pamphlet) (1952, 1990). New York: Alcoholic Anonymous World Services, Inc.

A.A. Service Manual Combined with 12 Concepts for World Service, 2006–2007. New York: Alcoholic Anonymous World Services, Inc. (Originally published in 1969)

Agar, M. H. (1986). *Speaking of ethnography*. Beverly Hill, CA: Sage.

*Alcoholics Anonymous: The story of how many thousands of men and women have recov*ered (1976). New York: Works Publishing. (Originally published in 1939)

AACA. (1957). *Alcoholics Anonymous comes of age: A brief history of A.A.* New York, NY: Alcoholics Anonymous World Services.

Alibrandi, L. A. (1978). The folk psychotherapy of Alcoholics Anonymous. In S. Zimberg, J. Wallace, & S. B. Blume (Eds.), *Practical approaches to alcoholism psychotherapy* (pp.163–180). New York, NY: Plenum.

A Member's-Eye View of Alcoholics Anonymous (pamphlet) (1970). New York: Alcoholics Anonymous World Services, Inc.

Arminen, I. (1998). *Therapeutic Interaction: A Study of Mutual Help in the Meetings of Alcoholics Anonymous.* Helsinki, Finland: The Finnish Foundation for Alcohol Studies, Vol. 45. Distributed by Rutgers University Center for Alcohol Studies, Publication Division, Piscataway, NJ.

Bales, R. F. (1944). The therapeutic role of Alcoholics Anonymous as seen by a sociologist. *Quarterly Journal of Studies on Alcohol,* 5(2), 267–278.

Barrows, D. C. (1980). *Informal interactions at an alcohol recovery home*. March 17. Berkeley, Social Research Group, School of Public Health, University of California.

Borden, A. (2007). *The history of gay people in Alcoholics Anonymous*. New York: Haworth Press.

Borkman, T. (1999). *Understanding self-help/mutual Aid: Experiential learning in the commons.* New Brunswick, N.J.: Rutgers University Press.

Borkman, T. (2006). Sharing experience, conveying hope: Egalitarian relations as the essential method of Alcoholics Anonymous. *Nonprofit Management & Leadership, 17*(2) (Winter), 145–161.

Borkman, T. (2007). A.A. and two sober house systems: Work-in-progress. Seminar presentation on federation forms, Hauser Center for Nonprofit Studies, Harvard University, April 30.

Brown, S. (1985). *Treating the alcoholic: A developmental model of recovery*. New York: Wiley.

Brown, S. (1995). A developmental model of alcoholism and recovery. In S. Brown (Ed.), *Treating Alcoholism* (pp. 27–51). San Francisco: Jossey-Bass.

Bruner, J. (1990). *Acts of Meaning*. Cambridge, Mass: Harvard University Press.

Cain, C. (1991). Personal stories: Identity acquisition and self-understanding in Alcoholics Anonymous. *Ethos, 19*(2), 210–251.

Chenhall, R. (2007). *Benelong's Haven,* Victoria. Australia: Melbourne University Press.

Denzin, N. K. (1997). *The alcoholic society: Addiction and recovery of the self*. New Brunswick, N.J.: Transaction Publishers.

De Soto, C. B., O'Donnell, W. E., & De Soto, J. L. (1989, September/October). Long-term recovery in alcoholics. *Alcoholism: Clinical and Experimental Research, 13*(5)(), 693–697.

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

Forsyth, D. R. (2006). *Group Dynamics* (4th ed.). Belmont Calif.: Thomson-Wadsworth.

Goldstrom, I. D., Campbell, J., Rogers, J. A., Lambert, D. B., Blacklow, B., Henderson, M. J., et al. (2006). National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(1)(January), 92–103.

Gottlieb, B. H., & Peters, L. (1991). A national demographic portrait of mutual aid group participants in Canada. *American Journal of Community Psychology, 19*(5), 651–666.

Gubrium, J. (1988). *Analyzing Field Reality*. Newbury Park, CA: Sage.

Hall, R. H. (1987). *Organizations: Structure and Process* (3rd ed.). Englewood Cliffs, NJ: Prentice – Hall.

Humphreys, K. (2003). Alcoholics Anonymous and 12-Step alcoholism treatment programs. In M. Galanter (Ed.). *Research on alcoholism treatment*. Vol 16 of Recent developments in alcoholism (pp. 149–164). New York: Kluwer Academic/Plenum Publishers.

Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge, England: Cambridge University Press.

Humphreys, K., & Noke, J. M. (1997). The influence of posttreatment mutual help group participation on the friendship networks of substance abuse patients. *American Journal of Community Psychology, 25*(1), 1–16.

Humphreys, K., Mavis, B. E., & Stoffelmayr, B. E.(1994). Are twelve step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help involvement. In F. Lavoie, T. Borkman, & B.Gidron (Eds.), *Self-help and mutual aid groups* (pp. 165–180). New York: Haworth.

Khantzian, E. J., & Mack, J. E. (1994). Alcoholics Anonymous and contemporary psychodynamic theory. In M. Galanter (Ed.), *Recent developments in alcoholism* (7) (pp. 68–89). New York, NY: Plenum.

Kitchin, H. A. (2002). Alcoholics Anonymous discourse and members' resistance in a virtual community: Exploring tensions between theory and practice. *Contemporary Drug Problems,* 29(Winter), 748–778.

Kurtz, E. (1979). *Not God: A history of Alcoholics Anonymous*. Center City, Minn.: Hazelden.

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

Kurtz, L. F. (1997). *Self-help and support groups: A handbook for practitioners*. Thousand Oaks CA: Sage.

Laudet, A. B. (2008). The impact of Alcoholics Anonymous on other substance abuse related Twelve Step programs. In M. Galanter & L. A. Kaskutas (Eds.), *Alcoholism research: Alcoholics Anonymous and spirituality* 18, pp. 71–89. New York, NY: Kluwer Academic/Plenum.

Lincoln, Y. S., & Denzin, N. K. (Eds.). (2003). *Turning points in qualitative research: Tying knots in a handkerchief*. Walnut Creek, CA: AltaMira, Division of Rowman & Littlefield Publ.

Makela, K., Arminen, I., Bloomfield, K., Eisenbach-Stangl, I., Helmersson Bergmark, K., Kurube, N., et al. (1996). *Alcoholics Anonymous as a mutual help movement: A study in eight societies*. Madison, WI: University of Wisconsin Press.

Makela, K. (1993). International comparisons of Alcoholics Anonymous. *Alcohol Health and Research World, 17*(3). 228–234.

Mattingly, C., & Garro, L. C. (Eds.). (2000). *Narrative and the cultural construction of illness and healing*. Berkeley: University of California Press.

Maxwell, M. A. (1984). *The A.A. experience*. New York: McGraw-Hill.

Medvene, L. J. (1984). Self-help and professional collaboration. *Social Policy, 14*(Spring), 15–18.

Miller, W. R., & McGrady, B. S. (1993). The importance of research on Alcoholics Anonymous. In W. R. Miller, & B. S. McGrady (Eds.), *Research on Alcoholics Anonymous* (pp. 3–11). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Pagano. M. E., Friend. K. B., Tonigan, J. S., & Stout, R. L. (2004). Helping other alcoholics in Alcoholics Anonymous and drinking outcomes: Findings from project MATCH. *Journal of Studies on Alcohol*, November, 65, 766–773.

Polcin D., & Borkman, T. (2008). The impact of A.A. on non-professionalized substance abuse recovery programs and sober living houses. In M. Galanter, & L. A. Kaskutas (Eds.), *Alcoholism research: Alcoholics Anonymous and spirituality* 18, pp. 91–108. New York, NY: Kluwer Academic/Plenum.

Pollner, M., & Stein, J. (1996). Narrative mapping of social worlds: The voice of experience in Alcoholics Anonymous. *Symbolic Interaction, 19*(3), 203–223.

Pollner, M., & Stein, J. (2001). Doubled over in laughter: Humor and the construction of selves in Alcoholics Anonymous. In J. F. Gubrium, & J. A. Holstein (Eds.), *Institutional selves: Troubled identities in a postmodern world*. New York, NY: Oxford University Press.

Rappaport, J. (1993). Narrative studies, personal stories, and identity transformation in the mutual help context. *Journal of Applied Behavioral Science, 29*(2) (June), 239–256.
Riessman, C. K. (1993). *Narrative analysis*. Newbury Park, California: Sage.
Riessman, F. (1965). The 'Helper Therapy' principle. *Social Work, 10*(2), 27–32.
Riessman, F., & Carroll, D. (1995). *Redefining self-help: Policy and practice*. San Francisco: Jossey-Bass.
Robertson, N. (1988). *Getting better: Inside Alcoholics Anonymous*. New York, NY: William Morrow & Co.
Room, R.(1993). Alcoholics Anonymous as a social movement. In B. S. McCrady, & W. R. Miller (Eds.), *Research on Alcoholics Anonymous* (pp. 167–187). New Brunswick, NJ: Rutgers Center of Alcohol Studies.
Seabright, M. A., & Delacroix, J. (1996, June). The minimalist organization as a postbureaucratic form: The example of Alcoholics Anonymous. *Journal of Management Inquiry, 5*(2), 140–154.
Slaymaker, V. T., & Sheehan, T. (2008). The impact of A.A. on professional treatment. In M. Galanter, & L. A. Kaskutas (Eds.), *Alcoholism research: Alcoholics Anonymous and spirituality* 18, pp. 59–70. New York, NY: Kluwer Academic/Plenum.
Steigerwald, F., & Stone, D. (1999). Cognitive restructuring and the 12-step program of Alcoholics Anonymous. *Journal of Substance Abuse Treatment, 16*(4), 321–327.
Summers, N. (2007, May). A struggle inside A.A. *Newsweek, 7*, 46–48.
Surgeon General's Workshop on Self-Help and Public Health (1988). DHHS Public Health Service. HRSA, Bureau of Maternal and Child Health and Resource Development Publication No. 224–250.Washington DC: US Government Printing Office.
Thoits, P. A., & Hewitt, L. N. (2001, June). Volunteer work and well-being. *Journal of Health and Social Behavior, 42*(), 115–131.
Tiebout, H. (1944). Therapeutic mechanisms in Alcoholics Anonymous. *American Journal of Psychiatry, 100*, 468–473.
Tonigan, J. S., Miller, W. R., & Schermer, C. (2002, September). Atheists, agnostics and Alcoholics Anonymous. *Journal of Studies on Alcohol, 63*(), 534–541.
Uehara, E. S. (1995). Reciprocity reconsidered: Gouldner's 'moral norm of reciprocity' and social support. *Journal of Social and Personal Relationships, 12*(4), 483–502.
Vaillant, G. E. (1995). *The natural history of alcoholism revisited*. Cambridge, MA: Harvard University Press.
Valverde, M., & White-Mair, K. (1999, May). One day at a time and other slogans for everyday life: The ethical practices of Alcoholics Anonymous. *Sociology, 33*(2), 393–440.
Van Til, J. (2000). *Growing civil society: From nonprofit sector to third space*. Bloomington: Indiana University Press.
Walters, G. D. (2002). Twelve reasons why we need to find alternative to Alcoholics Anonymous. *Addictive Disorders & Their Treatment, 1*(2), 53–59.
White, W. L. (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement.* Washington, D.C.: Johnson Institute.
White, W. A., & Kurtz, E. (2008). Twelve defining moments in the history of Alcoholics Anonymous. In M. Galanter, & L. A. Kaskutas (Eds.), *Alcoholism research: Alcoholics Anonymous and spirituality* 18, pp. 37–57. New York, NY: Kluwer Academic/Plenum.
Winegar, N., Stephens, T. A., Varney, E. D. (1987, April). Alcoholics Anonymous and the alcoholic defense structure. *Social Casework*(), 223–228.
Zemore, S. E., & Kaskutas, L. A. (2004, May). Helping, spirituality and Alcoholics Anonymous in recovery. *Journal of Studies on Alcohol, 65*(), 383–391.
Zohar, A., & Borkman, T. (1997, December). Emergent order and self-organization: A case study of Alcoholics Anonymous. *Nonprofit and Voluntary Sector Quarterly, 26*(4), 527–552.

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The Twelve-Step Program Model Spiritually Oriented Recovery Twelve-Step Membership Effectiveness and Outcome Research
Galanter, M.; Kaskutas, L.A. (Eds.)
2008, XXV, 449 p., Hardcover
ISBN: 978-0-387-77724-5