

Alcoholics Anonymous: Personal Stories, Relatedness, Attendance and Affiliation

by

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“The spiritual life is not a theory. *We have to live it.*”

Alcoholics Anonymous

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To Lynn, Joseph, and David,
Who taught me how to write the best chapters in my personal story.
Love, Stephen

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Abstract

Alcoholics Anonymous: Personal Stories, Relatedness, Attendance and Affiliation

by

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Alcohol misuse is a global health risk. Alcoholics Anonymous (AA) maintains a worldwide presence, with more than 2 million members and 110,000 groups in over 180 countries. Researchers and clinicians have become increasingly interested in mechanisms of action that contribute to positive outcomes in this “spiritual program of action,” but few have applied a theoretical framework to these efforts. In this three-paper dissertation, the nursing Theory of Human Relatedness (THR) was used to inform or direct qualitative, theoretical, and quantitative inquiries.

First, a set of personal stories from the fourth edition of *Alcoholics Anonymous* was examined. Using methods derived from narrative analysis, a normative model was proposed. The overall storyline followed classical literary conventions for tragedy and comedy, incorporating regressive, progressive, and stable narratives. Prototypical stages (first or early drinking, alcoholic regression, hitting bottom, progress in the AA program, and stable sobriety) were embedded in a subjective, evaluative function over time.

In a second paper, THR was applied to alcoholism and recovery in AA. The organizing construct was relatedness, an individual’s level of involvement with persons, objects, environments, or spiritual entities, and the concurrent level of comfort associated

with that involvement. Detailed analysis of an exemplar, and a survey of other personal stories, suggested that THR has the potential to serve as a unifying theory in the study of alcoholism and recovery in AA.

Finally, a prospective, longitudinal study was conducted in Warsaw, Poland. Patients were assessed at baseline, one month, and 6-12 months for AA meeting attendance, affiliation, and alcohol consumption. Outcomes were obtained from 118 of 154 participants, 77% of the baseline sample. AA attendance alone did not predict improved drinking outcomes. In contrast, self-report of a spiritual awakening (one of the affiliation items) was significantly associated with abstinence, and the absence of any heavy drinking. Spiritual awakening was further associated with a number of other AA-related behaviors, collectively referred to as affiliation. Greater AA affiliation increased the likelihood of having had a spiritual awakening which, in turn, predicted improved drinking outcomes. Affiliation items were aligned with the core construct and concepts from the Theory of Human Relatedness.

Chapter 1

Introduction

As a medical disease that also carries specific and related nursing diagnoses, alcoholism falls squarely in the purview of professional nursing practice. Given that alcohol use disorders are among the most prevalent mental disorders, and are leading causes of disability in the United States (Grant, Dawson, Stinson, Chou, Dufour & Pickering, 2004) and worldwide (WHO, 2001), it is essential for nurses everywhere, regardless of clinical setting or practice specialty, to have a basic understanding of alcoholism, and various modes of treatment and recovery (Strobbe, Finnell & Piano, in press).

Research that focuses on Alcoholic Anonymous is relevant to nursing in several respects. Pertinent considerations include (1) the history of alcoholism as a disease, (2) nursing diagnosis as it relates to alcohol use disorders, (3) Alcoholics Anonymous as a program of recovery, and (4) the potential application of nursing theory to Alcoholics Anonymous.

Alcoholism as a Disease: A Brief History

In 1784, Dr. Benjamin Rush (1814/1934) published *An Inquiry into the Effects of Ardent Spirits on the Human Mind and Body*, in which he described chronic drunkenness as a progressive, potentially fatal condition, affecting body and mind. “Thus we see poverty and misery, crimes and infamy, diseases and death, are all the natural and usual

consequences of the intemperate use of ardent spirits” (p. 197). Dr. Rush recommended total abstinence as the only effective cure—although hard cider, malt liquors, and wines were not excluded—and further “proposed the construction of detoxification establishments, asylums, and ‘sober houses’, where regular offenders would be shut in until cured” (Sournia, 1990, p. 29-30).

The term “alcoholism” was first coined in 1849 by Magnus Hess, a physician to Swedish kings, to describe the systematic adverse effects of alcohol. The use of the word “alcoholism” was popularized after the founding of Alcoholics Anonymous in 1935, and the subsequent publication of their basic text, *Alcoholics Anonymous* (AAWS, 2001), commonly referred to as the “Big Book,” in 1939. In a forward to that first edition, and all that have followed (1955, 1976, and 2001), Dr. William Silkworth—a respected physician who had treated thousands of alcoholics, including Bill Wilson, one of the co-founders of AA—described the heartbreaking affliction of alcoholism, along with remarkable examples of recovery in the fledgling program of Alcoholics Anonymous, through abstinence, “an entire psychic change”, and reliance “in a power greater than themselves” (AAWS, 2001, p. xxviii).

In the years and decades that followed, Alcoholics Anonymous and the medical community have engaged in a long, and generally beneficial, exchange of ideas about the nature of alcoholism. Nonetheless, AA itself—not to be confused with its individual members—originally avoided use of the word, “disease,” and opted, instead, for terms that carried less controversy, such as an “illness” or a “malady,” one that affected body, mind, and spirit (Kurtz, 1979/1991, 2002; Miller & Kurtz, 1992). In contrast, in a “Report on the First Sessions of the Alcoholism Subcommittee”, which convened in

Geneva, Switzerland in 1950, the World Health Organization recognized “alcoholism as a disease and a social problem” (WHO, 1951, p. 4). Not long thereafter, in 1956, the American Medical Association (AMA) also declared alcoholism to be a disease.

In 1960, Dr. E. M. Jellinek—a New England physiologist, biostatistician, and researcher, who was also a consultant to the World Health Organization—published *The Disease Concept of Alcoholism* (Jellinek, 1960), in which he provided an operational definition of alcoholism as “*the use of any alcoholic beverages that causes any damage to the individual, society, or both*” (p. 35; original italics). Jellinek went on to describe several “species” or subsets of alcoholism and alcoholics, including what he considered to be the predominant strain, at least in the United States, which he termed as “gamma alcoholism.” Based on his own research in the 1940s and 1950s, which included members of Alcoholics Anonymous, he listed the following characteristics: “(1) acquired increased tissue tolerance to alcohol, (2) adaptive cell metabolism..., (3) withdrawal symptoms and ‘craving,’ i.e., physical dependence, and (4) loss of control” (p. 37).

Decades later, the same foundational characteristics that were described by Jellinek could be found in literature widely distributed by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and posted on their web site:

Alcoholism, also known as alcohol dependence, is a disease that includes the following four symptoms: Craving—A strong need, or urge, to drink. Loss of control—Not being able to stop drinking once drinking has begun. Physical dependence—Withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety after stopping drinking. Tolerance—The need to drink greater amounts of alcohol to get “high” (NIAAA, 2001, p. 3; 2007).

In 1983, the American Society of Addiction Medicine (ASAM) issued a policy statement, identifying alcoholism as a primary disease:

Based on many years of clinical experience, reinforced by recent and continuing research into the genetic, biochemical and physiological aspects of the effects of alcohol on living systems and of alcoholics and their families, the American Society of Addiction Medicine finds that alcoholism is a complex primary physiological disease, and neither a primary behavior disorder nor a symptomatic manifestation of any other disease process (ASAM, 2005).

A comprehensive definition of alcoholism was later generated by a consensus committee of the National Council on Alcoholism and Drug Dependence (NCADD) and ASAM. The purpose of this committee was to create a revised definition that was “(1) scientifically valid, (2) clinically useful, and (3) understandable by the general public” (Morse & Flavin, 1992, p. 1012). The results of their efforts were published in the *Journal of the American Medical Association* in 1992, in which they described alcoholism as

...a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic (p. 1013).

Diagnostic criteria for alcohol dependence were formalized and expanded by the American Psychiatric Association (APA) in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, and further modified in the fourth edition (DSM-IV; APA, 2000; Appendix A). This taxonomy has been used both nationally and internationally.

Under the auspices of the World Health Organization (1992), the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) listed both “chronic alcoholism” and “dipsomania” as specific “dependence syndromes” under the broader heading of “Mental and behavioural disorders due to use

of alcohol”. A distinct convergence can be discerned between diagnostic criteria for substance dependence, including alcohol, as outlined in DSM-III and DSM-IV, and the ICD-10 entry for dependence syndromes:

A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state (WHO, 1992, Vol. I, p. 321).

In 2004, Dr. Nora Volkow, the Director of the National Institute on Drug Abuse (NIDA), and Dr. Ting-Kai Li, the Director of NIAAA, jointly published an article that described addiction to alcohol, tobacco, and other drugs, as a “disease of the brain”, with genetic, developmental, biological, and environmental influences that, together, “undermine voluntary control” (Volkow & Li, 2004, p. 963). Gradually, and over time, alcoholism has increasingly come to be viewed as a chronic, but treatable, medical illness, rather than the natural consequence of willful moral failings. In fact, when alcohol and other drug dependence are viewed as chronic medical illnesses, treatment response is comparable to other chronic diseases, including type II diabetes-mellitus, hypertension, and asthma (McLellan, Lewis, O’Brien & Kleber, 2000).

That is not to say that the disease concept of alcoholism is without its detractors. In 1989, Stanton Peele, an outspoken critic of the “disease theory” of addiction, the tenets of Alcoholics Anonymous, and the broader “addiction treatment industry,” first published *Diseasing of America: How We Allowed Recovery Zealots and the Treatment Industry to Convince Us We Are Out of Control*. Peele opposed the manner in which personal and social problems had become “medicalized,” and endorsed increased personal

responsibility and consequences, behavioral regulation, and basic social changes (Peele, 1995).

Nursing Diagnosis in Relation to Alcohol Use Disorders

In recent decades, nursing diagnosis has emerged as a means to better articulate, develop, and advance the philosophy, theory, and practice of nursing as a distinct and evolving profession. Nursing distinguishes itself from other health care professions, particularly medicine, by focusing its attention not only on *diseases*, but on human *responses* to actual or potential health problems. Nursing, as an art and a science, is intentionally “attuned to the whole person,” employing a “broad-based education and holistic focus” to help individuals “reach their fullest health potential” (American Nurses Association, ANA, 2007, p. 1).

In her *Notes on Nursing*, Florence Nightingale (1859/1992) put forth a treatise on nursing, in which she viewed disease as a reparative process, and the role of nursing to place the patient in the best possible condition for “Nature” to act upon him or her. Rather than the disease itself, the primary focus was placed on establishing and maintaining a healthy environment—internal and external—both for and with the patient, including biological, psychological, social, and spiritual influences.

Certain of these basic tenets continue to be reflected in *Nursing’s Social Policy Statement*: “Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations” (ANA, 2003, p. 6). This broader diagnostic and treatment

perspective is made manifest, in part, through the development, implementation, and clinical application of nursing diagnoses.

The North American Nursing Diagnosis Association (NANDA) was formed in 1982 to standardize nursing terminology, and to develop taxonomy for nursing diagnosis. In 2002, this organization became NANDA-International (NANDA-I), to better reflect the growing use of nursing diagnosis worldwide. In a statement of purpose, the organization has indicated that "...NANDA International exists to develop, refine, and promote terminology that accurately reflects nurses' clinical judgments. This unique, evidence-based perspective includes social, psychological and spiritual dimensions of care" (NANDA-I, 2008a, p. 1).

Nursing diagnoses are compound structures composed of (1) a *label*, from a list of approved nursing diagnoses, (2) a *definition*, which provides a precise meaning of the diagnosis, (3) *defining characteristics*, or a cluster of signs and symptoms that point to the nursing diagnosis, and (4) *related factors*, whether etiologic or contributing, that have influenced the health status change (Carpenito, 1995). At present, few nursing diagnoses focus exclusively on alcoholism. Among these, the nursing diagnosis of "Dysfunctional Family Process: Alcoholism", offers the following definition: "Psychosocial, spiritual, and physiological functions of the family unit are chronically disorganized, which leads to conflict, denial of problems, resistance to change, ineffective problem solving, and a series of self-perpetuating crises" (NANDA-I, 2007, p. 81).

From an historical perspective, Alcoholics Anonymous has long acknowledged the negative effects that alcoholism imposes on families. In Chapter 9 of the Big Book, entitled, "The Family Afterward," the author recounts a doctor having once said, "Years

of living with an alcoholic is almost sure to make any wife or child neurotic. The entire family is, to some extent, ill” (AAWS, 2001, p. 122). It was out of this recognition, and a desire for complementary and concurrent—but separate—recovery, that the second Twelve Step program, Al-Anon, was created in 1951 by Lois Wilson, who was married to Bill Wilson, one of the co-founders of AA. Al-Anon was later joined by Alateen, for youths aged 12 to 20, and together these formed the Al-Anon Family Groups (Al-Anon Family Groups, 2006).

Amid nursing diagnoses, “Potential Complications” are conditions that may emerge in the context of another nursing diagnosis, and contribute to an untoward outcome. Among these, “Alcohol Withdrawal” describes “a person experiencing or at high risk to experience the complications of alcohol withdrawal (eg , delirium tremens, autonomic hyperactivity, seizures, alcohol hallucinosis, and hypertension)” (Carpenito-Moyet, 2006, p. 887). While fatalities have decreased significantly with the use of benzodiazepines to treat alcohol withdrawal, this syndrome remains “a potentially life threatening condition” (DePetrillo & McDonough, 1999, p. 5).

In addition to these specific instances, a number of other nursing diagnoses can be generated by using primary labels that do not apply exclusively to alcoholism, but are still closely related to the disorder. One example that may have particular relevance to this area of study is the nursing diagnosis of “Spiritual Distress,” defined as, “Impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself” (NANDA-I, 2007, p. 208). A portion of this definition appears to have been drawn directly from language deeply embedded in the lexicon of Alcoholics Anonymous,

specifically Step Two, which refers to “a Power greater than ourselves” (AAWS, 2001, p. 59).

Nursing diagnoses are continually being developed, revised and, more recently, retired if an evidence-base is not established and maintained. To date, most nursing diagnoses have tended to focus on deficits, risks, potential risks or, conversely, on health promotion in the absence of illness. One area of nursing diagnosis that could still be seen as underdeveloped is that of adaptive responses or recovery in the presence of a chronic illness such as alcoholism, particularly when in a state of remission.

While details had not yet been released to the public at the time of this writing, the *NANDA-I Nursing Diagnoses: Definitions and Classification 2009-2011* held out promise along those lines. In particular, a new health promotion diagnosis, “Readiness for Enhanced Resilience”, was pending (NANDA-I, 2008b), along with a revised health promotion diagnosis, “Readiness for Enhanced Self Health Management” (NANDA-I, 2008c). It remains to be seen whether or not taxonomy for health promotion will be expanded to include participation in self-help or mutual-help groups, such as Alcoholics Anonymous, in the presence of a chronic disorder, in this case alcoholism, whether active or in remission.

Alcoholics Anonymous as a Program of Recovery

As a spiritual and social movement, Alcoholics Anonymous was founded on the principle of one alcoholic helping another. A concise description of this society can be found in the AA Preamble (Appendix G; AA Grapevine, 2005). The tripartite legacy of Alcoholics Anonymous is composed of *recovery*, *unity*, and *service*. In terms of personal *recovery*, it has been suggested that the active alcoholic must first “hit bottom,” i.e.,

really acknowledge the hopelessness of his or her current situation, and “surrender,” in order to avail himself or herself to “a spiritual program of action” (AAWS, 2001, p. 85) and a “new way of life” (p. 99). The newcomer is encouraged to stay sober, “one day at a time.” This simple coping strategy has helped AA members, new and old, avoid that first drink, which could otherwise lead to alcoholic relapse.

Sobriety is initiated and maintained through abstinence from alcohol and other potentially addictive drugs, and by “working the program” as outlined in the Twelve Steps of Alcoholics Anonymous (Appendix B). Dr. Bob is said to have offered a summary version of the program when he suggested that alcoholics “trust God, clean house, help others”. Self-described members frequently attend AA meetings, read AA literature, and work with a sponsor. A sponsor is typically another, more experienced, AA member (usually of the same sex, to reduce the risk of romantic complications), who serves as a guide or mentor, particularly as the newcomer works through the steps. An AA member’s length of continuous sobriety is often acknowledged and celebrated, at first more frequently (e.g., 30 days, 60 days, 90 days, 6 months, and 9 months), and annually thereafter.

Just as the Twelve Steps are principles for personal recovery, observance of the Twelve Traditions (Appendix C) ensures *unity* among individual AA groups and the fellowship as a whole (AAWS, 2001, p. 574). Tradition Three states that, “The only requirement for membership is a desire to stop drinking” (AAWS, 1952, p. 139). This open invitation represents a radical philosophy of inclusion, whereby anyone who says that he or she is a member of AA, is one. Groups, which “ought to be fully self-supporting” (p. 160), are considered autonomous, except in matters that affect other

groups, or AA as a whole. Decisions are made in accordance with “group conscience,” seeking consensus and, whenever possible, unanimity. “Each group has but one primary purpose—to carry its message to the alcoholic who still suffers” (p. 150).

Another important legacy of Alcoholics Anonymous is that of *service*. In various ways it has been said that “you have to give it away to keep it”. In other words, for the alcoholic to stay sober, he or she needs to help others. Service work can take many forms and may coincide, at least in part, with length and quality of sobriety. Examples include, but are not limited to, making coffee or greeting others at meetings, providing rides, giving talks at open speaker meetings, sponsoring others, and serving on various AA committees or boards. Along with the Twelve Steps and Twelve Traditions, the Twelve Concepts were designed “to help ensure that various elements of A.A.’s service structure remain responsive and responsible to those they serve” (AAWS, 2001, p. 574). Collectively, an attitude of accountability is reflected in the “Responsibility Statement,” adopted at the 30th Anniversary International Convention in Toronto, Canada, in 1965: “When anyone, anywhere, reaches out for help, I want the hand of A.A. always to be there, and for that, I am responsible” (AAWS, 1967, p. 332).

Those who wish to learn more about Alcoholics Anonymous are encouraged to (1) attend one or more “open” AA meetings, at which the general public is welcome, (2) visit the AA web site (www.aa.org) to access pamphlets and other information about Alcoholics Anonymous, and (3) read the “Big Book” and other AA General Service Conference-approved literature. At the same time, AA has consistently maintained that when it comes to “therapy for the alcoholic himself, we surely have no monopoly” (AAWS, 2001, p. xxi), and there are a number of other mutual-help groups that may

benefit those who seek to change their drinking behaviors, including Women For Sobriety (WFS), Secular Organizations for Sobriety/Save Our Selves (SOS), Moderation Management (MM), SMART Recovery, and LifeRing (Horvath, 2005; see Appendices D and E).

Most, if not all, of these “alternative” mutual-help groups were created in response or reaction to Alcoholics Anonymous as the prevailing norm. Each of these organizations offers an explicitly secular orientation to recovery, in marked contrast to the strong spiritual—and what some may view as distinctly religious—inclinations of Alcoholics Anonymous. Among these, Moderation Management is the only approach that overtly offers a choice between moderate or controlled drinking, and abstinence, as possible goals.

AA’s approach is generally consistent with a philosophy of nursing in that it concerns itself with the whole person, applying biological, psychological, social, and spiritual perspectives to alcoholism, treatment, and recovery. One nursing textbook on addictions (Sullivan, 1995) dedicated several pages to Alcoholics Anonymous, while another referred to AA as “a mainstay of addiction recovery and relapse prevention” (Allen, 1996, p. 199). The International Nurses Society on Addictions (IntNSA, formerly the National Nurses Society on Addictions) has included information about Alcoholics Anonymous and other mutual-help groups in its core curriculum of addictions nursing (IntNSA, 2006). More recently, the National Institute on Alcohol Abuse and Alcoholism (NIAAA, in press) prepared an undergraduate nursing curriculum on alcohol use disorders, in which mutual-help groups, including Alcoholics Anonymous, were described (Strobbe, Finnell & Piano, in press).

Potential Application of Nursing Theory to Alcoholics Anonymous

Despite the facts that (1) alcoholism is now being viewed from an international health perspective; (2) nurses frequently encounter and care for patients, families, and communities that are affected by alcoholism; and (3) Alcoholics Anonymous is a worldwide mutual-help program, surprisingly little has been written about AA and nursing in general, or AA and nursing theory in particular. On one hand, this may seem like a curious omission, given what might be seen as a natural affinity between these two holistic philosophies. Whatever the reasons for these past refractions, Alcoholics Anonymous will be viewed, from various perspectives, through the theoretical lens of human relatedness (Hagerty, Lynch-Sauer, Patusky & Bouwsema, 1993), in hopes that this will help to sharpen the focus on related research, education, and clinical practice.

Toward that end, this dissertation is composed of three complementary papers. The first of these is titled, “Personal Stories in the ‘Big Book’ of Alcoholics Anonymous: A Narrative Analysis” (Chapter 2). Considered a foundational paper for the rest of the project, it employed qualitative research methods to examine the written narratives of 24 demographically diverse members Alcoholics Anonymous, whose stories appeared for the first time in the fourth edition of the Big Book. In addition to proposing a normative model for these personal stories, thematic content was examined at critical stages in the storyline, including themes of relatedness. The second paper, “Applying the Theory of Human Relatedness to Alcoholism and Recovery in Alcoholics Anonymous” (Chapter 3), addresses the topic of nursing theory and alcoholism headlong. Taking one of the previously mentioned personal stories as an exemplar, an in-depth, theory-based analysis

was conducted, followed by a thematic survey across the remaining narratives in the data set.

Finally, while not a direct test of the Theory of Human Relatedness (THR), the third paper was based on a prospective, longitudinal study conducted in collaboration with the Medical University of Warsaw (MUW), Poland. The purpose of this study was to examine the roles of AA meeting attendance and affiliation on drinking outcomes in a Polish treatment sample. It appears that a number of AA-related behaviors, collectively referred to as AA affiliation, aligned with the construct of relatedness, and other key concepts associated with the Theory of Human Relatedness.

References

- Al-Anon Family Groups. (2006). *Al-Anon/Alateen*. Retrieved November 24, 2008, from <http://www.al-anon.alateen.org/english.html>
- AA Grapevine. (2005). AA Grapevine history: The story of the Grapevine. Retrieved April 23, 2005, from http://www.aagrapevine.org/history/history_index.html
- Alcoholics Anonymous World Services. (1952). *Twelve steps and twelve traditions*. New York, NY: Author.
- Alcoholics Anonymous World Services. (1967). *As Bill sees it: The A.A. way of life...selected writings of A.A.'s co-founder*. New York, NY: Author.
- Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (4th ed.). New York, NY: Author.
- Allen, K. M. (1996). *Nursing care of the addicted client*. Philadelphia, PA: Lippincott-Raven.
- American Nurses Association. (2003). *Nursing's social policy statement* (2nd ed.). Silver Springs, MD: Author.
- American Nurses Association. (2007). *What is nursing?* Retrieved on November 18, 2008, from <http://www.nursingworld.org/EspeciallyForYou/StudentNurses/WhatisNursing.aspx>
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- American Society of Addiction Medicine. (2005). *Public policy statement on alcoholism as a primary disease*. Retrieved December 4, 2008, from <http://www.asam.org/AlcoholismPrimaryDisease8.html>
- Carpenito, L. J. (1995). Types and components of nursing diagnosis. In *Nursing diagnosis: Application to clinical practice* (6th ed.). Philadelphia, PA: J. B. Lippincott Co.
- Carpenito-Moyet, L. J. (2006). *Nursing diagnosis: Application to clinical practice* (11th ed.). Philadelphia, PA: J. B. Lippincott Co.
- DePetrillo, P. B., & McDonough, M. K. (1999). *Alcohol withdrawal treatment manual*. Glen Echo, MD: Focused Treatment Systems.

- Grant, B. F., Dawson, D. A., Stinson, F. S., Chou, S. P., Dufour, M. C., & Pickering, R. P. (2004). The 12-month prevalence and trends in DSM-IV alcohol abuse and dependence: United States, 1991-1992 and 2001-2002. *Drug and Alcohol Dependence*, 74(3), 223-234.
- Hagerty, B. M. K., Lynch-Sauer, J., Patusky, K. L., & Bouwsema, M. (1993). An emerging theory of human relatedness. *IMAGE: Journal of Nursing Scholarship*, 25, 291-296.
- Horvath, V. (2005). Alternative support groups. In J. H. Lowinson, P. Ruiz, R. B. Millman, J. G. Langrod (Eds.), *Substance Abuse: A Comprehensive Textbook* (4th ed., pp. 599-609). Philadelphia, PA: Lippincott Williams & Wilkins.
- International Nurses Society on Addictions. (2006). *Core curriculum of addictions nursing* (2nd ed., text revised). Columbus, OH: Author.
- Jellinek, E. M. (1960). *The disease concept of alcoholism*. New Haven, CT: Hillhouse.
- Kurtz, E. (1991). *Not-God: A history of Alcoholics Anonymous*. Center City, MN: Hazelden.
- Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. *Alcoholism Treatment Quarterly*, 20(3-4), pp. 5-40.
- McLellan, T. A., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284(13), 1689-1695.
- Miller, W. R., & Kurtz, E. (1992). Models of alcoholism used in treatment: Contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol*, 55(2), 159-166.
- Morse, R. M., & Flavin, D. K. (1992). The definition of alcoholism. The Joint Committee of the National Council on Alcoholism and Drug Dependence and the American Society of Addiction Medicine to study the definition and criteria for the diagnosis of alcoholism. *Journal of the American Medical Association*, 269(5), 1012-1014.
- NANDA International (NANDA-I). (2007). *NANDA-I nursing diagnosis: Definitions & classification 2007-2008*. Philadelphia, PA: Author.
- NANDA International (NANDA-I). (2008a). *About NANDA-I: Defining the knowledge of nursing*. Retrieved November 23, 2008, from <http://www.nanda.org/AboutUs.aspx>

- NANDA International (NANDA-I). (2008b). *NANDA-I taxonomy updates: New health promotion diagnoses*. Retrieved November 23, 2008, from <http://www.nanda.org/DiagnosisDevelopment/NewsandUpdates/TaxonomyUpdates/HealthPromotion.aspx>
- NANDA International (NANDA-I). (2008c). *NANDA-I taxonomy updates: Revised diagnosis—health promotion*. Retrieved November 23, 2008, from <http://www.nanda.org/DiagnosisDevelopment/NewsandUpdates/TaxonomyUpdates/Revised.aspx>
- National Institute on Alcohol Abuse and Alcoholism. (2001). *Frequently asked questions about alcoholism and alcohol abuse*. [Pamphlet]. Rockville, MD: Author.
- National Institute on Alcohol Abuse and Alcoholism. (in press). *A nursing education model for the prevention and treatment of alcohol use disorders*. C.E. Savage (Ed.). Bethesda, MD: Author.
- Nightingale, F. (1992). *Notes on nursing: What it is, and what it is not*. Philadelphia, PA: J. B. Lippincott Co. (Original work published 1859)
- Peele, S. (1995). *Diseasing of America: How we allowed recovery zealots and the treatment industry to convince us we are out of control*. New York: Lexington Books.
- Rush, B. (1934). An inquiry into the effects of ardent spirits upon the human body and mind with an account of the means of preventing and of the remedies for curing them (8th ed., with additions). In Henderson, Y., *A New Deal in Liquor: A Plea for Dilution* (pp. 185-221). Garden City, NY: Doubleday, Doran & Co. (Original work published 1814)
- Sournia, J.-C. (1990). *A history of alcoholism*. (N. Hindley & G. Stanton, Trans.) Cambridge, MA: Oxford.
- Strobbe, S., Finnell, D.S., Piano, M. (in press). Assessment and treatment of alcohol use disorders. In C. E. Savage (Ed.), *A Nursing Education Model for the Prevention and Treatment of Alcohol Use Disorders*. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism (NIAAA).
- Sullivan, E. J. (1995). *Nursing care of clients with substance abuse*. St. Louis, MO: Mosby.
- Volkow, N. D., & Li, T-K. (2004). Drug addiction: The neurobiology of behavior gone awry. *Nature Reviews Neuroscience*, 5, 963-970.

World Health Organization. (1951). *Expert Committee on Mental Health: Report on the first session of the Alcoholism Subcommittee*. WHO Technical Report Series No. 42. Geneva, Switzerland: Author.

World Health Organization. (1992). Mental and behavioural disorders. In *International Statistical Classification of Diseases and Related Health Disorders* (10th revision). Geneva, Switzerland: Author.

World Health Organization. (2001). *The world health report, 2001*. Geneva, Switzerland: Author.

Chapter 2

Personal Stories in the “Big Book” of Alcoholics Anonymous: A Narrative Analysis

Introduction

Alcoholics Anonymous (AA) is viewed as a mainstay for the initiation and maintenance of abstinence and recovery from alcoholism, whether sought out independently, or as an adjunct to formal treatment. Despite its longevity, a worldwide presence, and increased interest among alcohol researchers, certain aspects of this “spiritual program of action” (AAWS, 2001, p. 85) still await discovery and description.

A few authors have written extensively about the importance of storytelling in Alcoholics Anonymous (e.g., Cain, 1991; Diamond, 2000; Jensen, 2000; Kurtz, 1979/1991; O’Reilly, 1997). Most of these accounts have dealt with storytelling in AA as an oral (spoken) tradition. For this study, we examined a set of 24 written personal stories as they appeared for the first time in the fourth edition of *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism* (AAWS, 2001), more commonly referred to as the “Big Book.” Using qualitative research methods derived from narrative analysis, a *normative model* was proposed for personal stories of alcoholism and recovery in Alcoholics Anonymous, focusing on overall structure, including critical events or stages in the storyline, and frequently invoked themes.

In the Beginning: Storytelling in Alcoholics Anonymous

From its humble and desperate beginnings back in 1935, AA has been rooted in “the telling and re-telling of ‘stories’” (Kurtz, 1991, p. 68), and in the reciprocal healing that can take place when one alcoholic speaks to another. In *Not-God: A History of Alcoholics Anonymous*, Kurtz (1991) wrote, “what made the program work was the telling of their stories by now sober alcoholics” (p. 71). A portent of this dynamic occurred when William Griffith Wilson (Bill W.), in order to remain sober himself, went to extraordinary lengths to get in touch with another alcoholic. Through an intermediary (Mrs. Henrietta Seiberling), Bill was introduced to Dr. Robert Holbrook Smith (Dr. Bob), whom he had never met before, and who was still drinking at the time. The result was a momentous meeting between two unlikely co-founders, and what later became known as “Alcoholics Anonymous” was born. In a subsequent recounting of these events, Dr. Bob wrote

He [Bill W.] gave me information about the subject of alcoholism which was undoubtedly helpful. *Of far more importance was the fact that he was the first living human with whom I had ever talked, who knew what he was talking about in regard to alcoholism from actual experience. In other words, he talked my language* (AAWS, 2001, p. 180; original italics).

This language—one of “communication,” “identification,” and the hope of liberation—later came to be called by Bill W., “the language of the heart” (AA Grapevine, 1960/1988, p. 243). Here, one can begin to see the potential for positive identification between a narrator (Bill W.) and his initially reluctant audience of one (Dr. Bob), even though what they held in common was “a seemingly hopeless state of mind and body” (AAWS, 2001, xiii) called alcoholism.

An Impulse to Narrate

Telling stories about past events is a universal human activity, and one of the first forms of discourse that we learn as children (Nelson, 1989). It has been said that humans have a “natural...impulse to narrate” (White, 1980, p. 5), and that the telling of stories, or narratives, can help us to organize and make sense of our lives. This is particularly true when coming to terms with difficult times or transitions (Riessman, 1993). In addition, our life stories are influenced by the social contexts in which they are told, and these play a significant role in the formation of personal identities (Rosenwald & Ochberg, 1992). In this way, the stories we tell about ourselves have the power to shape and change present and future behaviors, potentially altering who we are, and who we will become.

In 1993, Riessman stated

The precise definition of personal narrative is a subject of debate...For now it refers to talk organized around consequential events. 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 (p. 3).

Certainly, the lived experience of a once active, and now recovered, alcoholic provides plenty of grist for such an existential mill. In the time since Riessman’s definition, the boundaries of personal narratives have been expanded greatly, and are now seen to encompass a broader range of genres (Ochs & Capps, 1996), including both oral and written accounts.

Oral Narratives in Alcoholics Anonymous

While oral narratives are not the primary focus of this study, a brief overview of this genre may help to orient the reader to the broader context in which written, personal stories are embedded in the culture of Alcoholics Anonymous. First, oral narratives are shared across a variety of settings and circumstances in AA. These may include personal

conversations between members of the fellowship, with content that is predominately social, practical, or ideal in nature. A combination of these elements is most often the case. In terms of socialization, even the most basic verbal exchanges may help to promote increased social contact, interaction and, eventually, integration. Practical considerations might include basic strategies about how to avoid drinking during early recovery. At the same time, ideals may be reflected through the incorporation of certain principles or values of the program of Alcoholics Anonymous, such as the recognition of one's powerlessness over alcohol, and a willingness to ask for and to receive help.

A more deliberative and purposeful presentation or exchange of stories may occur between an AA member and his or her sponsor. A sponsor is typically another, more experienced, AA member who serves as a guide or mentor, particularly as a newcomer "works through the steps." These communications may deal with routine, daily concerns, as well as certain milestones in the AA program. For example, after having "made a searching and fearless moral inventory" (AAWS, 2001, p. 59) in Step Four (Appendix B), narratives are often elicited in conjunction with Step Five, which states, "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs" (AAWS, 2001, p. 59). Wrenching disclosures on the part of the newer member are tempered, and even normalized, as the sponsor listens and looks on unperturbed, perhaps acknowledging a similar or more harrowing personal history.

Other narrative encounters may occur during "open" or "closed" discussion meetings, speaker meetings, or Twelfth Step calls. In addition to self-identified members of Alcoholics Anonymous, the general public is also welcome to attend open AA meetings. In contrast, closed meetings are limited to those who have self-identified as

alcoholics or, in accordance with Tradition Three (Appendix C), have “a desire to stop drinking” (AAWS, 1952, p. 139). During discussion meetings, rather than engaging in free-form discourse, participants tend to weigh in briefly on an identified step or topic. This format often prompts, and on occasion almost requires, the inclusion of autobiographical anecdotes.

At speaker meetings, a member of AA is invited to tell his or her story of alcoholism and recovery, and may be allotted up to the better part of an hour to do so. Often, this occurs during open speaker meetings, considered by many to be an important port of entry for the prospective newcomer, who may still be in the process of trying to decide whether or not *she* thinks she has a drinking problem, and is ready to do something about it. Open meetings also provide an opportunity for other interested parties to learn more about AA through the stories of recovered alcoholics. Others in attendance may include, for example, the relatives or friends of a problem drinker, various health care professionals, and religious leaders within the broader community. Recordings of open talks are sometimes made available through local AA groups, or other enterprises.

In some respects, open talks can be categorized as public speech acts or “performances,” conducted before a select audience, similar to those described by the sociologist Erving Goffman (1959). More recently, Jensen (2000) applied rhetorical analysis—focusing on the interactions between author, audience, and text—to storytelling in Alcoholics Anonymous. Applying Bakhtin’s theory and lexicon to open talks in AA, Jensen suggested that it is this kind of “true confessional self-accounting...that leads to spiritual growth” (p. 104).

Although the frequency of these visits may have diminished over the years—due, in part, to an increased presence and reliance upon formal treatment centers—a Twelfth Step call is initiated in response to a cry for help, perhaps from an alcoholic who has reached the end of his rope and is ready to give AA a try. This process is described in detail in Chapter 7 of the Big Book, entitled, “Working with Others.” Done credibly and convincingly, it invariably involves a story.

Tell him enough about your drinking habits, symptoms, and experiences to encourage him to speak of himself. If he wishes to talk, let him do so... When he sees you know all about the drinking game, commence to describe yourself as an alcoholic... Keep his attention focused mainly on your personal experience. Explain that many are doomed who never realize their predicament... Even though your protégé may not have entirely admitted his condition, he has become very curious to know how you got well. Let him ask you that question, if he will. *Tell him exactly what happened to you* (AAWS, 2001, pp. 91-93; original italics).

Written Narratives in Alcoholics Anonymous

AA narratives also figure prominently in written form. The first edition of *Alcoholics Anonymous*, the basic text for this society, was published in 1939, with subsequent editions released in 1955, 1976, and 2001. Then, as now, “personal stories” occupied more than half the volume. In fact, the first chapter of the Big Book, “Bill’s Story” (AAWS, 2001, pp. 1-16), written by co-founder Bill W., offers a chilling depiction of alcoholism, as well as his eventual recovery by way of a spiritual experience, a moral program for personal change, and service work. With each new edition, some stories were carried over, others deleted, and new ones added. Two accounts that have been retained for decades, and still stand as archetypes for this genre, are those of Bill W., and Dr. Bob (Dr. Bob’s Nightmare, AAWS, 2001, pp. 171-181).

The dissemination of the Big Book, with its many personal stories, has been prolific. “Approximately 21 million copies of the first three editions of ‘Alcoholics

Anonymous' have been distributed" (AAWS, 2001, dust jacket). At the time that the fourth edition was published, worldwide membership of AA was estimated to be "two million or more, with nearly 100,800 groups meeting in approximately 150 countries around the world" (p. xxiii). These figures have since grown to more than two million members and 110,000 groups in over 180 countries (AAWS, 2008).

A second source of written narratives in Alcoholics Anonymous can be found in the *AA Grapevine*. A monthly magazine first published in June 1944, the Grapevine came to be called "our meeting in print." It is recognized as "the international journal of Alcoholics Anonymous," and is available in print or online by subscription. A brief history of the Grapevine stated, "At the heart of the early Grapevines, then as now, were first-person stories" (AA Grapevine, 2005, p. 1). Of the 42 personal stories now included in the fourth edition of *Alcoholics Anonymous*, five (12%) of these first appeared as stories in the Grapevine, and were reprinted by permission.

In recent decades—distinctly outside the realm of conference-approved literature in Alcoholics Anonymous—another genre of written narratives about alcoholism and recovery has emerged in the popular press. Examples include collections of interviews (Lawford, 2009; Wholey, 1984), sometimes of famous public figures, as well as more fully developed autobiographical accounts (Knapp, 1996). Tradition Eleven in Alcoholics Anonymous calls for "personal anonymity at the level of press, radio, and films" (AAWS, 1952, p. 180). In some instances, this AA tradition has been observed by the broader publishing industry, while in other cases it has not.

A Brief Orientation to Narrative Analysis

Readers might be less familiar with narrative analysis than other forms of qualitative inquiry (e.g., grounded theory), so a brief orientation or review may be helpful. “Generally, narratives are understood as stories that include a temporal ordering of events and an effort to make something of those events: to render, or to signify, the experiences of persons-in-flux in a personally and culturally coherent, plausible manner” (Sandelowski, 1991, p. 162). Narrative analysis is generally considered to be a fairly complex qualitative research methodology that can operate on a number of levels.

According to Riessman (1993)

Narrative analysis takes as its object of investigation the story itself...The methodological approach examines the informant’s story and analyzes how it is put together, the linguistic and cultural resources it draws on, and how it persuades a listener of authenticity. Analysis in narrative studies opens up the forms of telling about experience, not simply the content to which language refers (p. 1).

The initial development of narrative analysis is generally credited to the sociolinguist, William Labov (1972; Labov & Waletzky, 1967), who viewed a complete narrative as being composed of an *abstract* (what the story is about), *orientation* (other situational details), a *complicating action* (what happened then), an *evaluation* (subjective reaction), *resolution* (a final outcome), and a *coda* (an indication that the story is over, with a return to the present), with narrative clauses serving as the primary unit of measure. Each of these basic elements can be identified, implied, or inferred in the recounting of a story as short in length as a few or several phrases. A variety of elaborate systems have been devised for the coding and analysis of narratives, using qualitative and/or quantitative techniques.

These same, basic structural elements can also be found in the examination of more extensive personal narratives, creating a matrix in which any number of shorter

autobiographical anecdotes, or vignettes, might also be embedded. Prime examples of expanded narratives include the telling of life stories, among which personal stories in Alcoholics Anonymous could be viewed as a distinct subcategory. While Linde (1993) made no specific mention of Alcoholics Anonymous in her treatise on life stories, her description resonates when applied to AA:

Life stories express our sense of self: who we are and how we got that way. They are also one very important means by which we communicate this sense of self and negotiate it with others. Further, we use these stories to claim or negotiate group membership and to demonstrate that we are in fact worthy members of those groups, understanding and properly following their moral standards. Finally, life stories touch on the widest of social constructions, since they make presuppositions about what can be taken as expected, what the norms are, and what common or special belief systems can be used to establish coherence (p. 3).

Beyond that, and pertinent to this chapter, narrative analysis can also be applied to multiple examples within a given genre and across a variety of individuals, while simultaneously searching for patterns in structure. This raises the concept of *frames*—sometimes also referred to as schemas or scripts—in relation to narratives. According to Norrick (2000), Tannen “showed how frame concepts account for expectations about story patterns themselves as well as for relations between the elements of a narrative” (p. 8). Norrick (2000) continued by noting that

Frames encode prototypes for objects, sequences of events, and causal relationships, which facilitate recognition, categorization and memories for stories; in addition, they guide tellers in what kind of stories are appropriate and what to include in them as well as suggesting to hearers what to expect and how to respond to stories” (p. 8).

In complementary alignment with this perspective, Mankowski and Rappaport (2000) discussed the importance of reciprocal relationships between individual and “community narratives” in spiritually-based settings, including Alcoholics Anonymous, and their

respective roles in “fostering development of members’ identities, defining community membership...building a sense of community, and facilitating personal change” (p. 479).

So prevalent and persistent are certain assumptions regarding the nature of narratives as being both “transformed and transformative” over time (Bruner, 1986/1997, p. 146), that a schematic illustration of this process is offered (Figure 1), along with an assertion of its applicability to personal stories in AA. In brief, stories about the past can only be told from the perspective of a narrator as he or she resides in the present, and so are necessarily and constantly filtered through the lenses of our ever-changing personal circumstances, including our ideas of self in relation to our selves and others, all of which occurs in a particular historical, social, and cultural context.

What we tell ourselves and others about the past, at any given moment, has implications and consequences not only for the present, and the future as it is yet to unfold, but also for our thoughts, feelings, memories, and evaluations about the past. In this respect, we can and do rewrite—or at least edit—our personal histories. In addition, to the degree that we identify with a particular community, our identities, values, and behaviors will tend to align themselves more and more closely with the predominant narrative. With repeated iterations, our personal stories, and the lives on which they are based, become increasingly consonant, consolidated, and coherent, both internally and externally. In summary, our narratives change over time, and so do we.

A Focused Review of the Literature

This chapter builds upon and extends the work of Cain (1991), O’Reilly (1997) Humphreys (2000), and Jensen (2000), each of whom contributed to the conversation regarding the structure of narratives in Alcoholics Anonymous, whether written or oral,

without exhausting the topic. Specifically, Cain (1991) described “a general AA story structure” (p. 235) based on a sample of personal accounts from the third edition of *Alcoholics Anonymous* (AAWS, 1976), and several AA pamphlets. She indicated that

This general structure included categories such as “first drink,” “negative effects of drinking,” “progression of drinking,” “suggestion (by others) that drinking may be a problem,” “denial,” “attempts to control drinking,” “entering AA,” “giving AA an honest try,” and “becoming sober” (p. 235)

Her findings suggested that, “over time, the individual learns to tell his drinking history according to the AA structure, and as the AA identity is internalized the life story narrated comes to resemble the prototypic AA story more and more closely” (p. 236).

O’Reilley (1997) reported having had the opportunity to observe a particular AA group for a period of two years, and making comparative observations with other groups in the urban Northeastern United States. At the end of his book, *Sobering Tales*, he also included the transcribed talks of five “ordinary” AA speakers, three men and two women. Based on his studies as a folklorist, O’Reilley described AA stories as a “three-part narrative—a performed, oral description of the speaker’s own gradual degradation, transformation, and recovery”. He asserted that, “Telling the story...enables the speaker to reconstrue a chaotic, absurd, or violent past as a meaningful, indeed a *necessary* prelude to the structured, purposeful, and comparatively serene present” (p. 24; original italics).

Humphreys (2000) employed a “narrative point of view” to describe the “typical content, function(s), and structure of five types of A.A. stories.” Of these, particular emphasis was placed on what Humphreys called a “drunk-a-log...a personal account of descent into alcoholism and recovery through A.A.” In addition to oral renditions provided to him by a few volunteers, Humphreys also made specific reference to written

stories found in the third edition of the Big Book (AAWS, 1976). According to Humphreys, key elements of a drunk-a-log included, “initial involvement with alcohol... [in which] Members often describe early experiences with alcohol positively...initial problems with alcohol...attempts to control the drinking problem... ‘hitting bottom’ ...[and] contact with A.A.” (p. 498-499). Humphreys was especially interested in “the interplay between the community narrative of A.A. and the personal life stories of individual A.A. members” (p. 495). Toward that end, he noted that, “Functionally, drunk-a-logs help storytellers incorporate aspects of the A.A. world view into their own identity and approach to living” (p. 499).

Jensen (2000) founded his rhetorical analysis on “the ethnographic study of the ‘culture’ of AA...attending open AA and Al-Anon meetings” for over three years. His references also included a number of audiotapes. He described the sequencing of “life stories in AA” (p. viii) in this way: “speakers describe their childhoods as a time when they felt ‘different’; speakers begin drinking, life seems wonderful, things fall apart, the disease progresses; speakers find AA, struggle with early sobriety, and eventually find a better life” (p. 123). Throughout his book, Jensen “alluded to the differences between newcomers and oldtimers [in AA], differences in how they speak at meetings and how they tell their stories” (p. 129). To help verify this claim, Jensen compared and contrasted prototypical accounts, both in terms of delivery or “narrative voice,” and stages in the storyline, including “Childhood...Drunkolog...Coming to AA...[and] Now” (pp. 131, 133).

From among these four authors, it was noted that two described a “drunk-a-log” as a specific type of AA narrative (Humphreys, 2000), or included the “drunkolog” as

part of an AA storyline (Jensen, 2000). In contrast, and differences in spellings aside, O'Reilly (O'Reilly) observed that a “drunkalogue,” in his experience, was used “not to describe the ‘drinking part of a testimonial,’ but rather as a pejorative description of a talk that recounts drinking exploits without interpretation or connection to the present” (p. 152).

The important contributions of these individuals warrant recognition. At the same time, they call into question certain methodological issues, exhibit some inconsistencies in the reporting of findings, and point to opportunities for subsequent research, including the present study. First, some of these investigators obtained data from more than one type of source and, in some instances, combined the use of both oral and written narratives, which Jensen (2000) considered to be qualitatively different. Second, while a number of similarities can be found in the lists that were generated by these authors, there are also some distinct inconsistencies. For example, Cain (1991) moved directly from “attempts to control drinking” to “entering AA” (page 235), and Jensen (2000) jumped from “the disease progresses” to “speaker finds AA” (p. 123), each without any apparent intervening event or process. In contrast, Humphreys specifically included the phenomenon of “hitting bottom,” often considered a critical juncture in an AA life story (AAWS, 1952; Kurtz, 1991; Kurtz & Ketcham, 1992).

In response to these observations, the current data set was purposefully limited to a single, consistent genre and source, specifically a subset of written narratives as they appeared for the first time in the fourth edition of *Alcoholics Anonymous* (AAWS, 2001). As conference-approved literature, the Big Book stands as an authoritative text for the society. In this respect, the written personal stories included for publication may be

viewed as exemplars or templates for AA narratives: written and oral, individual and community.

These new personal stories were selected because they had not yet been the focus of an in-depth analysis. This particular collection of narratives offered considerable diversity in terms of age, race or ethnicity, gender, religion, sexual orientation, and socio-economic status. The preface to the fourth edition specifically stated that, “All changes made over the years...have had the same purpose: to represent the current membership of Alcoholics Anonymous more accurately, and thereby reach more alcoholics” (AAWS, 2001, p. xii). While previous researchers have suggested particular *formats* for personal stories of alcoholism and recovery in Alcoholics Anonymous, this has not yet resulted in the creation of a structured *normative model* for these narratives, which may prove to be of some heuristic value, with implications for theory, research, and clinical care.

Positionality, Data Set, and Methods

Positionality: A Frame of Reference

Thomas S. Kuhn (1962/1996), in *The Structure of Scientific Revolutions*, dispelled the myth of detached objectivity in the pursuit of scientific knowledge, even when sought under the guise of logical positivism and quantitative research methods. Instead, Kuhn contended that we approach scientific problems with a slate of preconceived notions that influence our decisions about what to examine, the manner in which we conduct our inquiries, and how we interpret and convey our findings.

In comparison, qualitative research actively strives for greater proximity to its human participants and related subject matter, hence a preference for interviews,

recordings, texts, and artifacts over disembodied statistics. Another characteristic of some qualitative research—including ethnography, feminist studies, and narrative analysis—pertains to *positionality*, expressed as both a concept and a principle. In human dynamics, the concept of positionality refers to the relationship of the researcher to study participants, and the phenomenon being studied (Johnson-Bailey, 2004). In the conduct of research, the principle of positionality is realized through the recognition and acknowledgment of qualifications and potential biases, both positive and negative, on the part of the researcher.

As the author of this dissertation, and in the spirit of “transparent reflexivity” (Rose, 1997), I would describe myself as a white male with personal, professional, and academic interests in the phenomenon of recovery, particularly in the context of Alcoholics Anonymous. Over the past 20 years, I have heard and read hundreds of personal stories emanating from AA, including open speaker meetings, various audio recordings, AA conference-approved literature, and articles in the AA Grapevine. My professional and academic roles and identities have included those of an advanced practice psychiatric-mental health nurse, with added qualifications in addictions nursing; study coordinator and co-investigator in addictions research; graduate, post-graduate, and doctoral student in nursing, with a concentration in bio-behavioral health; and clinical director for an addictions treatment program at a major university in the Midwestern United States.

During this time, I have come to regard AA with a sense of fascination, reverence, and awe, viewing this 12-step program and fellowship as a radical and successful social experiment that has played an active role in saving and changing the lives of countless

alcoholics. While I do not consider Alcoholics Anonymous to be the only path to sobriety, I have openly encouraged others to attend and affiliate with AA and/or other mutual help groups, and have considered these communities to be a godsend for those who have benefited from them. At the same time, I am aware that many individuals are not attracted to or retained by spiritual programs of recovery, and some are actively repelled by what they perceive to be strong religious overtones. On a more personal note, I would neither confirm nor deny membership in AA or any other 12-step program, specifically “at the level of press, radio, and films” (AAWS, 1952, p. 180), not to be coy, but out of knowledge and respect for the vital tradition of anonymity.

Data Set: A Collection of Personal Stories

The data set for this study was composed of a subset of personal stories as they appeared for the first time in the Big Book, specifically the fourth edition of *Alcoholics Anonymous* (AAWS, 2001). All told, of the 42 stories included in this edition, 24 (57%) were categorized as “new.” Each of these personal stories appeared in one of three sections: Part I, “Pioneers of A.A.” (p. 169), Part II, “They Stopped in Time” (p. 279), and Part III, “They Lost Nearly All” (p. 435). Of these, one such written narrative appeared in Part I, 11 came from Part II, and the remaining 12 were to be found in Part III.

Since these stories were written and published anonymously, routine demographic and clinical information were neither collected nor routinely reported. To assist the reader in attaching some semblance of voice to these narratives, Table 1, “New personal stories in the fourth edition of *Alcoholics Anonymous*,” identifies each story by (1) study reference number, (2) location in the Big Book by part, story number, and page, (3) title

of the story, (4) gender of the narrator, and (5) some other snippet of descriptive information that the author has chosen to share. Of course, the best way to encounter these narratives, both individually and as a set, would be to read them firsthand. For those who are so interested, this need not be a burdensome proposition, as the average length of these stories is less than nine pages each (8.75), with a range of 6-12 pages.

Methods: An Organic Process of Reflective Iteration

Consistent with qualitative research in general and narrative analysis in particular, this project unfolded and evolved over time through an organic process of reflective iteration. It began with the idea, based on extensive exposure to AA culture, that a prevailing narrative did exist, along with the supposition that this narrative could be identified and described. Practical steps, which were more circular and recursive than linear, included (1) identifying a unique yet representative data set, (2) engaging in repeated, close readings of these new personal stories, (3) organizing thematic content around proposed stages, and (4) assembling and testing a conceptual model that could bear the weight of these transformational stories at the levels of personal and community narratives.

Findings: A Normative Model for Personal Stories in AA

Figure 2 depicts a normative, idealized, and prescriptive model for personal stories of alcoholism and recovery in Alcoholics Anonymous. It was found that these stories, both individually and collectively, contained a number of attributes frequently associated with classical literary, even mythical, conventions. Beginning with a subjective baseline, five major points or stages in the story line were identified, along with thematic content specific to each.

In his treatise, *On Poetics*, Aristotle (~350 B.C.E./1952) described a whole story as “that which has a beginning, middle, and end” (p. 685). AA stories are said to follow a similar format. In Chapter 5 of the Big Book (How It Works), the reader is told, “Our stories disclose in a general way what we used to be like, what happened, and what we are like now” (p. 58). Regardless of the form or medium employed—whether written or spoken—what is produced is an imitation, a representation. In terms of “the mimetic question” of representation, this project was aligned with that of Mattingly (1998), who rejected “both naïve realism and the variety of anti-mimetic positions” (p. 25), offering instead a third alternative that recognized and honored the insight that “narratives and experience are deeply intertwined” (p. 45).

Next, the reader is referred to certain aspects of the model, specifically the vertical and horizontal axes. Following Gergen and Gergen (1983/1997) and their treatment of temporal forms in “narratives of the self” (p. 161), the assignment of absolute, objective values to either axis on the graph was avoided. Instead, the y axis (vertical) reflects a subjective evaluative function relative to an individualized baseline. Labov (1997) spoke to the issues of subjectivity and evaluation when he distinguished between “a narrative of personal experience” and the simple recounting of more generic observations. He defined the former as “a report of a sequence of events that have entered into the biography of the speaker” by virtue of their emotional and social import, or salience, and so are “transformed from raw experience” (p. 379).

Similarly, the x axis (horizontal), denoting time, is neither fixed nor anchored to an external, quantified measure. While patterns of alcoholism and recovery can be expected to share certain essential and sequential features, especially in the context of a

formulaic narrative, this progression can vary in relation to time from one individual to another. In this way, the model can accommodate differences in age of onset (e.g., between adolescents and older adults), as well as the compression or prolongation of symptoms (e.g., between women and men).

Gergen and Gergen (1997) stated that at the most rudimentary level, there were three fundamental options for the types and directions of narratives in evaluative space: *regressive* (downward), *progressive* (upward), and *stable* (horizontal), and that these provided the foundation “for other more complex variants” (p. 166). Each of these is evident as stages in the model, numbered and identified as (1) first or early drinking, (2) alcoholic regression, (3) hitting bottom, (4) progress in the AA program, and (5) stable sobriety.

Aristotle also described the various “poetic” forms, including *tragedy* and *comedy*. Tragedy is defined, in more modern terms, as “a serious drama typically describing a conflict between the protagonist and a superior force (as destiny) and having a sorrowful or disastrous conclusion that elicits pity or terror” (Merriam-Webster, 2004, p. 1325). In the typology of Gergen and Gergen (1997), tragedy takes shape as a regressive narrative, accurately reflecting the “pitiful and incomprehensible demoralization” (AAWS, 2001, p. 30) that is untreated alcoholism.

In contrast, definitions of comedy include “a medieval narrative that ends happily” (Merriam-Webster, 2004, p. 247), which would be categorized as progressive. An example given is that of “Dante’s *Divine Comedy*” (p. 247; original italics), in which the protagonist, who found himself in a dark wood midway through his life, undertakes a

guided journey first to hell, then upward to purgatory, toward the ultimate destination of paradise (Alighieri, ~1320/1952).

A third alternative, a sort of dramatic dialectic, can be found in *tragicomedy*, “a drama or situation blending tragic and comic elements” (Merriam-Webster, 2004, p. 1325). This genre, which Gergen and Gergen (1997) referred to as *melodrama*, is represented first by the decline of a regressive narrative, followed by the ascent of a progressive narrative.

The proposed normative model for AA stories readily reveals this basic, underlying “v” structure, not once but twice: first in an inverted form during “first or early drinking,” marking a change in direction from a progressive to a regressive narrative (tragedy), and again upon “hitting bottom,” where an ascent is initiated through abstinence and recovery (comedy). In both cases, this altered course constitutes a critical element of drama and narrative, what Aristotle (1952) referred to as a peripety, “the change...from one state of things...to its opposite, and...in the probable or necessary sequence of events” (p. 686). Aristotle considered this to be one of three parts of a tragic plot: peripety, discovery, and suffering. This necessary twist or turn is now more commonly called the *peripeteia*. Defined as “a sudden or unexpected reversal of circumstances or situation especially in a literary work” (Merriam-Webster, 2004, p. 922), this convention becomes, both literally and figuratively, the “point” of the story.

Thematic Content

The means and methods for analyzing narrative content are almost unlimited. However, for the sake of brevity, current descriptions were fixed at the level of *thematic content*, an appropriate strategy when examining community narratives (Mankowski &

Rappaport, 2000). Of course, there is no substitute for the immediacy, raw power, texture and depth of original narratives, whether written or spoken, and so the reader is once again encouraged to seek out these personal stories firsthand.

1. First or Early Drinking

At least initially, storytellers drank because they liked the effects of alcohol. In the normative model, in order to qualify as a positive subjective experience relative to baseline (on the y axis), the effects of alcohol must either (1) elevate a pre-existing negative state, (2) induce a predominately positive state, or (3) both. It was found that each of these 24 personal stories (100%) mentioned a first or early drinking episode, and all but one (96%) attached a positive overall evaluation to the event—even though, in a number of cases, the narrator also reported one or more untoward effects, such as blacking out, throwing up, or being hungover.

The majority of storytellers in this sample approached life, and alcohol, as if from a deficit position. Many specifically mentioned feeling different, not fitting in or belonging, of being an outsider or an outcast. Feelings of anxiety and fear were commonly expressed. Many sought to forget or escape the emotional pain associated with his or her personal history or present circumstances. The discovery of alcohol changed all that, and proved to be a watershed event for many. Alcohol was taken repeatedly and in large doses for its psychoactive effects as a tonic, remedy, elixir, or magic potion. For some, the relationship to alcohol was described in terms of friendship, or a love affair. For others, drinking instilled a newfound sense of power and glory.

2. Alcoholic Regression

It was from this newly elevated height, a precarious perch of hubris, that the protagonist would fall. Tragedy involves a dramatic reversal in the evaluative function of a narrative, from a previous mode of progression to one of regression. The predominant theme in the midst of this alcoholic decline was that of loss: loss of control over drinking; loss of time, opportunities, jobs, money, and careers; loss of friendships, love, marriages, families, homes; loss of reputations, respect, and self-respect; loss of physical, emotional, and spiritual health; loss of freedom; loss of hope, and faith. In many cases, this downward slide—or plunge—was precipitated, compounded, and perpetuated by denial (which would only be recognized later): the inability or refusal to acknowledge that alcohol had become the problem, rather than the solution. In the normative model, stages 1 (first or early drinking) and 2 (alcoholic regression) coincide most closely with the portion of the AA storyline that describes, “what we used to be like.”

3. Hitting Bottom

As might be expected, this critical stage was linked to the most serious of themes, including alienation from self and society, moral and spiritual bankruptcy, life and death itself. Some described their plight as having been cast down into hell. The prospect of unmitigated alcoholic suffering caused many to contemplate, plan, or attempt suicide, or otherwise long for release through death. From among these troubled testimonies, nearly half (11/24, 46%) described such ideations or attempts.

This is the point in the storyline when something truly remarkable happened. With the acknowledgment of hopelessness, defenses crumbled, and new possibilities rushed in. The alcoholic surrendered, and the universe shifted. Individual responses ranged from the emergence of seemingly simple cognitions, to profound spiritual

experiences. At the cognitive level, these insights approximated what Baumeister (1994) described as “the crystallization of discontent” (p. 184), in which previously isolated facts become part of a newly formed neural network of comprehension. Spiritual accounts varied widely, up to and including frank conversion experiences like those described among chronic alcoholics by the American psychologist, William James (1902), in *The Varieties of Religious Experience*.

It is important to note that in these stories, hitting bottom was a highly subjective and individualized occurrence, one that may or may not have been tied directly to an episode of drinking, or its immediate consequences. In tone and content, a number of narrators characterized this series of events in a manner that corresponded to the benevolent quality of “quantum change” described by Miller and C’de Baca (2001), as if they were somehow being taken care of.

4. Progress in the AA Program

The progressive stage of the AA narrative pertained to practical aspects and activities in the program: attending meetings, getting a sponsor, working the steps. Some of the most common and recurrent themes focused on a newfound sense of belonging, struggles during early recovery, and the importance of remaining sober. Relationships to self and others were said to improve, independent of material wealth. Instead, emphasis was placed on spiritual growth. Given that AA has repeatedly described itself as a “spiritual program” (AAWS, 2001, pp. 85, 126, 130), it may not be surprising to some that the vast majority of these personal stories made some specific, positive reference to God or a Higher Power (22/24, 92%). This was often coupled with a sense of grace and gratitude, viewing sobriety as a gift, a blessing, or a miracle. Generally speaking, stages

3 (hitting bottom) and 4 (progress in the AA program) describe “what happened” in a personal story of alcoholism and recovery in AA.

5. *Stable Sobriety*

In relation to the AA storyline, stable sobriety corresponded to “what we are like now” (AAWS, 2001, p. 58), and Labov’s (1972) resolution and coda. This was usually the shortest part of the personal story although, chronologically, it may have covered many years. In the normative model (Figure 2), stable sobriety is initiated and maintained once a progressive narrative surpasses an individually determined evaluative baseline—as well as the period of first or early drinking—and is sustained for some time thereafter. During early recovery, comparisons for progress are generally measured in comparison to hitting bottom, a sensible point of departure. However, if an individual does not consider sobriety to be an improvement over baseline, as well as previously romanticized first or early drinking, then the likelihood that he or she will remain sober is markedly diminished. Some authors reported continued improvement in their subjective evaluations over time, despite good days and bad days in sobriety; the primary thematic emphasis was on spiritual growth and emotional stability.

A number of personal stories specifically mentioned the stark contrast between *then* (active alcoholism), and *now* (recovery in AA). They gratefully attributed their positively altered fates to continued involvement in the fellowship and program of Alcoholics Anonymous. This included active engagement in sponsorship and other service work, and seeking to further improve their conscious contact with God or a Higher Power. As a result, consistent with “the promises” that they may have heard at

their very first meetings, they had come to know “a new freedom and a new happiness”, comprehending the word serenity, and knowing peace (AAWS, 2001, pp. 83-84).

Discussion

Strengths and Limitations

Based on principles of narrative analysis, a normative model was constructed for personal stories of alcoholism and recovery in Alcoholics Anonymous. The model itself was composed of five primary stages (first or early drinking, alcoholic regression, hitting bottom, progress in the AA program, and stable sobriety) embedded in a subjective, evaluative function over time. Strengths of this study included the use of a single type and source of data—written narratives from the fourth edition of the Big Book—with broad diversity in terms of age, gender, race and ethnicity, sexual orientation, religion, and socio-economic status. In addition, the author enjoyed considerable familiarity with the culture and history of AA, consistent with the qualitative research principle of immersion.

Limitations included the potential for several layers of editing and self-selection bias within the data set, calling into question the general representativeness of the sample. First, written narratives are inherently subject to greater self-editing than their more spontaneous, oral counterparts. Second, anonymity aside, the authors likely knew or imagined that they might be addressing a more public audience than their immediate AA cohort, which may have affected style and content. Third, those who were charged with selecting stories for publication in the Big Book likely did so with an eye toward purposefully choosing prototypical and, perhaps, dramatic examples. Fourth, the Big Book has now been translated into at least 43 languages (AAWS, 2001); at least some

other countries and cultures have substituted their own respective personal stories, while those examined for this study were limited to the United States.

Another limitation resides within the physical constraints of the model. As a simple, idealized schematic, the model cannot hope and does not seek to capture the subtleties of each and every personal story in detail. Like an impressionistic painting, it is through broader, bolder strokes that one might better depict the light. In reality, the trajectories of regressive, progressive, and even stable narratives are more seismic than linear, as life stories themselves are constructed of a great many shorter narratives, each with its own peaks and valleys.

What Makes a Good AA Story?

These stories may well have been chosen precisely because they *did* reflect a desired community narrative, and were *meant* to be viewed as prototypes. In fact, historic evidence indicates that personal stories for the first edition of *Alcoholics Anonymous* may have been fairly heavily edited by Bill Wilson himself (AAWS, 1984) in order to adhere to and establish certain standards. This dynamic between the individual and the community, the specific and the general, may help to explain just how and why personal stories of alcoholism and recovery continue to capture the attention and sustain the interest of audiences, story after story, meeting after meeting, year after year. At the individual or *idiographic* level, personal stories exhibit the undeniable intrigue and pathos of a life gone horribly wrong, that is somehow subsequently made right. At a more general or *nomothetic* level, speakers and writers, listeners and readers, have individually and collectively developed a set of criteria—consciously or unconsciously—about what to expect from this type of story. In this sense, these stories can be said to be

truly co-created. It has been said that every AA story is different. Equally accurate is the claim that “there is really only *one* story in AA” (O’Reilly, 2000, p. 24; original italics). A synthesis of these seemingly disparate views creates a dialectic for what constitutes a “good” AA story: one that is worth listening to, contains the essential elements and themes of alcoholism and recovery, and conveys an appropriate message about AA.

This is not to say that all of the personal stories within this data set aligned themselves neatly and completely with the identified structure. One outlier in particular stood out. “Drunk Like You” (AAWS, 2001, pp. 398-420) was notable for being comparatively uneventful, and flat in terms of subjective evaluation. There was little indication of personal insight, and most of the writer’s experiences, both before and after entering AA, seemed to be directed and interpreted by others. In terms of its inclusion in the text, it is possible that by offering multiple perspectives a prospective AA member will hear at least one voice that calls out to him or her, and prompt a sense of recognition and identification.

Given the emphasis on storytelling, it is important to note another interesting variation that emerged during the course of this study. In no fewer than three of the highlighted narratives (3/24, 13%), what made the *real* difference to the narrators was unexpectedly having heard the personal story of someone else who was now in AA. In one such instance (My Bottle, My Resentments and Me, pp. 437-435), the active alcoholic and his recovered counterpart had previously known one another as bums. As the protagonist told it, “My first thought was If he can do that, I can do that” (p. 442).

The Monomyth

In many respects, a journey of recovery resembles other epic tales. The similarities between Campbell's concept of the "monomyth" (1956, cited in Gergen and Gergen, 1997), and personal stories of recovery in AA, are striking: "The monomyth...concerns the hero who has been able to overcome personal and historical limitations to reach a transcendent understanding of the human condition" (p. 165). Moreover, structural and directional elements of the monomyth are wholly consistent with the proposed model that has been presented and described here (Figure 2). "We see that the monomyth carries a form similar to that of the comedy-melodrama. That is, negative events (trials, terrors, tribulations) are followed by a positive outcome (enlightenment)" (p. 165).

There are two important ways in which personal stories in AA differ from the traditional monomyth. First, in personal stories, the narrator is recounting an adventure in which he or she is also cast in the role of the protagonist or "hero" of the monomyth, adding a curious spin to the already complicated interactions between the teller, the story, and the audience. Second, as long as the storyteller is still alive, the hero's tale is not yet complete, and remains subject to alternative endings. Frank (1995) commented at length about the ways in which narratives are affected by the presence of chronic illness, even when held in sustained remission. In the context of AA, both the audience and the storyteller share in the belief that, ultimately, there are really only two likely outcomes to chronic alcoholism: (1) sobriety though continued involvement in a spiritual program of recovery, or (2) relapse to drinking, culminating in a wretched, alcoholic death. This pool of shared knowledge is often based on extensive personal experience, having witnessed a stark dichotomy played out time and time again in the lives and deaths of

other alcoholics, both inside and outside of AA. This kind of foreshadowing helps to maintain a taut, dramatic tension across each and every recounting of the tale.

Implications: Clinical Care, Theory, and Research

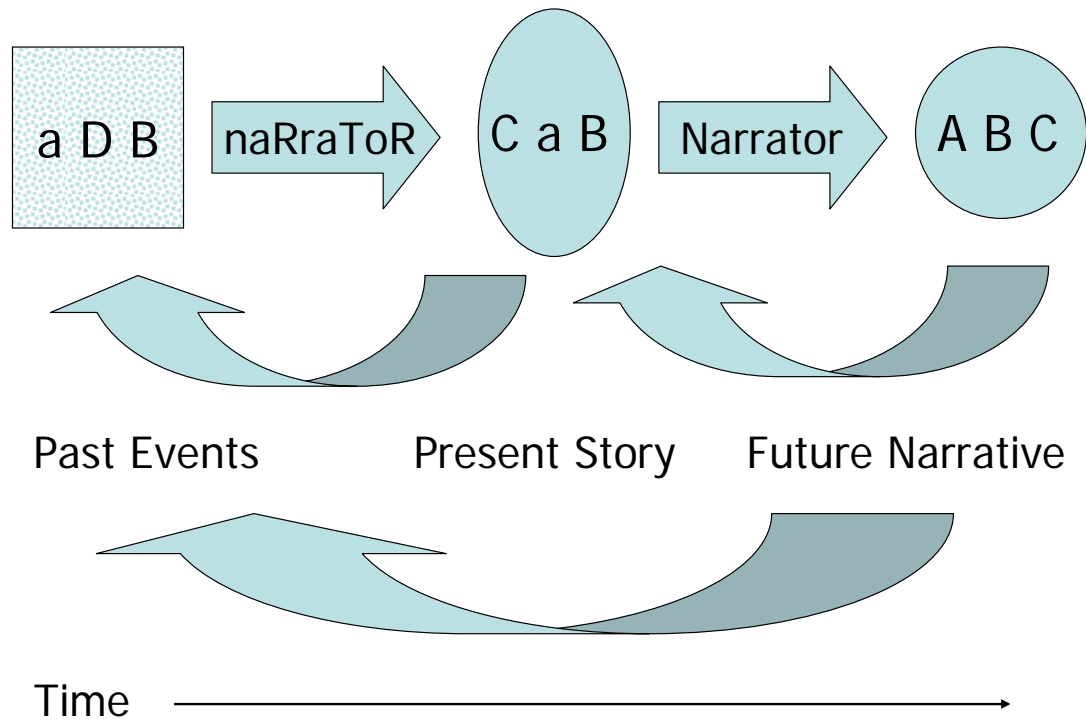
These findings carry implications for clinical care, theory, and research. First, a graphic representation of this kind can help “locate” a patient or prospective AA member along a dynamic continuum in relation to his or her perceptions of alcoholism and recovery. An initial storyline that coincides with the dominant narrative for AA may suggest receptivity to other aspects of the program.

In some corners, research pertaining to Alcoholics Anonymous has been criticized for a lack of theory-driven initiatives. Throughout this study, we were struck by the prevalence of one overarching and recurrent theme: that of relationships. At virtually every step along the way, narrators were describing their alcoholism and recovery in the context of relationships to self, others, alcohol, society, and spiritual entities. The nursing Theory of Human Relatedness (Hagerty, Lynch-Sauer, Patusky & Bouwsema, 1993) has the potential to serve as a unifying theory for these pursuits, and this possibility is examined in greater detail in Chapter 3.

Opportunities for future research may include (1) deeper exploration of certain pivotal points or stages in the AA storyline, particularly first or early drinking, and hitting bottom, (2) examining the transformation of personal stories in AA over time within given individuals, and (3) increased use of a mixed methods in AA research, better integrating qualitative and quantitative approaches (Creswell & Plano Clark, 2007). In closing, it is hoped that this project will spark new and renewed interest in the

phenomenon of storytelling in Alcoholics Anonymous. Most importantly, what we would not want to have is the last word.

Figure 1. Personal narratives are transformed and transformative over time



Personal narratives of past events change over time to better align themselves with personal and social identities, as well as community or master narratives. This is an iterative process of co-creation, during which the shape, content, order, and emphasis of the stories evolve. At the same time, the narrator also changes to increase his or her concordance with the values, ideals, and behaviors associated with the prevailing narrative.

Figure 2. Normative model for personal stories of alcoholism and recovery in Alcoholic Anonymous

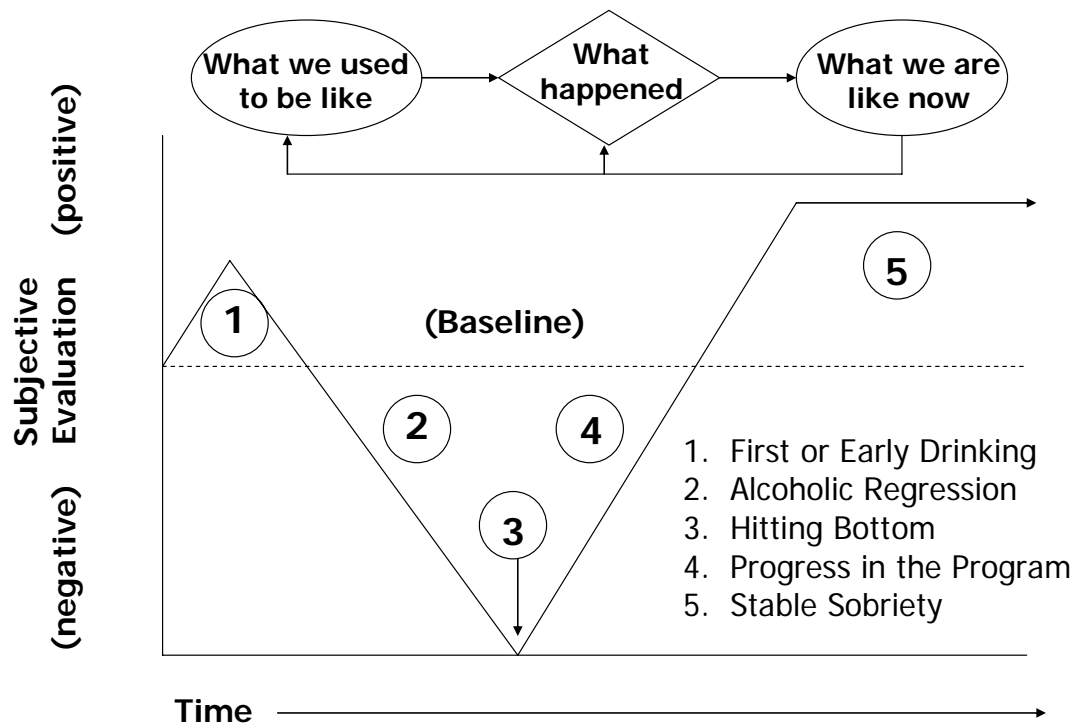


Table 1. New personal stories in the fourth edition of *Alcoholics Anonymous*

#	Location: Part, Story, Page	Title	Gender	Other
1	I, (2), p. 193	Gratitude in Action	M	Pioneer of AA in Canada
2	II, (1), p. 281	The Missing Link	M	AA at age 18
3	II, (5), p. 309	My Chance to Live	F	AA at age 17
4	II, (6), p. 319	Student of Life	F	College student
5	II, (7), p. 328	Crossing the River of Denial	F	Six-figure income
6	II, (8), p. 338	Because I'm an Alcoholic	F	Lesbian
7	II, (10), p. 359	Tightrope	M	Gay
8	II, (11), p. 369	Flooded with Feelings	M	Teacher
9	II, (12), p. 375	Winner Takes All	F	Legally blind
10	II, (14), p. 388	The Perpetual Quest	F	Lawyer
11	II, (15), p. 398	Drunk Like You	M	Jewish
12	II, (17), p. 421	Window of Opportunity	M	AA at age 19
13	III, (1), p. 437	My Bottle, My Resentments, and Me	M	Mother murdered when he was 11, lived as a "hobo"
14	III, (2), p. 446	He Lived Only to Drink	M	Black, Southern Baptist, son of a minister, teacher
15	III, (3), p. 452	Safe Haven	M	Prisoner
16	III, (4), p. 452	Listening to the Wind	F	Native American, prostitute, mother
17	III, (5), p. 470	Twice Gifted	F	Recipient, liver transplant
18	III, (6), p. 476	Building a New Life	M	Spanish-speaking
19	III, (7), p. 486	One the Move	M	Jewish, Multiple Sclerosis
20	III, (8), p. 494	A Vision of Recovery	M	Mic-Mac Indian
21	III, (9), p. 501	Gutter Bravado	M	Midwest, "baby boomer"
22	III, (10), p. 512	Empty on the Inside	F	Father was in AA
23	III, (11), p. 522	Grounded	M	Part Comanche Indian, airline pilot
24	III, (13), 535	A Late Start	F	"Seventy-five-year-old alcoholic"

References

- AA Grapevine (1988). The language of the heart. (Reprinted from *AA Today*, 1960). In *The language of the heart: Bill W.'s Grapevine writings*. New York: AA Grapevine, Inc., pp. 242-250.
- AA Grapevine. (2005). AA Grapevine history: The story of the Grapevine. Retrieved April 23, 2005, from http://www.aagrapevine.org/history/history_index.html
- Alcoholics Anonymous World Services. (1952). *Twelve Steps and Twelve Traditions*. New York: Author.
- Alcoholics Anonymous World Services. (1976). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism*. (3rd ed.). New York: Author.
- Alcoholics Anonymous World Services. (1984). *'Pass it on': The story of Bill Wilson and how the A.A. message reached the world*. New York, NY: Author.
- Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism*. (4th ed.). New York: Author.
- Alcoholics Anonymous World Services. (2008). Estimates of AA groups and members as of January 1, 2008. Retrieved December 7, 2008 from http://www.aa.org/lang/en/en_pdfs/smf-53_en.pdf
- Alighieri, D. (1952). The divine comedy of Dante Alighieri. In R. M. Hutchins (Ed.), C. E. Norton (Trans.), *Great books of the western world* (Vol. 21). Chicago: Encyclopaedia Britannica, Inc.
- Aristotle. (1952). On poetics. In R. M. Hutchins (Ed.), I. Bywater (Trans.), *Great books of the western world* (Vol. 9, The Works of Aristotle, Vol. II, pp. 679-699). Chicago: Encyclopaedia Britannica, Inc.
- Baumeister, R. F. (1994). The crystallization of discontent in the process of major life change. In T. F. Heatherton & J. L. Weinberger (Eds.), *Can Personality Change?* Washington, DC: American Psychological Society, pp. 281-297.
- Bruner, Edward (1997). Ethnography as narrative. In V. Turner & E. M. Bruner (Eds.), *The anthropology of experience*. Chicago: University of Chicago Press. Reprinted in L. Hinchman & S. Hinchman (Eds.), *Memory, identity, community: The idea of narrative in the human sciences*. Albany, NY: State University of New York Press, pp. 264-280.

- Cain, C. (1991). Personal stories: Identity acquisition and self-understanding in Alcoholics Anonymous. *Ethos*, 19(2), 210-253.
- Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage Publications.
- Diamond, J. (2000). *Narrative means to sober ends: Treating addiction and its aftermath*. New York, NY: Guilford Press.
- Frank, A. W. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago, IL: University of Chicago Press.
- Gergen, K., & Gergen, M. (1997). Narratives of the self. In T. Sarbin & K. Scheibe (Eds.), *Studies in social identity*. Reprinted in L. Hinchman & S. Hinchman (Eds.), *Memory, identity, community: The idea of narrative in the human sciences*. Albany, NY: State University of New York Press, pp.161-184.
- Goffman, E. (1959). *The presentation of self in everyday life*. New York: Anchor Books, Doubleday.
- Hagerty, B.M.K., Lynch-Sauer, J., Patusky, K.L., Bouwsema, M. (1993). An emerging theory of human relatedness. *IMAGE: Journal of Nursing Scholarship*, 25, 291-296.
- Humphreys, K. (2000). Community narratives and personal stories in Alcoholics Anonymous. *Journal of Community Psychology*, 28(5), 495-506.
- James, W. (1902). *The varieties of religious experience*. Cambridge, MA: Harvard University Press.
- Jenson, G. H. (2000). *Storytelling in Alcoholics Anonymous: A rhetorical analysis*. Carbondale and Edwardsville, IL: Southern Illinois University Press.
- Johnson-Bailey, J. (2004). Enjoying positionality and power in narrative work: Balancing contentious and modulating forces. In K. deMarrais & S. D. Papan (Eds.), *Foundations for research: Methods of inquiry in education and the social sciences*. (pp. 123-138). Mahwah, NJ: Lawrence Erlbaum Associates.
- Knapp, C. (1996). *Drinking: A love story*. New York, NY: Delta.
- Kuhn, T. S. (1996). *The structure of scientific revolutions* (3rd ed.). Chicago: The University of Chicago Press.
- Kurtz, E. (1991). *Not-God: A history of Alcoholics Anonymous*. Center City, MN: Hazelden.

- Kurtz, E., & Ketcham, K. (1992). *The spirituality of imperfection*. New York, NY: Bantam Books.
- Labov, W. (1972). *Language in the inner city*. Philadelphia, PA: University of Pennsylvania Press.
- Labov, W. (1997). Some further steps in narrative analysis. *Journal of Narrative and Life History*, 7, 395-415.
- Labov, W., & Waletzky, J. (1967). Narrative analysis. In J. Helm (Ed.), *Essays on the Verbal and Visual Arts*. Seattle, WA: University of Washington Press, pp. 12-44.
- Lawford, C. K. (2009). *Moments of clarity: Voices from the front lines of addiction and recovery*. New York, NY: William Morrow.
- Linde, C. (1993). *Life stories: The creation of coherence*. New York, NY: Oxford University Press.
- Mankowski, E.S., & Rappaport, J. (2000). Narrative concepts and analysis in spiritually-based communities. *Journal of Community Psychology*, 28(5), 479-493.
- Mattingly, C. (1998). *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge, UK: Cambridge University Press.
- Merriam-Webster. (2004). *Merriam-Webster's collegiate dictionary* (11th ed.). Springfield, MA: Author.
- Miller, W. R., & C'de Baca, J. (2001). *Quantum change: When epiphanies and sudden insights transform ordinary lives*. New York, NY: Guilford Press.
- Nelson, K. (1989). *Narratives from the crib*. Cambridge, MA: Harvard University Press.
- Norrick, N. R. (2000). *Conversational narrative: Storytelling in everyday talk*. Amsterdam: John Benjamins Publishing.
- Ochs, E., & Capps, L. (1996). Narrating the self. *Annual Review of Anthropology*, 25, 19- 43.
- O'Reilly, E. B. (1997). *Sobering tales: Narratives of Alcoholism and Recovery*. Amherst, MA: University of Massachusetts Press.
- Riessman, C.K. (1993). *Narrative analysis*. (Vol. 30, Qualitative Research Methods). Newbury Park, CA: SAGE Publications, Inc.
- Rose, G. (1997). Situating knowledges: Positionality, reflexivities, and other tactics. *Progress in Human Geography*, 21(3), 305-320.

Rosenwald, G. C., & Ochberg, R. L. (Eds.). (1992). *Storied lives: The cultural politics of self-understanding*. New Haven, CT: Yale University Press.

Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. *IMAGE: Journal of Nursing Scholarship*, 23(3), 161-166.

White, H. (1980). The value of narrativity in the representation of reality. *Critical Inquiry*, 7(1), pp. 5-27.

Wholey, D. (1984). *The courage to change: Personal conversations about alcoholism with Dennis Wholey*. Boston, MA: Warner Books.

Chapter 3

Applying the Theory of Human Relatedness to Alcoholism and Recovery in Alcoholics Anonymous

Introduction

Regardless of clinical setting or level of practice, nurses the world over will likely find themselves caring for patients and families affected by alcohol misuse. Alcohol consumption has been listed among the 10 leading risk factors for disease burden globally, and carries serious health and social consequences associated with intoxication, dependence, and other toxic, biochemical effects. To compound matters, global alcohol consumption has increased in recent decades, with most or all of this increase occurring in developing countries (World Health Organization, WHO, 2002). As a result of changing patterns of consumption, certain vulnerable subpopulations have become increasingly exposed to the direct, deleterious effects of alcohol, including women and young people (WHO, 2007).

Founded in 1935, Alcoholics Anonymous (AA) describes itself as “a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism” (AAWS, 2005, p.5). Over the past several decades, AA has developed and sustained a growing international presence. Total membership in 2008 was estimated at more than 2 million people and 110,000 groups in over 180 countries (Alcoholics Anonymous World Services, AAWS, 2008). Resnick (1986) suggested that nurses were in an ideal position

to assist patients who may be able to benefit from mutual–help groups, including AA, and that it was important for nurses to have a good working knowledge of active groups that were available, and to make appropriate referrals.

Since then, the International Collaborative Study of Alcoholics Anonymous (ICSAA) was conducted across eight different societies in cooperation with the WHO Regional Office for Europe. The purposes of that project were to (1) analyze AA “as an international mutual-aid movement” and (2) “study how AA activities adapted to various cultural surroundings” (Mäkelä, Arminen, Bloomfield, Eisenbach-Strangl, Bergmark, Kurube, et al., 1996, p. 5). In their conclusion, the authors stated, “When the history of the twentieth century is written, AA will merit discussion not only for its influence in the specific field of alcohol problems, [but] because AA is also the prototype of a new kind of social movement” (p. 252).

In a meta-analysis of research related to Alcoholics Anonymous, an observation was made regarding the paucity of theory-driven research, and a call was put forth to remedy the situation (Emrick, Tonigan, Montgomery & Little, 1993). More recently, researchers have become increasingly interested in specific mechanisms of action that may contribute to positive outcomes for those affiliated with Alcoholics Anonymous, yet few have applied a theoretical framework to their efforts. Consistent with this continued trend, nursing theory has remained conspicuously silent in conversations related to alcoholism in general, and Alcoholics Anonymous in particular.

In this chapter, the nursing Theory of Human Relatedness (THR; Hagerty, Lynch-Sauer, Patusky & Bouwsema, 1993) will be applied to the phenomena of alcoholism and recovery in AA. Steps include (1) reviewing the Theory of Human

Relatedness, (2) describing the methods used for this project, (3) presenting an exemplar from AA literature, (4) employing THR in the analysis, and (5) discussing findings and conclusions, including implications for clinical care, and opportunities for future research.

Theory of Human Relatedness

Definition and Dimensions

The Theory of Human Relatedness addresses relatedness as a primary, persistent, and pervasive aspect of human existence. Serving as the organizing construct for the theory, relatedness is defined here as an individual's level of involvement with persons (self, others, groups, or society), objects, environments (natural or cultural), or spiritual entities—all categorized as referents—and the concurrent level of comfort or discomfort associated with that involvement. Rooted in early attachment behaviors and patterns, relatedness is viewed as a functional behavioral system. Disruptions in relatedness can be caused by and/or contribute to biological, psychological, social, and spiritual disturbances. The two dimensions of relatedness are involvement-noninvolvement, and comfort-discomfort, each of which exists on a continuum. When these two dimensions are fixed as intersecting axes on a grid (Figure 3), four states of relatedness emerge: connectedness, disconnectedness, enmeshment, and parallelism (Hagerty et al., 1993).

States of Relatedness

The four states of relatedness—or the manner in which an individual interacts with a specific referent—arise under the following circumstances. *Connectedness* occurs when a person is actively involved with a referent (e.g., a person, place, or thing), and that involvement promotes a sense of comfort, well-being, and anxiety-reduction.

Disconnectedness is experienced when a person is not actively involved with a referent, and this lack of involvement results in discomfort, anxiety, and a reduced sense of well-being. *Parallelism* occurs when an individual's lack of involvement with a referent generates a sense of comfort and well-being. While a lack of involvement is often interpreted as isolative, lonely, and detrimental to health, the authors noted that there was support for the idea that parallelism also plays an adaptive role in energy conservation, psychological renewal, and creativity. *Enmeshment* refers to involvement with a referent that is coupled with discomfort, anxiety, and a lack of well-being, indicative of fusion, or a lack of differentiation (Hagerty et al., 1993).

In the context of the theory, the following characteristics apply to these states of relatedness (i.e., connectedness, disconnectedness, parallelism, and enmeshment). First, at any given time, each state is experienced in relation to a specific referent. Second, an individual may experience varying states in relation to different referents. Third, people do not inherently exist in any one state, but move between states in response to specific referents over time. "What appears to be important is the pattern of movement throughout these states, including patterns of duration, intensity and frequency" (p. 294). In this respect, it appears that the capacity for movement within and between states may be indicative of greater health than residing consistently within one state.

Relatedness Competencies

In addition to the states of relatedness, there are four major processes, or social competencies, that are involved in establishing and promoting these states; these are (1) sense of belonging, (2) reciprocity, (3) mutuality, and (4) synchrony. If states of relatedness are viewed as a map (Figure 3), then relatedness competencies might

correspond to vehicles that facilitate or hinder movement within or across these states in relation to specific referents. It is also worth noting that competencies—like other skills and abilities—can improve or deteriorate over time, based on individual temperament, circumstances, learning, and practice.

Sense of belonging refers to “personal involvement in a system or environment so that persons feel themselves to be an integral part of that system or environment” (Hagerty, Lynch-Sauer, Patusky, Bouwsema & Collier, 1992, p. 173). In the context of THR, sense of belonging is the most well-developed concept to date. Published works include a concept analysis (Hagerty et al., 1992), a description of sense of belonging as one of the states of relatedness (Hagerty et al., 1993), and the development of a reliable and valid tool, called the Sense of Belong Instrument (SOBI; Hagerty, Williams, Coyne & Early, 1996). *Reciprocity* pertains to an individual’s perception that he or she is engaged in an “equitable, alternating, interchange” (Hagerty et al., 1993, p. 294) with a referent, accompanied by a sense of complementarity. A common theme in descriptions of reciprocity is the quality and intensity of exchange. *Mutuality* is defined as “the experience of real or symbolic shared commonalities of visions, goals, sentiments, or characteristics, including shared acceptance of differences, that validate the person’s world-view” (p. 294). *Synchrony* speaks to issues of rhythm—biological, psychological, social, and spiritual—and is defined as “a person’s experience of congruence with his or her internal rhythms and external interaction with persons, objects, groups or environments...[conveying] a sense of shared movement through time and space” (p. 294).

Finally, the authors of THR proposed that a relationship existed between an individual's competencies and his or her state of relatedness toward a specific referent, such that (1) higher levels of sense of belonging, reciprocity, mutuality, and synchrony result in a greater sense of connectedness with that referent, whereas (2) lower levels of relatedness competencies result in a sense of disconnectedness with respect to that referent.

Methods

The prospective application of THR to alcoholism and recovery in AA was determined through a reflective, iterative process, employing deductive and inductive strategies, repeatedly moving between the theory and AA literature. These efforts were further informed and directed by clinical experience in the field of alcoholism, and familiarity with 12-step culture.

A first reading of the theory (SS) sparked immediate interest in terms of its potential applicability to Alcoholics Anonymous. First, it was readily apparent to a student of nursing and AA that these two entities shared a strong, holistic perspective, viewing people as biological, psychological, social, and spiritual beings. Second, it will be argued that the entire program and fellowship of Alcoholics Anonymous—including the conceptualizations of alcoholism and recovery—were predicated on the basis of relationships: to self, others, alcohol, environments, and spiritual entities. Third, since alcoholism and recovery are themselves dynamic processes, they require a similarly equipped theory to describe and explain their characteristics.

On one hand, THR allows for the detailed assessment of a person in relation to one or more referents over time, embedded in the rich and complex matrix of his or her

personal circumstances. This level of assessment, focused on the individual and the specific, is referred to as an *idiographic* approach. At the same time, this theory can also be used to help gather information, increase understanding, and generate knowledge through a complementary, *nomothetic* stance, based on observations across a broader cohort or population (Allport, 1937). Windelband, the neo-Kantian philosopher, had previously asserted that any given object could be studied by both kinds of science (White, 1967). To demonstrate the utility of the Theory of Human Relatedness, an exemplar will be presented, followed by an analysis, and conclusions.

Student of Life: An Exemplar

Alcoholics Anonymous (AAWS, 2001), more commonly referred to as the “Big Book,” is the basic text for the society of Alcoholics Anonymous. Since the first edition was published in 1935, more than half the book has been composed of “personal stories,” written narratives about alcoholism and recovery in AA. With the publication of subsequent editions (in 1955, 1976, and 2001), some stories were retained, others dropped, and new ones added to better reflect the changing membership of AA. This exemplar, as well as a broader narrative analysis (Chapter 2), was derived from a subset of 24 new personal studies as they appeared in the fourth edition of the Big Book of Alcoholics Anonymous (AAWS, 2001). The larger data set was notable for its diversity in terms of age, race and ethnicity, gender, sexual orientation, and religion (Table 1). Because these stories were highly personal—but anonymous—accounts, many are devoid of the kinds of demographic and historical information that researchers might otherwise normally expect to find.

“Student of Life” (pp. 319-327) tells the story of a former high school honor student whose life stalled, then careened dangerously downhill because of alcoholism. It was only after “hitting bottom,” and a chance encounter with a struggling member of AA, that her own life was put back on track. In order to help personalize an otherwise anonymous account, she will be given the name of “Allison.”

Allison came from a loving and supportive family, but grew up feeling extremely insecure, unable to handle and understand her emotions, and terrified of the world around her. “I always felt as if everyone else knew what was going on...and my life was the only one that was delivered without an instruction book” (pp. 319, 320). In college, she discovered alcohol, and everything changed. “When I was drinking, I was okay. I understood. Everything made sense. I could dance, talk, and enjoy being in my own skin” (p. 320). She blacked out nearly every time she drank, and in less than six months was almost a daily drinker. She wound up on academic probation in the first semester of her sophomore year. She managed to graduate, and tried to change her drinking patterns, but was unable to do so. She took a low-paying sales job and continued to live with her parents, drinking and watching television by herself every night until she passed out. This went on for almost two years.

Her parents were at a total loss. Allison knew that she drank too much, and that her life was miserable, but she never put the two together. Her parents offered to help her financially if she wanted to go back to graduate school. She jumped at the chance, and the “geographical cure” helped for a while, but within months she had slipped back into her old patterns. Once again she managed to graduate, this time with a master’s degree, but was unable to secure employment, and returned home. “I had no job, no friends; I

saw no one but my parents” (p. 323). She took a job with a local entrepreneur, and struggled to beat her obsession with alcohol.

Not long after taking this position, Allison was confronted by the stark reality of her situation. Sick from drinking the night before, she returned home from work, knowing that she did not want to drink. Nonetheless, “I watched myself get up off the couch and pour myself a drink. When I sat back down on the sofa, I started to cry. My denial had cracked; I believe I hit bottom that night, but I didn’t know it then” (p. 324; see Chapter 2 for the importance of “hitting bottom” in personal stories in AA).

A few months later, Allison traveled to a trade show as part of her job. Having struggled to put together a month of abstinence, she was terrified that she would give in to temptation. She found herself talking to Mike—a sales representative for the same company, from another part of the country. In response to an innocent question from Allison, Mike indicated that he was in AA, but was struggling, and had recently “slipped.” She was amazed to hear herself say that she thought she was an alcoholic, too. Mike carried the message of Alcoholics Anonymous by taking Allison to her first few meetings.

It was only her second meeting but, because she was visiting from out-of-town, Allison was invited to speak. She recalled finding her Higher Power at that meeting, in the faces of the people in the room. “I saw it...the understanding, the empathy, the love...This is what I had been looking for all my life” (p. 326). What she experienced could be described as a sense of belonging. She threw herself into AA, attending 90 meetings in 90 days, obtaining a sponsor (an AA mentor), joining a home group (a regularly attended meeting), fulfilling commitments (e.g., making coffee), and engaging

in service work (helping others or AA as a whole). Several years later, Allison still maintained a high level of affiliation with AA, including continued meeting attendance, studying AA literature, working the steps, having a sponsor, and being a sponsor.

Other areas of Allison's life bloomed as well. Gainfully employed, she was supporting herself financially, with plans to buy a house. She had friends because, as she described it, she had learned how to be a friend. There was a special man in her life with whom she had been involved for almost five years. Allison summarized her progress by saying, "most importantly, I know who I am. I know my goals, dreams, values...Those are the true rewards of sobriety...I am so grateful that my Higher Power stepped in to show me the way to truth...I came to A.A. in order to stop drinking; what I received in return was my life" (p. 327).

Analysis

Every clinical case is unique. At the same time, close and thoughtful examination of a well-chosen exemplar can also help to identify areas in which patterns may emerge across cohorts or populations. It appears that THR has value and utility in both domains: the specific and the general, individuals and groups, the idiographic and the nomothetic. With this in mind, focus will be placed on the story of "Allison," paying particular attention to states of relatedness and competencies (when discernable) for a few primary referents. This is not meant to be an exhaustive treatment; instead, it will be demonstrated, in the context of alcoholism and recovery in AA, that (1) with relative ease, and a reasonable amount of information, a state of relatedness can be identified (a) for an individual, (b) in relation to a specific referent, (c) at any given time; (2) these states can and do change in response to alterations in health, illness, and circumstances

over time; and (3) certain combinations or patterns of states and competencies across referents may help to plot and track an individual's progress, or lack of progress, in terms of his or her alcoholism and recovery.

Object: Alcohol

Allison described herself as being “extremely insecure” and unable to handle and understand her emotions prior to her experiences with alcohol. She also complained of feeling different from her peers, and lacking close friends, suggesting deficits in the relatedness competency of sense of belonging. This, coupled with an apparently exaggerated subjective response to the psychoactive effects of alcohol, left her especially vulnerable to repeated and protracted bouts of abusive and dependent drinking.

In childhood, Allison's state of relatedness to alcohol was probably that of parallelism, i.e., a lack of involvement and relative comfort, since there was no known family history of alcoholism. In any case, Allison drank excessively from the very start, describing her experience as transformational, despite a terrific hangover. “Life was great; I had finally found the answer—alcohol!” (p. 320). Clearly, her state of relatedness to alcohol during this initial phase of drinking was connectedness, marked by involvement and a perceived sense of well-being. This portion of Allison's experience corresponds to a stage in the normative model for personal stories in AA (Chapter 2), called “first or early drinking,” during which the neophyte drinker attaches a strong and positive subjective evaluation to alcohol and its effects.

In an alarmingly short time, however, with loss of control and deteriorating personal circumstances, Allison's state of relatedness changed to enmeshment, i.e., continued involvement, accompanied by discomfort and a lack of well-being. Prior to

her introduction to and affiliation with AA, Allison reported repeated failed attempts to curb her alcohol use, changing her state of relatedness to disconnectedness; although she was not directly involved in drinking, she still lacked any sense of well-being.

At the end of her personal story, Allison appears to have achieved a state of parallelism in relation to alcohol, with lack of involvement and a sense of well-being. This coincides with certain “promises” that follow Step Ten in AA (Appendix B), stating, “...we have ceased fighting anything or anyone—even alcohol...We feel as if we had been placed in a position of neutrality—safe and protected” (pp. 84, 85).

Others: Parents, and Mike

“Others” is an exceptionally broad category that can include any number of individuals as separate and distinct referents. Throughout most of her drinking career, Allison’s story was notable for the sheer poverty of relationships with others, leading one to assume that most or all of them were relegated to a state of disconnectedness. Since her parents appear to have been present or available during significant portions of her story, attention will be paid to the relationship between Allison and her parents.

Parents. At the outset, Allison was quick to point out that she could not blame her drinking on her upbringing, describing her parents as loving and supportive. This suggests but does not confirm a state of connectedness, i.e., involvement and comfort (Figure 3). Although Allison described her parents in positive terms, her subjective experience of relatedness toward them may have differed. During the extended period in which Allison was living with her parents, drinking heavily and watching television alone, she exhibited a distinct state of disconnectedness in relation to her parents, with a lack of involvement, and discomfort. The information provided may be insufficient to

determine whether the offer by Allison's parents to provide financial support for graduate studies represented a logical intervention for someone they loved, or a state of enmeshment, over-involvement, or "enabling" (Weisner, 1993), considered a common dynamic in some alcoholic families.

Allison did not specifically mention her parents when describing a full and satisfying life in recovery. This might indicate an adaptive state of parallelism, with decreased involvement and increased comfort, consistent with movement toward healthy differentiation and maturity. Alternatively, this may simply represent the reparation or enhancement of a previous state of connectedness between Allison and her parents, respectful of appropriate boundaries. In this regard, the reader is disadvantaged by not being able to ask additional questions of the written text. In the context of a clinical relationship, however, a nurse might be able to clarify this information fairly quickly and easily, simply by asking a question or two of Allison or her parents (assuming proper consent), and observing interactions or individual responses.

It is important to note that Allison always referred to her parents as a unit. In other families, or under different circumstances, it is possible that a person could experience markedly different states of relatedness toward each of his or her parents, or any other couple, which would warrant addressing them as separate referents. Allison's parents appear to have maintained stability and constancy, even as the states of relatedness shifted, lending credence to the idea that it truly was Allison who changed.

Mike. Although he was only part of her story for a very short time, Mike's role helps to illustrate a few key points as they pertain to the Theory of Human Relatedness and Alcoholics Anonymous. First, Allison described having "hit bottom" only months

prior to their paths having crossed at the trade show, without which their encounter might have proved inconsequential. Instead, their meeting demonstrated one of the assumptions of THR (Appendix F), that “Persons experience sensitive periods during which interventions can influence the nature of their relatedness experiences” (Hagerty et al., 1993, p. 292). The result was an instance of synchrony, one of the relatedness competencies, reflected in the congruence of internal rhythms and external interaction. Specifically, these included Allison’s impulse to inquire about Mike’s well-being, his reply regarding personal struggles with alcohol, and Allison’s disclosure regarding her own difficulties. Alcoholics Anonymous was founded on the idea that “one alcoholic could affect another as no nonalcoholic could” (AAWS, 2001, pp. xvi, xvii). Kurtz (1979/1991) described this kind of identification as “*the shared honesty of mutual vulnerability openly acknowledged*” (p. 61; original italics), one that contributes to surrender, healing, and growth.

Spiritual Entities: God or a Higher Power

Alcoholics Anonymous is a spiritual program, but one that encourages its members to seek their “own conception of God” (AAWS, 2001, p. 47). For many like Allison, “*a Power greater than ourselves*” (p. 45; original italics) was first discovered in the collective strength, wisdom, love, and caring of the people in AA. In her personal story, Allison made no mention of spiritual entities or beliefs until finding her Higher Power at her all-important second meeting, at which point she appears to have established an immediate state of connectedness, both to AA and a Higher Power. Many people in AA have reported far more complex histories and ideas related to God, religion, and

spirituality, in which case one might expect their states of relatedness, and perhaps even the referents themselves, to change over time.

Alcoholics Anonymous as a Group, Society, and Environment

In relation to referents as listed in the Theory of Human Relatedness, Alcoholics Anonymous can be viewed in terms of groups, environments, and a society, thereby creating complex, interconnected communities at local, national, and international levels. Rather than try to isolate and parcel out the effects of each of these referents individually, some of these attributes will be considered collectively.

What AA offered and provided to Allison was a safe and supportive environment (social and cultural), in which relationships were initiated, cultivated, and then generalized into ever-widening concentric circles, reaching beyond AA itself to help create a larger life. Her personal story demonstrated the benefits of connectedness, which were reinforced through the four competencies. Sense of belonging and synchrony were mentioned earlier.

The competency of mutuality is based on shared visions and values. Founded on the Twelve Steps (Appendix B) and related spiritual principles, AA set forth an unequivocal mission in its preamble (Appendix G) by stating, “Our primary purpose is to stay sober and help alcoholics to achieve sobriety” (AAWS, 2005, p. 5). This principle is propelled into action through sponsorship and service work, both of which were evident in Allison’s story. In addition, the Twelve Traditions (Appendix C) “apply to the life of the Fellowship itself. They outline the means by which A.A. maintains its unity and relates itself to the world about it, the way it lives and grows” (AAWS, 1952, p. 15).

According to THR, mutuality also includes a “shared acceptance of differences”

(Hagerty et al., 1993, p. 294). The Big Book acknowledges that the membership of Alcoholics Anonymous is represented by diverse “occupations...as well as many political, economic, social, and religious backgrounds.” In brief, “We are people who normally would not mix. But there exists among us a fellowship, a friendliness, and an understanding that is indescribably wonderful.” (AAWS, 2001, p. 17). This ideal is further reflected in the AA motto, “*Live and Let Live*” (p. 135; original italics), as well as reminders to practice “patience, tolerance...and love” (AAWS, 2001, pp. 83, 118).

The relatedness competency of reciprocity is firmly embedded in the culture of AA, and visible at the end of Allison’s story when she stated that she was sponsoring two women herself. Heard often around AA, this sentiment is captured in the saying, “You have to give it away to keep it.” Its historical roots go all the way back to the first story in the first edition of the Big Book when Bill W., one of the co-founders of AA, discovered, “When all other measures failed, work with another alcoholic would save the day...I would be amazingly lifted up and set on my feet. It is a design for living that works in tough going” (p. 15).

Discovery of Self

Allison began her story uncertain of herself and those around her. For people who are anxious, self-conscious, and preoccupied, the relationship to self may be described as one of enmeshment, with a high degree of involvement, accompanied by discomfort. This coincides with the belief in AA that alcohol is but a symptom, and that the real problem lies with the alcoholic. “Selfishness—self-centeredness. That, we think, is the root of our troubles” (p. 62). During her first or early drinking, alcohol induced a feeling of connectedness for Allison, but this false sense of confidence and comfort were

short-lived. Drinking every night until she passed out, she exemplified a state of disconnectedness—not only with others, but with herself—characterized by a lack of involvement, and a lack of well-being. Allison had become little more than a passive, anguished spectator in her own life. Only when she finally hit bottom, and her denial cracked, was she able to consider different possibilities for her life. By taking risks, getting out of herself, and connecting with people and a Higher Power, Allison established a state of connectedness with herself.

Discussion

The nursing Theory of Human Relatedness (THR, Hagerty et al., 1993) demonstrated a strong affinity for, and high applicability to, the study of alcoholism and recovery in Alcoholics Anonymous. Evidence included the detailed analysis of an exemplar taken from the 24 new personal stories in the fourth edition of the Big Book of Alcoholics Anonymous (AAWS, 2001). Initial observations were validated and strengthened by surveying the remaining narratives from the broader cohort, a collection that offered considerable demographic and clinical diversity.

Taken together, these accounts led to the formation of the following assumptions: (1) alcoholism and recovery in AA can be described in terms of an individual's relatedness to alcohol, self, others, environments, society, and spiritual entities; (2) in active alcoholism, an individual's involvement with the drug alcohol, described by THR as enmeshment, will impair, limit, or preclude healthy or adaptive relatedness to all other referents, including self; (3) the Twelve Steps of Alcoholics Anonymous (Appendix B) specifically address an individual's relationship to self, alcohol, God or a Higher Power, and others (Table 2), reinforcing the use of THR to better understand these phenomena;

(4) the process of recovery in AA involves a radical reordering in the nature and quality of relatedness with each of these referents, resulting in increased connectedness; (5) the goal of recovery is to improve relatedness to referents in each of the identified domains, resulting in a healthy, whole, and integrated life.

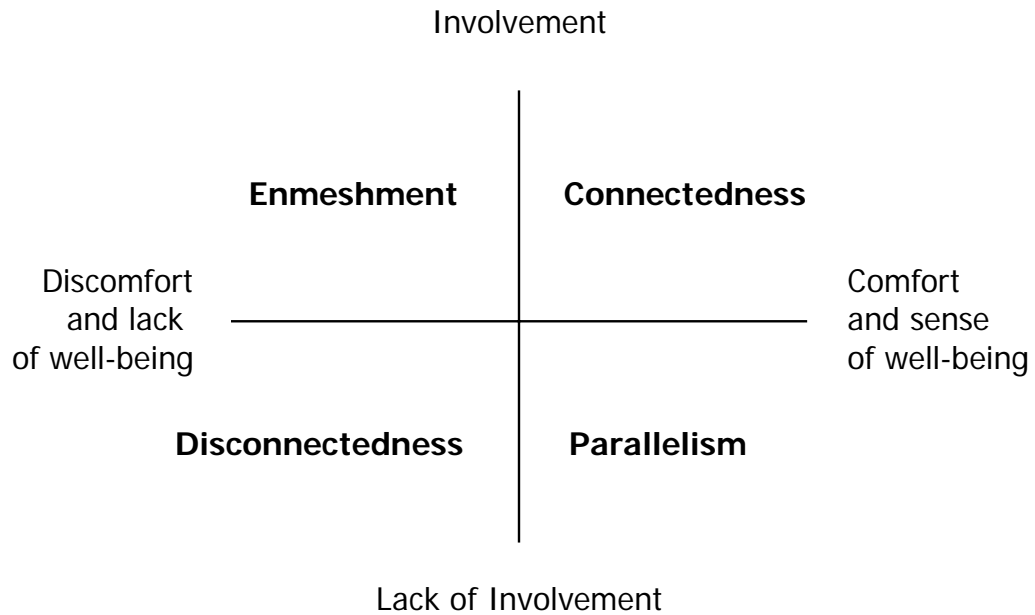
Strengths of this study included the application of a theoretical framework to alcoholism, recovery, and Alcoholics Anonymous. A review of the literature suggested that this was the first time that THR has been used to examine these areas of interest, either individually or collectively. Based on the detailed analysis of an exemplar, and a review of the broader cohort from which it was drawn, a set of assumptions was generated pertaining to relatedness in the context of Alcoholics Anonymous. Finally, the topic of spirituality was actively included, consistent with perspectives from nursing, AA, and the Theory of Human Relatedness.

Several limitations also warrant discussion. The stories selected for publication in the Big Book may have been subject to significant sample selection bias as archetypes for this type of narrative. Since these accounts were anonymous, some demographic, clinical, and historical data were lacking. Despite the worldwide presence of AA, this collection of stories was limited to individuals in the United States.

Nonetheless, it appears that THR has the potential to serve as a unifying theory in the study of alcoholism and recovery, helping to better inform and direct patient care, education, and research. In terms of clinical relevance, THR may help to locate and orient patients in respect to illness and recovery from alcoholism, and enhance the use of nursing process in the assessment, treatment, and evaluation of these important patient populations.

To date, sense of belonging is the most fully developed concept associated with relatedness. Future research will evaluate the Sense of Belonging Instrument (SOBI) as a potential predictor, process variable, and outcome measure for alcoholism treatment and recovery. Other opportunities for future research include the application of this theory to different data sets, including oral narratives, interviews, and individuals who have recovered from alcoholism, whether inside or outside the context of Alcoholics Anonymous.

Figure 3. States of relatedness



From Hagerty, B. M. K., Lynch-Sauer, J., Patusky, K. L., & Bouwsema, M. (1993). An emerging theory of human relatedness. *IMAGE: Journal of Nursing Scholarship*, 25, 291-296.

Table 2. Relatedness to referents in the Twelve Steps of Alcoholics Anonymous

Step	We/Self	Alcohol	God/Higher Power	Others
1.	X	X		
2.	X		X	
3.	X		X	
4.	X			X
5.	X		X	X
6.	X		X	
7.	X		X	
8.	X			X
9.	X			X
10.	X			X
11.	X		X	
12.	X		X	X

Each of the Twelve Steps of Alcoholics Anonymous (Appendix B) addresses self (in the first person plural form of “we”) in relation to one or more other referents, including alcohol, God or a Higher Power, and others.

References

- Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism*. (4th ed.). New York: Author.
- Alcoholics Anonymous World Services. (2005). *A.A. fact file*. New York: Author. Retrieved January, 15, 2006, from http://www.alcoholics-anonymous.org/en_pdfs/m-24_aafactfile.pdf
- Alcoholics Anonymous World Services. (2008). *Estimates of A.A. groups and members as of January 1, 2008*. Retrieved December 7, 2008, from http://www.aa.org/lang/en/en_pdfs/smf-53_en.pdf
- Allport, G. W. (1938). *Personality: A psychological interpretation*. New York: Holt, Rinehart & Winston.
- Emrick, C. D., Tonigan, J. S., Montgomery, H. A., & Little, L. (1993). Alcoholics Anonymous: What is currently known? In B. S. McCrady & W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Alternatives and Opportunities* (pp. 41-76). Piscataway, NJ: Rutgers Center of Alcohol Studies.
- Hagerty, B. M. K., Lynch-Sauer, J., Patusky, K. L., & Bouwsema, M. (1993). An emerging theory of human relatedness. *IMAGE: Journal of Nursing Scholarship*, 25, 291-296.
- Hagerty, B. M. K., Lynch-Sauer, J., Patusky, K. L., Bouwsema, M., & Collier, P. (1992). Sense of belonging: A vital mental health concept. *Archives of Psychiatric Nursing*, 6(3), 172-177.
- Hagerty, B. M., Williams, R. A., Coyne, J. A., & Early, M. R. (1996). Sense of belonging and indicators of social and psychological functioning. *Archives of Psychiatric Nursing*, 10(4), 235-244.
- Kurtz, E. (1991). *Not-God: A history of Alcoholics Anonymous*. Center City, MN: Hazelden.
- Mäkelä, K., Arminen, I., Bloomfield, K., Eisenbach-Strangl, I., Bergmark, K. H., Kurube, N., et al. (1996). *Alcoholics Anonymous as a mutual-aid movement: A study in eight societies*. Madison, WI: University of Wisconsin Press.
- Resnick, W. M. (1986). Nursing and the voluntary association: Origin, development, and collaboration. *Psychiatric/Mental Health Nursing*, 21(3), 515-525.

- Weisner, C. (1993). Toward an alcohol treatment entry model: A comparison of problem drinkers in the general population and in treatment. *Alcoholism: Clinical and Experimental Research*, 17(4), 746-752.
- White, H. (1967). Wilhelm Windelband. In P. Edwards (Ed.), *The Encyclopedia of Philosophy: Vol. 8.* (pp. 320-322). New York: Macmillan.
- World Health Organization. (2002). *The world health report 2002: Reducing risks, promoting healthy life.* Geneva, Switzerland: Author.
- World Health Organization. (2007). *WHO expert committee on problems related to alcohol consumption (2nd report).* Geneva, Switzerland: Author.

Chapter 4

Alcoholics Anonymous: Attendance, Affiliation, and Drinking Outcomes in a Polish Treatment Sample

Introduction

The purpose of this study was to examine relationships between Alcoholics Anonymous (AA) meeting attendance, AA affiliation, and drinking outcomes (abstinence and heavy drinking) among patients treated for alcohol dependence at a medical university in central Europe, controlling for demographic and clinical factors.

Specific aim 1: To examine the relationship between AA meeting attendance and drinking outcomes in a Polish treatment sample. Hypothesis 1: AA meeting attendance will be positively associated with improved drinking outcomes.

Specific aim 2: To examine the relationship between AA affiliation and drinking outcomes in this same sample. Hypothesis 2: AA affiliation will be positively associated with improved drinking outcomes.

Background

Alcohol Use in Poland

Alcohol misuse is now viewed as a global health risk. About two billion people worldwide consume alcoholic beverages, and more than 76 million have a diagnosable alcohol use disorder (WHO, 2004). Causal relationships have been established between average volumes of alcohol consumption and more than 60 types of disease and injury. Alcohol consumption is listed among the top ten leading health risk factors globally, accounting for 1.8 million deaths (3.2% of total) and 58.3 million Disability-Adjusted

Life Years (DALYs, 4% of total) annually. The proportion of disease burden is reportedly greatest in the Americas and Europe (WHO, 2002).

One nation that may be disproportionately affected is Poland. Since 1989, there has been a substantial increase in alcohol consumption, together with changes in drinking patterns and alcohol-related health problems (Cherpitel, Moskalewicz & Swiatkiewicz, 2004). This increase has been attributed to changing political, social, and economic forces associated, at least in part, with the fall of communism and an abrupt shift to a market economy (Moskalewicz, 1991). Poland is predominately a spirits-drinking country, characterized by relatively infrequent but heavy drinking, with high levels of intoxication (Wald, Morawski & Moskalewicz, 1986), particularly among males (Wojtyniak, Moskalewicz, Stojwiszewski & Rabczenko, 2005). From a cultural perspective, it is worth noting that some Poles may consider themselves to be abstinent from alcohol even if they consume beer or wine, but not vodka (Zielinski, 1987).

A study of brief interventions in primary care settings in Poland found that among more than 4,000 patients screened in 20 physician offices, nearly 25% met criteria for at-risk, problem, or dependent drinking (Fleming, 1999). In another study, injured male patients treated by emergency services in a large public hospital in Warsaw, Poland were significantly more likely to have positive breathalyzer readings, and to report heavy or problem drinking when compared to their non-injured counterparts. In addition, among those who reported drinking prior to such a mishap, nearly 50% reported feeling drunk, and 75% reported a causal relationship between their drinking and the injury (Cherpitel et al., 2004). In 1999, using the CAGE (Ewing, 1984), an internationally validated alcohol screening tool, it was estimated that 12.2% of the adult population in Poland (4.1% of

females, and 23.3% of males) qualified for a diagnosis of alcohol dependence (WHO, 2004).

Alcoholics Anonymous in Poland

Alcoholics Anonymous (AA) has been described as “the largest and most popular mutual-help program for individuals with alcohol-related problems” (Tonigan, Connors & Miller, 2003, p. 184). Founded in 1935 by William Griffith Wilson (Bill W.) and Dr. Robert Holbrook Smith (Dr. Bob), two chronic alcoholics, AA recently reported having more than two million members and 110,000 groups in over 180 countries throughout the world (AAWS, 2008), including Poland. As early as 1981, the World Health Organization (WHO) began to view self-help groups, more recently referred to as mutual-help groups, as an integral part of public health (WHO, 1981). Despite a worldwide presence, even basic information about the role of AA in treatment and recovery remains lacking for many countries outside of the United States. One notable exception was an international research initiative that examined Alcoholics Anonymous as a mutual-help movement in eight societies, including Poland (Mäkelä, Arminen, Bloomfield, Eisenbach-Stangl, Bergmark & Kurube, 1996). Nonetheless, specific mechanisms of change that may contribute to improved outcomes are not yet fully understood, either in the U.S. or in other parts of the world.

Alcoholics Anonymous is present and active in Poland. According to minutes from the 2006 World Service Meeting Report, Poland has “one of the fastest growing fellowships in Europe.” At that time, the national delegate reported that “the Fellowship of Alcoholics Anonymous in Poland consisted of more than 2,000 groups” (AAWS, 2006, p. 41). The General Service Office (GSO) in Warsaw has translated and published

a wide array of AA conference-approved literature, including an official translation of the “Big Book,” or *Alcoholics Anonymous* (AAWS, 1976), the basic text for the society, which was released in Poland in 1996. The GSO in Warsaw has also launched an official AA web site (www.aa.org.pl). Although AA maintains no formal relationships with hospitals, treatment centers or other outside entities, and AA membership is strictly voluntary, AA meeting attendance is expected in at least some alcohol treatment programs in Poland, and continued involvement in AA is frequently recommended and encouraged.

A Focused Review of the Literature

AA Attendance

Earlier studies across a number of alcohol treatment samples have reported positive relationships between AA meeting attendance and drinking outcomes (Ferris-Kurtz, 1981; Pettinati, Sugerma, DiDonato & Maurer, 1982; Thurstin, Alfano & Nerviano, 1987)—most notably abstinence—while others failed to find such relationships, or reported mixed results (McLatchie & Lomp, 1988; Miller, Leckman, Delaney & Tinkcom, 1992; Ogborne & Bornet, 1982). Two meta-analyses (Emrick, Tonigan, Montgomery & Little, 1993; Tonigan, Toscova & Miller, 1996) and Project MATCH (Tonigan et al., 2003) each reported modest, positive associations. In light of varied results, it has been suggested that AA meeting attendance may be “an indirect reflection” of other important processes that are more strongly related to outcomes, and that attendance by itself may not indicate “genuine involvement” (Montgomery, Miller & Tonigan, 1995).

AA Affiliation

Subsequent efforts have been directed toward the development of psychometrically sound measures of treatment process variables in AA, variously referred to as involvement, participation, commitment, engagement, or affiliation. In a brief summary of several such measures, Allen (2000) pointed out that the development of AA process instruments remained in the early stages, and questioned whether AA attendance or involvement should be considered together, or as independent factors. AA *attendance* is a relatively simple concept, merely indicating physical presence at one or more AA meetings, whereas *affiliation* has been seen as a more “complex construct composed of many 12-step behaviors and beliefs” (Cloud, Ziegler & Blondell, 2004). Allen (2000) noted that most of the research to that point had been restricted to establishing the basic psychometric properties of these instruments, but anticipated that future research would “extend to relating them to treatment outcome.”

The nursing Theory of Human Relatedness (THR; Hagerty, Lynch-Sauer, Patuskay & Bouwsema, 1993) provided a broad conceptual framework for this study. While not a direct test of the theory itself, a number of factors associated with the measurement of AA affiliation for this study (see Measures, below) appeared to align closely with the construct of *relatedness*, defined as an individual’s level of involvement with a specific referent (persons, objects, environments, or spiritual entities) and the concurrent level of comfort or discomfort associated with that involvement. In particular, the instrument used for this study (Appendix H) addressed issues of membership or belonging, relationships across multiple referents, and a component of spirituality, all of which figure prominently in the theory. See Chapter 3 for additional information pertaining to the applicability of THR to alcoholism and recovery in Alcoholics Anonymous.

Methods

Design

A prospective, naturalistic, longitudinal study design was employed, using three data collection points: baseline (Time 1 or T1), one month post-baseline (T2), and 6-12 months post-baseline (T3; Figure 4). These time-points were selected because (a) the greatest risk for relapse to alcohol use is during the first month following the initiation of treatment or abstinence (Hunt, Barnett & Branch, 1971); (b) following treatment, more than half of all patients can be expected to return to some level of drinking within 6-12 months (Project MATCH Research Group, 1997); and (c) course specifiers for early and sustained remission from alcohol dependence, as defined by the Diagnostic and Statistical Manual for Mental Disorders, 4th edition, text revision (DSM-IV-TR), are determined at one and 12 months, respectively (APA, 2000).

This study was part of a larger, collaborative project between the University of Michigan and the Medical University of Warsaw (MUW), Poland, examining suicidality, genetics, and treatment outcomes for alcohol problems (e.g., Wojnar, Brower, Strobbe, Ilgen, Matsumoto, Rowosad et al., 2009; Wojnar, Ilgen, Czyz, Strobbe, Klimkiewicz, Jakubczyk et al., in press; Wojnar, Ilgen, Jakubczyk, Wnorowska, Klimkiewicz & Brower, 2008).

The project as a whole was reviewed and approved by the Institutional Review Board for Human Subjects Research (IRBMED) at the University of Michigan, and the Bioethics Committee at the Medical University of Warsaw. Participation was voluntary, with full, written, informed consent. Consistent with cultural norms for research

participants in Poland, no financial compensation was offered or provided for taking part in the study.

Participants

Included in the study were men and women, ages 18 years and older, with a DSM-IV diagnosis of alcohol dependence, treated at one of four addiction treatment facilities in Warsaw, Poland. Diagnoses were determined by discussion and consensus within a multidisciplinary team of specialists, including a psychiatrist and an addictions therapist. The baseline study sample ($n = 154$) was Caucasian (100%), and predominately male (76%), unmarried (53%), unemployed (62%), and admitted to residential treatment (78%). See Table 3 for additional details regarding the baseline sample. At baseline, female participants (24%) differed significantly from their male counterparts in that women had lower MAST scores (mean = 30.7, SD = 9.3 vs. 37.2, SD = 8.3, $t(116) = 3.6$, $p < .001$); were less likely to have been court-ordered to treatment ($n = 0/28$, 0% vs. 11/83, 13%, $\chi^2 = 4.1$, $p = .042$), and were more likely to have been an AA sponsor ($n = 2/30$, 7% vs. 0/86, 0%, $\chi^2 = 5.8$, $p = .016$).

Setting

The study was conducted simultaneously at four addiction treatment centers (two residential, and two intensive outpatient programs) in Warsaw, Poland. These programs were abstinence-based, and included group and individual therapy, incorporating elements of relapse prevention and 12-step facilitation. Residential treatment was typically eight weeks in length, with intensive daily group therapy sessions and up to three individual sessions per week, followed by weekly outpatient visits for a period of up to two years. Intensive outpatient treatment convened for three hours a day, three

days a week for 8 to 12 weeks, followed by weekly individual outpatient sessions for up to a year.

Measures

Background information was obtained using a modified version of the University of Arkansas Substance Abuse Outcomes Module (SAOM), a self-report tool that assesses a number of patient characteristics, including demographics, family history, social support, alcohol and drug use, and consequences. Measures in this module have good psychometric properties, and compare favorably with several other substance abuse research instruments (Smith, Burnam, Mosley, Hollenberg, Mancino & Grimes, 2006).

Primary variables of interest included AA attendance, AA affiliation, and alcohol consumption. Alcohol use and AA attendance were measured using the Timeline Followback (TLFB). The TLFB was designed for use in clinical and research settings, facilitating the collection of retrospective reports of drinking over a designated period of up to 12 months (Sobell & Sobell, 1996). This calendar method has been shown to have good psychometric properties across a variety of drinking groups, with test-retest reliability coefficients generally greater than 0.85 (Sobell, Sobell, Leo & Cancilla, 1988). Pertinent to this study, an official version of the TLFB method and instructions was available in Polish. Data collection worksheets were modified to include the number of AA meetings attended. These measures were collected at baseline (T1), recording data for 90 days prior to entry into treatment, and then again at T2 and T3, with each assessment going back to the previous study visit.

AA affiliation was measured using a modified version of the Alcoholics Anonymous Involvement (AAI) scale (Tonigan, Connors & Miller, 1996), incorporating

certain changes from the subsequently released and revised Twelve-Step Participation Questionnaire (TSPQ-2I, initial; and TSPQ2F, follow-up) (Tonigan, Miller & Connors, 1997a; Tonigan, Miller & Connors, 1997b), while retaining an exclusive focus on AA-related activities. In the present study, Cronbach's alpha for the modified AAI at T3 was 0.79. Items were also examined separately in order to (a) distinguish between AA attendance and other elements of affiliation, and (b) identify what other aspects of AA affiliation might be pertinent to this treatment sample. See Appendix H for AA affiliation questions and scoring at T2 and T3.

Improved drinking outcomes included *abstinence*, defined as no alcohol use from baseline to T3, and *no heavy drinking*, meaning no episodes of ≥ 5 standard European drinks (10 gm ethanol) per day for men, or ≥ 4 standard European drinks for women (Dawson, Grant & Li, 2005) throughout the study. Self-reports of drinking behaviors were further corroborated with breathalyzer readings taken at each study visit, and structured assessment interviews with designated family members or other identified sources, either in person or by phone, using the Form 90 Collateral Interview on Drinking (Miller, 1996). Any research instruments for which Polish versions were not available were translated using the simultaneous forward/single back-translation method (Cella, Lloyd & Wright, 1996; Guillemin, Bombadier & Beaton, 1993; Hunt, 1988). The approval and translation process used for this study has been described at length elsewhere (Wojnar et al., 2008).

Analysis

Bivariate associations between baseline variables and drinking outcomes were tested using chi-square tests, independent group *t*-tests, and correlational analyses. If

significant, then these items were controlled during subsequent analyses. AA attendance was measured as a continuous variable derived from Timeline Followback data, and compared to dichotomous drinking outcomes using independent group *t*-tests. AA affiliation items were scored and examined individually in relation to drinking outcomes using chi-square and correlational analyses, and collectively using independent group *t*-tests. Multiple logistic regression analyses were used to examine the effects of AA-related variables (attendance and affiliation) on the two binary drinking outcome variables (abstinence and no heavy drinking). Comparisons between study completers and non-completers were made using chi-square and independent group *t*-tests.

Results

Of 154 participants at baseline, 118 (77%) were assessed at T3, and constituted the sample of interest for this study. Mean time to study completion was 313.9 (SD = 85.4) days, or approximately 10.5 months. See Table 4 for a comparison of characteristics between study completers ($n = 118$) and non-completers ($n = 36$) at baseline.

At study completion, more than half of the participants ($n = 64/118$, 54%) reported having remained abstinent from alcohol. A greater number still ($n = 77$, 65%) reported no episodes of heavy drinking. Conversely, 46% ($n = 54$) reported having used at least some alcohol during the study, and 35% ($n = 41$) reported heavy drinking. Of those who engaged in heavy drinking, the mean number of heavy drinking days was 44.6 (SD = 53.0), with a range of 2 to 117 days, suggesting a variety of drinking behaviors, from a brief “slip” to full alcoholic relapse, if abstinence or recovery were initiated at all.

Those who abstained from alcohol throughout the study were more likely at baseline to have been employed ($n = 29/44$, 66% vs. $34/73$, 47%, $\chi^2 = 4.1$, $p = .04$); had

greater tangible social support (i.e., the provision of material aid or behavioral assistance) as measured by a subscale from the Medical Outcomes Study Social Support Survey (Sherborne & Stewart, 1991) (mean 17.9 vs. 15.8, $\chi^2 = 2.1, p = .04$); and were admitted to intensive outpatient rather than residential treatment ($n = 21/30, 70\%$ vs. $n = 42/87, 48\%$, $\chi^2 = 4.2, p = .04$). Similarly, those who reported no episodes of heavy drinking were more likely to have been employed ($n = 34/44, 77\%$ vs. $n = 42/73, 58\%$, $\chi^2 = 4.7, p = .03$), and to have had greater tangible support (17.8 vs. 15.2, $\chi^2 = 2.6, p = .009$) than those who engaged in any heavy drinking during the study. Other demographic factors (e.g., age, gender, education, and marital status) were not shown to have had a direct effect on drinking outcomes).

Contrary to our first hypothesis, AA meeting attendance alone did not result in improved drinking outcomes, as measured by abstinence or the absence of any heavy drinking (Table 3). This was true regardless of the period assessed, including lifetime AA attendance prior to entry into the study (T1); baseline to one month (T1-T2); one month to approximately one year (T2-T3); or throughout the duration of the study (T1-T3).

In contrast, one of the affiliation items—self-report of a spiritual awakening between T2 and T3—was significantly associated both with abstinence ($n = 36/57, 63\%$ vs. $n = 26/58, 45\%$, $\chi^2 = 3.9, p = .049$) and an absence of any heavy drinking ($n = 43/57, 75\%$ vs. $n = 32/58, 55\%$, $\chi^2 = 5.2, p = .020$) during study participation. Multiple logistic regression analyses showed that spiritual awakening between T2 and T3 predicted greater likelihood of abstinence (OR = 2.5, $p = .024$) and no heavy drinking (OR = 3.1, $p = .011$). These associations remained significant even when AA attendance and other known

significant correlates of drinking outcomes (e.g., employment status, tangible support, and level of care) were statistically controlled.

To better understand the associations between spiritual awakening and other dimensions of AA affiliation, we examined correlates to spiritual awakening at study completion (T3) from among the remaining affiliation items in the revised Alcoholics Anonymous Involvement (AAI) scale at each of the respective time points. At baseline (T1), having ever had a spiritual awakening prior to entry into treatment was positively associated with having a spiritual awakening between T2 and T3 ($r = 0.29, p = .002$). Similarly, reports of a spiritual awakening between T1 and T2 were positively associated with a spiritual awakening at T3 ($r = 0.29, p = .006$), along with having read AA literature since the last study visit ($r = 0.25, p = .019$).

At study completion (T3), from among the 10 remaining indicators of AA affiliation, seven (70%) showed significantly positive associations with reports of a spiritual awakening ($p < .05$), and two (20%) approached statistical significance ($p > 0.05 < 0.10$). Furthermore, there was a strong positive correlation between the total number of AA-related activities between T2 and T3 and having had a spiritual awakening at T3 ($r = 0.44, p < .001$).

Discussion

Associations between AA meeting attendance, AA affiliation, and drinking outcomes were examined in an alcohol-dependent treatment sample in Warsaw, Poland. In summary, we found that AA meeting attendance alone did not predict drinking outcomes, whereas self-reports of a spiritual awakening between one month (T2) and approximately one year (T3) post-baseline predicted abstinence, as well as the absence of

any heavy drinking, throughout the course of the study. No other AA affiliation items exhibited a direct effect on these drinking outcomes, either individually or collectively (Table 5).

In addition, a number of AA-related behaviors were positively associated with having had a spiritual awakening. Together, these factors were thought to reflect the broad concept of AA affiliation. There was also a significant additive effect, in that greater AA affiliation increased the likelihood of having had a spiritual awakening which, in turn, resulted in improved outcomes. In essence, spiritual awakening appears to have served as a mediator between other aspects of AA affiliation—including, but not limited to, attendance—and subsequent drinking outcomes. See Figure 5 for a conceptual model depicting study findings.

The role of spirituality in recovery has captured the attention of addiction researchers. Zemore (2007), for example, suggested that spiritual change may play a mediational role in recovery outcomes. More specifically, Forcehimes (2004) regarded spiritual awakening as “the true mechanism of change in AA”. Our findings appear to support and extend these assertions by (a) directly linking spiritual awakening to improved drinking outcomes, (b) demonstrating clear associations between spiritual awakening and other important elements of the fellowship and program of Alcoholics Anonymous, and (c) conducting this research with an international treatment sample.

Findings from this study reflected favorably on the Theory of Human Relatedness, further substantiating its consideration for future research and clinical care as it pertains to alcoholism, recovery, and AA. Broadly speaking, the constructs of AA affiliation and relatedness appear to share an array of primary characteristics, including

the quality of relationships across multiple referents, the importance of a sense of belonging, and the capacity to address issues of spirituality. Specific to this study, several affiliation items were significantly associated with having had a spiritual awakening which, in turn, contributed to improved drinking outcomes. Among these were the number of AA steps worked between T2 and T3. As indicated in Chapter 3, virtually each of the Twelve Steps of Alcoholics Anonymous addresses an individual's relationship with one or more referents, including self, alcohol, God or a Higher Power, and others (Table 2). Finally, there was an additive effect between the number of AA-related behaviors, conceptualized as AA affiliation, and the likelihood of having experienced a spiritual awakening. This cumulative effect suggests that relatedness competencies (sense of belonging, reciprocity, mutuality, and synchrony; Chapter 3) may generalize as a skill set that can be applied across a number of diverse referents.

Several limitations also warrant discussion. First, the term “spiritual awakening” was not directly defined in the context of this study. However, the vast majority of study participants were exposed to Alcoholics Anonymous meetings before ($n = 100/117$, 85%) and during formal treatment ($n = 114/117$, 97%), and were highly likely to have encountered this notion. For example, Step Twelve specifically states, “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, p. 60; Appendix B). In addition, Appendix II of the Big Book is dedicated to the topic of spiritual experiences. For some, this may mean “an immediate and overwhelming ‘God Consciousness’”, while others may experience transformations of the kind that the

American psychologist, William James (1902/1958), described as “the ‘educational variety’ because they develop slowly over a period of time” (AAWS, 2001, p. 567).

Although associations between spiritual awakening and AA affiliation were positive, the temporal direction of these relationships, or causality, cannot be assigned. It may be that a spiritual awakening leads to participation in other AA-related behaviors, or that AA affiliation creates conditions that are conducive to having a spiritual awakening. Alternatively, it may be that spiritual awakenings and AA affiliation reinforce one another, regardless of which occurs first, creating a kind of positive feedback system.

The study sample was notably homogeneous in relation to several characteristics, including gender (male), race (Caucasian), ethnicity (Polish), and religion (Roman Catholic), which may limit the ability to generalize findings. At the same time, fewer potentially confounding variables may have contributed to reduced statistical noise, allowing other associations to be more readily identified. Finally, results from attrition analyses revealed significant differences between study completers and non-completers in relation to several baseline measures (Table 4), further limiting the ability to generalize findings.

Despite these limitations, the study generated a number of intriguing findings which may hold implications for clinical care and research. First, it appears that AA attendance alone may represent, at best, a necessary but insufficient condition for the initiation and maintenance of long-term sobriety in Alcoholics Anonymous. Second, this study cast spirituality in a practical—even pragmatic—light, illuminating relationships between spiritual awakening and improved drinking outcomes. Third, the possibility of achieving such an outcome did not appear to be remote. All told, nearly half of those

who completed the study ($n = 57/118$, 48%) reported having had a spiritual awakening between one month and approximately one year post-baseline. Of those, 63% remained abstinent from alcohol, while 75% refrained from any heavy drinking. The fact that this effect appeared to be somewhat “delayed” may speak to the need for a minimum period of abstinence from alcohol before certain bio-behavioral or spiritual changes can be expected to take place, at least for some.

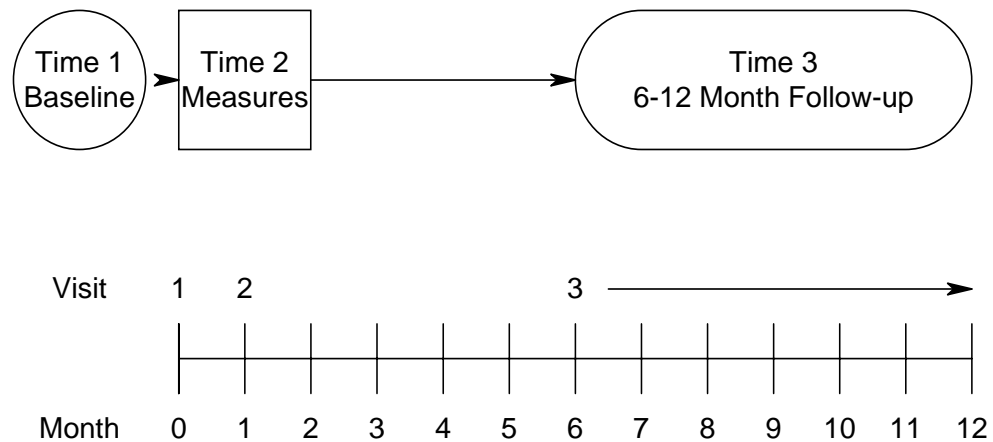
Finally, it is possible that a certain subset of people may be more prone to spiritual awakenings than others, and that these individuals may experience more than one such event in their lives. These same men and women may further tend to self-select for continued affiliation with Alcoholics Anonymous, which refers to itself as a “spiritual program of action” (AAWS, 2001, p. 85). Our data showed that one of the best predictors of a spiritual awakening at study completion was the report of a previous spiritual awakening, either prior to admission or during the first month of treatment. This idea of multiple awakenings is consistent with the writings of Bill W., one of the co-founders of AA, as reflected in the December, 1957 issue of the Grapevine, the international journal of Alcoholics Anonymous:

Is sobriety all that we are to expect of a spiritual awakening? No, sobriety is only a bare beginning. It is only the first gift of the first awakening. If more gifts are to be received, our awakening has to go on...a new life of endless possibilities can be lived if we are willing to continue our awakening, through the practice of A.A.'s Twelve Steps (AAWS, 1967, p. 8).

Spirituality has established itself as a viable area for research in the field of addictions. Future investigations may include (a) study replication across different populations and cultures, (b) recruitment from AA communities, rather than treatment samples only, (c) examining relationships between AA affiliation, spiritual awakenings,

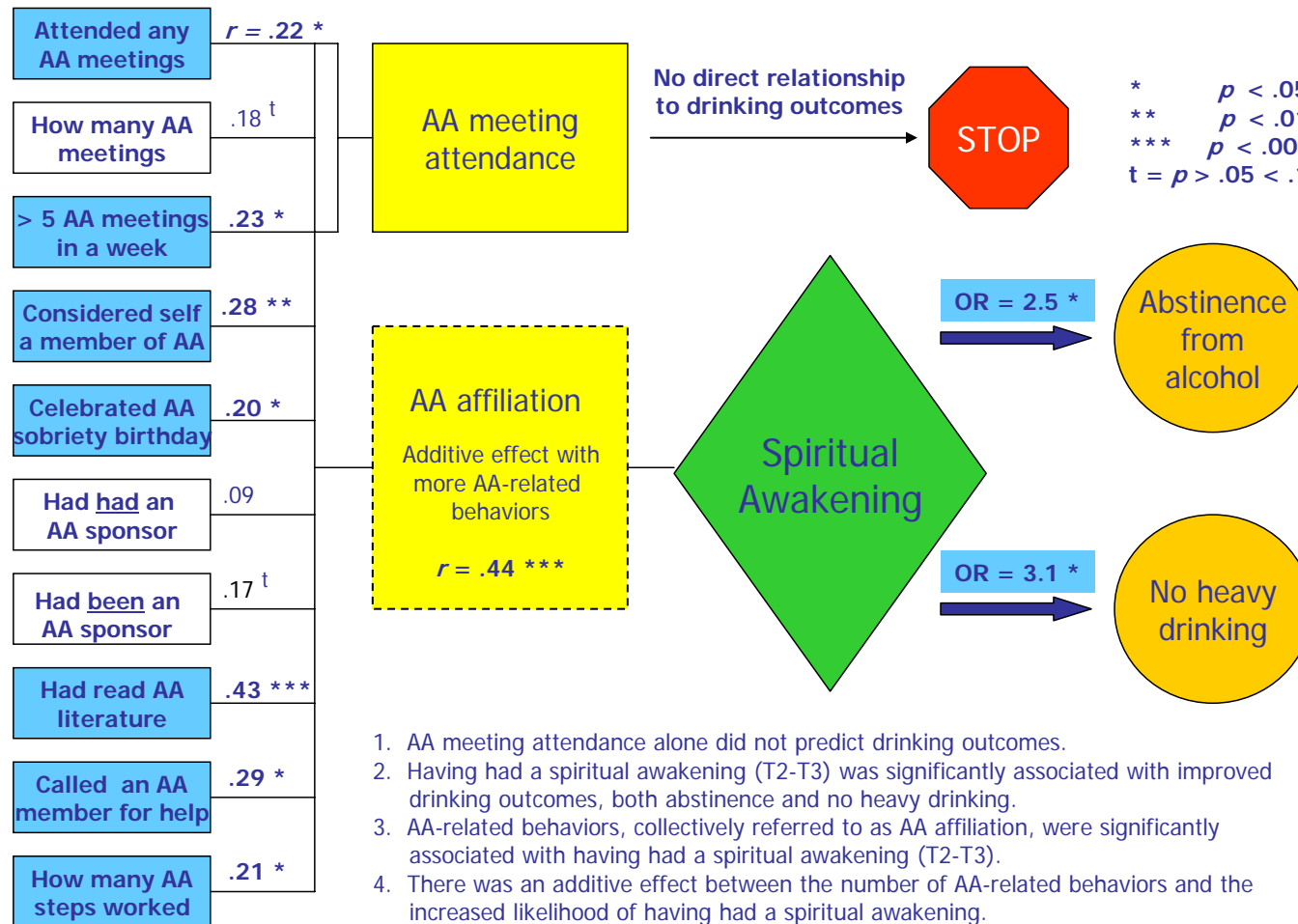
and other quality-of-life measures, (d) applying qualitative and mixed-methods approaches to the study of spiritual awakenings, including the use of brain-imaging studies, and (e) exploring possible genetic links to AA affiliation and spiritual awakening.

Figure 4. Study design



Prospective, naturalistic, longitudinal study, with 3 data collection points: Baseline (Time 1 or T1; n=154), 1 month post-baseline (T2), and 6 to 12 months post-baseline (T3; n=118).

Figure 5. Conceptual model of study findings: AA attendance, affiliation, and drinking outcomes in a Polish treatment sample



1. AA meeting attendance alone did not predict drinking outcomes.
2. Having had a spiritual awakening (T2-T3) was significantly associated with improved drinking outcomes, both abstinence and no heavy drinking.
3. AA-related behaviors, collectively referred to as AA affiliation, were significantly associated with having had a spiritual awakening (T2-T3).
4. There was an additive effect between the number of AA-related behaviors and the increased likelihood of having had a spiritual awakening.

Table 3. Demographic and clinical characteristics of the baseline study sample (n=154)

Characteristic	Participants
Age, years: mean (SD)	43.65 (9.64)
Race, Caucasian: <i>n</i> (%)	154 (100%)
Gender, male: <i>n</i> (%)	117 (76%)
Education, years: mean (SD)	12.27 (3.66)
Employment status, unemployed: <i>n</i> (%)	102 (62%)
Marital status, unmarried: <i>n</i> (%)	81 (53%)
Tangible support (MOS-SSS) score: mean (SD)	16.8 (5.2)
Lifetime alcohol severity, MAST score: mean (SD)	35.7 (9.5)
Psychiatric severity (GSI) score: mean (SD)	49.9 (11.9)
Drinking days past 90 days: mean (SD)	24.71 (26.72)
Drinks per drinking day: mean (SD)	20.87 (14.12)
Other drug use past 28 days, yes: <i>n</i> (%)	23 (18%)
Court-ordered treatment: <i>n</i> (%)	14 (22%)
Level of care, residential: <i>n</i> (%)	120 (78%)
Ever attended an AA meeting, yes: <i>n</i> (%)	130 (84%)
AA meetings, lifetime number: mean (SD)	58.7 (162.3)
AA steps worked at baseline, number: mean (SD)	1.7 (2.9)
Spiritual awakening since participation in AA: <i>n</i> (%)	64 (41%)

SD = standard deviation; MOS-SSS = Medical Outcomes Study Social Support Scale; MAST = Michigan Alcoholism Screening Test; GSI = Global Severity Index; AA = Alcoholics Anonymous

Table 4. Comparison of characteristics between study completers ($n=118$) and non-completers ($n=36$) at baseline (Time 1, or T1)

Characteristic	Completers	Non-completers	χ^2 or t	p
Age, years: mean (SD)	44.2 (9.4)	41.8 (10.2)	-1.3	0.18
Gender, male: n (%)	88 (75%)	30 (81%)	0.5	0.46
Education, years: mean (SD)	12.6 (3.4)	11.1 (4.1)	-2.0	0.04 *
Employment status, unemployed: n (%)	73 (62%)	29 (81%)	4.1	0.04 *
Marital status, unmarried: n (%)	67 (57%)	29 (81%)	6.6	0.01 *
Tangible support (MOS-SSS) score: mean (SD)	16.9 (5.2)	16.4 (5.4)	-1.5	0.59
Lifetime alcohol severity, MAST score: mean (SD)	35.6 (9.0)	36.1 (11.2)	0.3	0.77
Psychiatric severity (GSI) score: mean (SD)	49.8 (12.0)	50.5 (11.6)	0.3	0.74
Drinking days past 90 days: mean (SD)	23.5 (26.9)	28.6 (26.3)	1.0	0.32
Drinks per drinking day: mean (SD)	18.3 (11.6)	27.9 (18.0)	3.2	0.002 **
Other drug use past 28 days, yes: n (%)	18 (19%)	5 (16%)	0.1	0.76
Court-ordered treatment: n (%)	11 (10%)	11 (33%)	10.8	0.001 **
Level of care, residential: n (%)	87 (74%)	33 (92%)	5.2	0.02 *
Ever attended an AA meeting, yes: n (%)	100 (86%)	30 (83%)	0.1	0.75
AA meetings, lifetime number: mean (SD)	52.3 (147.4)	79.4 (204.0)	0.9	0.40
AA steps worked, number: mean (SD)	1.8 (3.0)	1.3 (2.4)	-0.9	0.35
Spiritual awakening since participation in AA: n (%)	50 (42%)	14 (40%)	0.1	0.80

* $p < .05$, ** $p < .01$; SD = standard deviation; MOS-SSS = Medical Outcomes Study Social Support Scale; MAST = Michigan Alcoholism Screening Test; GSI = Global Severity Index; AA = Alcoholics Anonymous.

Table 5. AA attendance and drinking outcomes: abstinence and no heavy drinking (HD) among study completers ($n=118$) at baseline (T1), one month (T2), and study completion (T3)

Study visit and AA-related variables	Abstinent ($n=64$, 54%)	Not abstinent ($n=54$, 46%)	χ^2 / t	p
Baseline (T1)				
Ever attended an AA meeting: n (%)				
Yes	51 (51%)	49 (49%)	2.2	0.13
No	12 (71%)	5 (29%)		
AA meetings lifetime: mean (SD)	55.9 (166.0)	47.9 (122.3)	0.3	0.78
Baseline to one month (T2)				
Attended any AA meetings: n (%)				
Yes	40 (61.5%)	25 (38.5%)	0.8	0.38
No	9 (50%)	9 (50%)		
Number of AA meetings: mean (SD)	4.1 (3.1)	3.9 (3.0)	0.3	0.77
One month to 6-12 months (T3)				
Attended any AA meetings: n (%)				
Yes	56 (57%)	42 (43%)	2.8	0.09
No	6 (35%)	11 (65%)		
Number of AA meetings: mean (SD)	29.0 (27.0)	30.6 (44.2)	-0.2	0.82
Had a spiritual awakening since T2				
Yes	36 (63%)	21 (37%)	3.9	0.049 *
No	26 (45%)	32 (55%)		
AA affiliation score: mean (SD)	4.9 (2.4)	4.6 (2.4)	0.6	0.56

Study visit and AA-related variables	No HD (n=77, 65%)	HD (n=41, 35%)	χ^2 / t	<i>p</i>
Baseline (T1)				
Ever attended an AA meeting: <i>n</i> (%)				
Yes	64 (64%)	36 (36%)	0.3	0.60
No	121 (71%)	5 (29%)		
AA meetings lifetime: mean (SD)	52.7 (154.2)	1.4 (135.7)	0.04	0.96
Baseline to one month (T2)				
Attended any AA meetings: <i>n</i> (%)				
Yes	48 (74%)	17 (26%)	1.1	0.29
No	11 (61%)	7 (39%)		
Number of AA meetings: mean (SD)	4.1 (3.1)	3.7 (3.0)	0.5	0.60
One month to 6-12 months (T3)				
Attended any AA meetings: <i>n</i> (%)				
Yes	66 (67%)	32 (33%)	1.3	0.25
No	9 (53%)	8 (47%)		
Number of AA meetings: mean (SD)	28.7 (27.9)	31.6 (48.0)	-0.4	0.69
Had a spiritual awakening since T2				
Yes	43 (75%)	14 (25%)	5.2	0.02 *
No	32 (55%)	26 (45%)		
AA affiliation score: mean (SD)	4.8 (2.3)	4.7 (2.5)	0.2	0.82

Note: * $p < .05$. For all χ^2 tests, $df=1$. *Ns* do not always sum to 118 due to missing data.

References

- Alcoholics Anonymous World Services. (1967). *As Bill sees it: The A.A. way of life* (selected writings of A.A.'s co-founder). New York, NY: Author.
- Alcoholics Anonymous World Services. (1976). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (3rd ed.). New York, NY: Author.
- Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous: the story of how many thousands of men and women have recovered from alcoholism* (4th ed.). New York, NY: Author.
- Alcoholics Anonymous World Services. (2006). *Anonymous but not invisible: 19th world service meeting 2006*. New York, NY: Author.
- Alcoholics Anonymous World Services. (2008). Estimates of AA groups and members as of January 1, 2008. Retrieved December 7, 2008, from http://www.aa.org/lang/en/en_pdfs/smf-53_en.pdf
- Allen, J. P. (2000). Measuring treatment process variables in Alcoholics Anonymous. *Journal of Substance Abuse Treatment, 18*, 227-230.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual for mental disorders* (4th ed., text revision). Washington, DC: Author.
- Cherpitel C. J., Moskalewicz, J., & Swiatkiewicz, G. (2004). Drinking patterns and problems in emergency services in Poland. *Alcohol & Alcoholism, 39*(3), 256-261.
- Cella, D. F., Lloyd, S. R., & Wright, B. D. (1996). Cross-cultural instrument equating: Current research and future directions. In: B. Spilker (Ed.), *Quality of life and pharmacoconomics in clinical trials* (2nd ed., pp. 707-714). Philadelphia, PA: Lippincott-Raven.
- Cloud, R. N., Ziegler, C. H., & Blondell, R. D. (2004). What is Alcoholics Anonymous affiliation? *Substance Use and Misuse, 39*(7), 1117-1136.
- Dawson, D.A, Grant, B., Li. T. K. (2005). Quantifying the risks associated with exceeding recommended drinking limits. *Alcoholism: Clinical and Experimental Research, 29*(5), 902-908.
- Emrick, C. D., Tonigan, J. S., Montgomery, H.A., & Little, L. (1993). Alcoholics Anonymous: What is currently known? In: McCrady BS, Miller WR (Eds.), *Research on Alcoholics Anonymous: Alternatives and opportunities* (pp. 41-76). Piscataway NJ: Rutgers Center of Alcohol Studies.

- Ewing, J. A. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association*, 252(14), 1905-1907.
- Ferris-Kurtz, L. (1981). Time in residential care and participation in Alcoholics Anonymous as predictors of continued sobriety. *Psychological Reports*, 48, 633-634.
- Fleming, M. (1999). Preliminary data from the Polish brief intervention in primary care study. Madison, WI: University of Wisconsin Center for Addiction Research and Education.
- Forcehimes, A.A. (2004). De profundis: Spiritual transformations in Alcoholics Anonymous. *Journal of Clinical Psychology*, 60(5) 503-517.
- Guillemin, F., Bombardier, C., & Beaton, D. (1993). Cross-cultural adaptation of health-related quality of life measures: Literature review and proposed guidelines. *Journal of Clinical Epidemiology*, 46, 1417-1432.
- Hagerty, B. M. K., Lynch-Sauer, J., Patusky, K. L., & Bouwsema, M. (1993). An emerging theory of human relatedness. *IMAGE: Journal of Nursing Scholarship*, 25, 291-296.
- Hunt, S. M. (1988). A methodology for the translation of health measures. Manchester, UK: Galen Research and Consultancy, pp. 1-8.
- Hunt, W. A., Barnett, L. W., & Branch, L. G. (1971). Relapse rates in addictions programs. *Journal of Clinical Psychology*, 27, 455-456.
- James, W. (1958). *The varieties of religious experience*. New York, NY: New American Library.
- Mäkelä K., Arminen, I., Bloomfield, K., Eisenbach-Stangl, I., Bergmark, K. H., Kurube, N. (1996). *Alcoholics Anonymous as a mutual-help movement: a study in eight societies*. Madison, WI: University of Wisconsin Press.
- McLatchie, B. H., Lomp, K. G. E. (1988). Alcoholics Anonymous affiliation and treatment outcome among a clinical sample of problem drinkers. *American Journal of Drug and Alcohol Abuse*, 14, 309-324.
- Miller, W. R. (1996). Form 90: A structured assessment interview for drinking and related behaviors. Bethesda (MD): National Institute on Alcohol Abuse and Alcoholism. NIH Publication No. 96-4004.
- Miller, W. R., Leckman, A. L., Delaney, H. D., & Tinkcom, M. (1992). Long-term follow-up of behavioral self-control training. *Journal of Studies on Alcohol*, 53, 249-261.

- Montgomery, H. A., Miller, W. R., & Tonigan, J. S. (1995). Does Alcoholics Anonymous involvement predict treatment outcome? *Journal of Substance Abuse Treatment, 12*(4), 241-246.
- Moskalewicz, J. (1991). Alcohol as an economic issue: Recent Polish experience. *Contemporary Drug Problem, 18*(3), 407-415.
- Ogborne, A. C., & Bornet, A. (1982). Brief report: Abstinence and abusive drinking among affiliates of Alcoholics Anonymous: Are they the only alternatives? *Addictive Behaviors, 7*, 199-202.
- Pettinati, H. M., Sugeran, A. A., DiDonato, N., & Maurer, J. S. (1982). The natural history of alcoholism over four years of treatment. *Journal of Studies on Alcohol, 43*(3), 201-215.
- Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol, 58*, 7-29.
- Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social Science and Medicine, 32*(6), 705-714.
- Smith, G. R., Burnam, M.A., Mosley, C. L., Hollenberg, J. A., Mancino, M., & Grimes, W. (2006). Reliability and validity of the Substance Abuse Treatment Module. *Psychiatric Services, 57*(10), 1452-1460.
- Sobell, L. C., & Sobell, M. B. 1996). *Timeline Followback: A calendar method for assessing alcohol and drug use: User's guide*. Toronto, Ontario (Canada): Addiction Research Foundation.
- Sobell, L. C., Sobell, M. B., Leo, M. B., & Cancilla, A. (1988). Reliability of a timeline method: assessing normal drinkers' reports of recent drinking and a comparative evaluation across several populations. *British Journal of Addictions, 83*, 393-402.
- Thurstin, A. H., Alfano, A. M., & Nerviano, V. J. (1987). The efficacy of A.A. attendance for aftercare of inpatient alcoholics: Some follow-up data. *International Journal on Addictions, 22*, 1083-1090.
- Tonigan, J. S., Connors, G. J., Miller, W.R. (1996). Alcoholics Anonymous Involvement (AAI) scale: Reliability and norms. *Psychology of Addictive Behaviors, 10*(2), 75-80.
- Tonigan, J. S., Connors, G. J., & Miller, W.R. (2003). Participation and involvement in Alcoholics Anonymous. In: Babor TF, del Boca, FK (editors). *Treatment matching in alcoholism* (pp. 184-204). Cambridge, UK: Cambridge University Press.

- Tonigan, J. S., Miller, W. R., & Connors, G. (1997). *Twelve-Step Participation Questionnaire (Initial, TSPQ-2I)*. Retrieved February 25, 2009, from <http://casaa.unm.edu/inst/Twelve-Step%20Participation%20Questionnaire%202I.pdf>
- Tonigan, J. S., Miller, W. R., & Connors, G. (1997). *Twelve-Step Participation Questionnaire (Follow-up, TSPQ-2F)*. Retrieved February 25, 2009, from <http://casaa.unm.edu/inst/Twelve-Step%20Participation%20Questionnaire%202F%20-%20201.pdf>
- Tonigan, J. S., Toscova, R., & Miller, W.R. (1996). Meta-analysis of the literature on Alcoholics Anonymous: Sample and study of characteristics moderate findings. *Journal of Studies on Alcohol*, *57*, 65-72.
- Wald, I., Morawski, J., & Moskalewicz, J. (1986). International review series: Alcohol and alcohol problems research 12. Poland. *British Journal of Addiction*, *81*(6), 729-734.
- Wojnar, M., Ilgen, M. A., Jakubczyk, A., Wnorowska, A., Klimkiewicz, A., & Brower, K. J. (2008). Impulsive suicide attempts predict post-treatment relapse in alcohol-dependent patients. *Drug and Alcohol Dependence*, *97*, 268-275.
- Wojnar, M., Brower, K. J., Strobbe, S., Ilgen, M., Matsumoto, H., Nowosad, I., et al. (2009). Association between val66met brain-derived neurotrophic factor (BDNF) gene polymorphism and post-treatment relapse in alcohol dependence. *Alcoholism: Clinical and Experimental Research*, *33*(4), 693-702.
- Wojnar, M., Ilgen, M. A., Czyz, E., Strobbe, S., Klimkiewicz, A., Jakubczyk, A., et al. (in press). Impulsive and non-impulsive suicide attempts in patients treated for alcohol dependence. *Journal of Affective Disorders*.
- Wojtyniak, B., Moskalewicz, J., Stokwiszewski, J., & Rabczenko, D. (2005). Gender-specific mortality associated with alcohol consumption in Poland in transition. *Addiction*, *100*, 1779-1789.
- World Health Organization. (1981). *Self-help and health: Report on a WHO consultation*. Copenhagen, Denmark: WHO Regional Office for Europe.
- World Health Organization. (2002). *The World Health Report 2002: Reducing risks, promoting healthy life*. Geneva, Switzerland: Author.
- World Health Organization. (2004). *Global status report on alcohol 2004*. Geneva, Switzerland: Author.
- Zemore, S. E. (2007). A role for spiritual change in the benefits of 12-step involvement. *Alcoholism: Clinical and Experimental Research*, *33*(10 Suppl), S76-S79.

Zielinski, A. (1987). Social attitudes towards abstinence in the light of the 1987 survey.
Alcoholism Symposium Proceedings, Warsaw, Poland, 398-404.

Chapter 5

Conclusion

The purpose of this chapter is to (1) summarize briefly the findings from each of the three main papers, (2) synthesize these elements into a greater whole, and (3) identify possibilities for future research and nursing care based on this synthesis. Broadly speaking, these chapters approached the phenomena of alcoholism and recovery in Alcoholics Anonymous from divergent but complementary perspectives—qualitative, theoretical, and quantitative—and then converged to create new understanding and insights that hold promise for future developments.

Summaries of Individual Studies

Personal Stories in the “Big Book” of Alcoholics Anonymous

The first paper (Chapter 2) was a qualitative study based on 24 new personal stories from the fourth edition of the “Big Book” of Alcoholics Anonymous (AAWS, 2001), using methods derived from narrative analysis. In this study, evidence was generated to support the idea of a *normative model* for personal stories of alcoholism and recovery in AA. Varied formats for similar stories in Alcoholics Anonymous had previously been described as “prototypical” (Cain, 1991), “community” (Mankowski & Rappaport, 2000), and “master” narratives (O’Reilly, 2000).

Unique contributions from this study included the construction of a schematic model composed of five stages (first or early drinking, alcoholic regression, hitting

bottom, progress in the AA program, and stable sobriety), set against a subjective evaluative function over time (Figure 2). This model was found to coincide closely with classical literary conventions for drama, including heroic epics, with some important differences. First, in these personal stories, the narrator and the protagonist (or hero) were the same person. As a result, the true “end” of the story had not yet been written. The audience and the narrator shared the understanding that the protagonist could still drink again, which served to maintain dramatic tension, and added a curious twist to the convention of “dramatic irony,” in which an audience knows something that the character does not.

Applying the Theory of Human Relatedness

The second paper (Chapter 3) applied the nursing Theory of Human Relatedness (THR; Hagerty, Lynch-Sauer, Patusky & Bouwsema, 1993) to alcoholism and recovery in Alcoholics Anonymous. Relatedness, the core construct for the theory, was defined as an individual’s level of involvement with a specific referent (persons, objects, environments, or spiritual entities) and his or her concurrent level of comfort associated with that involvement. Together, levels of involvement and comfort result in one of four states of relatedness: (1) connectedness, (2) disconnectedness, (3) parallelism, and (4) enmeshment (Figure 2). Individuals move within and across states of relatedness with respect to a given referent, based on four relatedness competencies: (1) sense of belonging, (2) reciprocity, (3) mutuality, and (4) synchrony.

Using one of the same personal stories from the Big Book as an exemplar, an in-depth analysis was conducted. The Theory of Human Relatedness clearly corresponded to key relationship issues associated with alcoholism and recovery. States

of relatedness for certain referents were followed over the course of a storyline that spanned a number of years and changing personal circumstances. Following this individualized (or idiographic) approach, the remaining stories from the larger data set were then surveyed, identifying shared thematic content across the broader cohort (nomothetic approach). This methodology resulted in the generation of several key assumptions pertaining to relatedness in Alcoholics Anonymous.

AA Attendance, Affiliation, and Drinking Outcomes

The third paper (Chapter 4) was based on a prospective longitudinal study in which AA meeting attendance and affiliation were examined at three time points (baseline or T1, one month or T2, and 6-12 months or T3) in relation to drinking outcomes in a Polish treatment sample in Warsaw, Poland. See Table 3 for demographic and clinical characteristic of the baseline sample, $n = 154$. Attendance and alcohol consumption were measured using the Timeline Followback (TLFB) method (Sobell & Sobell, 1996). Affiliation, operationalized as an array of AA-related behaviors (Appendix H), was measured using a modified version of the Alcoholics Anonymous Involvement (AAI) scale (Tonigan, Connors & Miller, 1996).

AA meeting attendance alone was not significantly associated with drinking outcomes. One of the affiliation items, however, self-report of a spiritual awakening between T2 and T3, predicted both abstinence ($OR = 2.5, p = .024$) and the absence of any heavy drinking ($OR = 3.1, p = .011$) throughout the study. In addition, spiritual awakening was significantly associated with a number of other affiliation items (Figure 2), and appeared to exert a mediating effect between affiliation and drinking outcomes. There was also an additive effect, so that a greater number of affiliation behaviors

increased the likelihood of having had a spiritual awakening which, in turn, positively influenced drinking outcomes ($r = .44, p < .001$).

Synthesis

As a three-paper dissertation, this project afforded an opportunity to examine the phenomena of alcoholism and recovery in Alcoholics Anonymous from a variety of perspectives, using markedly different investigational approaches. While each of these papers (Chapters 2, 3, and 4) was written to stand independently, a number of overlapping themes, concepts, and findings emerged that warrant additional comment. At the intersection of all of these stands the construct of relatedness.

In the first paper (Chapter 2), as the normative model for personal stories began to take shape, the role of relatedness became increasingly apparent. During the initial stage of *first or early drinking*, several storytellers described an immediate, profound, and powerful relationship to alcohol. Some spoke as if alcohol were a friend or lover. During the second stage, *alcoholic regression*, involvement with alcohol increased, while other relationships suffered. The third stage, *hitting bottom*, often involved the painful realization of a growing disconnectedness to other referents, while relatedness to alcohol had reached a state of enmeshment. In contrast, the initiation and maintenance of recovery in Alcoholics Anonymous during the fourth and fifth stages (*progress in the AA program*, and *stable sobriety*) required a radical reordering of relatedness to alcohol, self, others, and God or a Higher Power.

AA is often described as both a *fellowship* and a *program* of recovery. In terms of relatedness, the fellowship could be viewed as a richly populated environment in which people are accepted and supported, not *in spite of*, but *because of* their shared

condition of alcoholism. Within this environment—which may be local, national, or international—opportunities are provided to develop, practice, and enhance relatedness competencies, including sense of belonging, reciprocity, mutuality, and synchrony. From a practical standpoint, this is best achieved by “working the steps” (Appendix B).

While the quantitative study on AA attendance, affiliation, and drinking outcomes (Chapter 4) did not directly employ or test the construct of relatedness, the ways in which *affiliation* and *relatedness* aligned with another were noteworthy. Consider the items listed among the affiliation questions (Appendix H), some of which were associated with having had a spiritual awakening. For example, item 3 asked whether an individual considered himself or herself to be “a member of AA,” which speaks to a sense of belonging. Two of the items (6 and 7) asked about having or being an AA sponsor, which are viewed as important relationships in Alcoholics Anonymous. Item 9 inquired about asking an AA member for help; with time and experience, this practice may result in connectedness by way of increased interdependence and a sense of well-being. Item 10 asked about a spiritual awakening, which may suggest connectedness with a spiritual entity. Item 11 asked about each of the Twelve Steps, which were previously shown to refer to specific referents (Table 2). Ultimately, it is possible that each of the relatedness competencies, cultivated in the context of Alcoholics Anonymous, may eventually generalize to relationships across a broader segment of society.

Spirituality is a theme that crosses nursing, Alcoholics Anonymous, and the Theory of Human Relatedness, and was a topic that emerged in all three papers. In relation to personal stories, this occurred most frequently with direct references made to God or a Higher Power, and was mentioned positively in the vast majority of narratives.

With the application of the Theory of Human Relatedness, spiritual entities became specific referents, located within states of relatedness. Among relatedness competencies, spiritual occurrences and interpretations appeared to reside most readily in the realm of synchrony. Finally, in the quantitative study, self-report of a spiritual awakening served as a mediator between other aspects of AA affiliation, and improved drinking outcomes.

While each of the individual chapters identified respective limitations, a few collective concerns warrant consideration as well. For example, a number of elements pertaining to the Theory of Human Relatedness have not yet been sufficiently developed to allow for quantification. Even the most fully developed instrument to date, the Sense of Belonging Instrument (Hagerty et al., 1996) has not yet been tested for reliability and validity in an alcohol-dependent sample. Finally, the utility of this instrument across international samples has yet to be determined.

Future Research and Nursing Care

Based on findings from this dissertation, a number of opportunities present themselves for future research. First, hitting bottom and spiritual awakening each appeared to play critical roles in recovery from alcoholism, yet neither of these phenomena has been adequately studied nor described. Toward that end, mixed methods research (Creswell & Plano Clark, 2007) may be promising, combining qualitative interviews with quantitative measures, and could include including brain-imaging studies, and genetics.

As the most fully developed concept in the Theory of Human Relatedness to date, *sense of belonging* will be incorporated into future alcohol studies, using the Sense of Belonging Instrument (SOBI; Hagerty, Williams, Coyne & Early, 1996), which has

established itself as a reliable and valid scale in other populations. One might expect that sense of belonging would be compromised during active alcoholism. In contrast, sense of belonging might be expected to improve through affiliation with Alcoholics Anonymous.

Clinical implications for these findings include the prospect of better “locating” individuals in their personal stories of alcohol misuse, and tailoring interventions accordingly. For example, states of relatedness to primary referents might serve as earlier and more sensitive indicators for emerging problems with alcohol when compared to traditional clinical signs or symptoms. Beyond that, given the frequency with which personal stories reflected feelings of being different, and not fitting in or belonging—even *before* alcohol use—it would be interesting to determine if this could one day serve as a predictor for future problems with alcohol. Similarly, if alcohol misuse is prompted or fueled by deficits in relatedness competencies, could the enhancement of these competencies serve as a protective factor against future alcohol misuse? In summary, it appears that the nursing Theory of Human Relatedness has the capacity to serve as a unifying theory for future studies in alcoholism and recovery.

References

- Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism*. (4th ed.). New York: Author.
- Cain, C. (1991). Personal stories: Identity acquisition and self-understanding in Alcoholics Anonymous. *Ethos*, 19(2), 210-253.
- Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage Publications.
- Hagerty, B.M.K., Lynch-Sauer, J., Patusky, K.L., Bouwsema, M. (1993). An emerging theory of human relatedness. *IMAGE: Journal of Nursing Scholarship*, 25, 291-296.
- Hagerty, B. M., Williams, R. A., Coyne, J. A., & Early, M. R. (1996). Sense of belonging and indicators of social and psychological functioning. *Archives of Psychiatric Nursing*, 10(4), 235-244.
- Mankowski, E.S., & Rappaport, J. (2000). Narrative concepts and analysis in spiritually-based communities. *Journal of Community Psychology*, 28(5), 479-493.
- O'Reilly, E. B. (1997). *Sobering tales: Narratives of Alcoholism and Recovery*. Amherst, MA: University of Massachusetts Press.
- Sobell, L. C., & Sobell, M. B. (1996). *Timeline Followback: A calendar method for assessing alcohol and drug use: User's guide*. Toronto, Ontario (Canada): Addiction Research Foundation.
- Tonigan, J. S., Connors, G. J., Miller, W.R. (1996). Alcoholics Anonymous Involvement (AAI) scale: Reliability and norms. *Psychology of Addictive Behaviors*, 10(2), 75-80.

Appendix A

DSM-IV-TR criteria for substance dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

- (1) tolerance, as defined by either of the following:
 - (a) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect
 - (b) markedly diminished effect with continue use of the same amount of the substance
 - (2) withdrawal, as manifested by either of the following:
 - (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
 - (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
 - (3) the substance is often taken in larger amounts or over a longer period than was intended
 - (4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
 - (5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects
 - (6) important social, occupational, or recreational activities are given up or reduced because of substance use
 - (7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exasperated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)
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From American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision, pp. 197-198). Washington, DC: Author.

Appendix B

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.
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From Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (4th ed., pp. 59-60). New York: Author.

Appendix C

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.
-

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From Alcoholics Anonymous World Services (AAWS). (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (4th ed., p. 562). New York: Author.

Appendix D

Mutual help groups for alcohol problems: Alternatives to Alcoholics Anonymous

Women For Sobriety (WFS) is both an organization and a self-help program that was created to address the unique needs of women alcoholics. The “New Life” Acceptance Program, which consists of 13 Statements, promotes behavioral changes by (1) positive reinforcement, (2) cognitive strategies, (3) letting the body help, and (4) dynamic group involvement. Meetings are open to all women alcoholics, and are led by a Certified Moderator (WFS, n.d.).

Secular Organizations for Sobriety/Save Our Selves (SOS), a non-profit network of non-professional groups, offers an alternative recovery method to alcoholics or drug addicts who are uncomfortable with the spiritual content of 12-Step programs (SOS, n.d.). The “cycle of addiction” is replaced by “the cycle of sobriety” through the Sobriety Priority, a cognitive approach to behavioral change (SOS, 2000). SOS credits the individual for initiating and maintaining sobriety, without reliance on a “Higher Power” (SOS, n.d.).

Moderation Management (MM) is the only mutual-help organization to offer its members a choice between moderate drinking (Humphreys, 2003) and abstinence, by way of a behavioral change program and national support group network. Members are encouraged to take personal responsibility for their own recovery from a drinking problem, beginning with 30 days of abstinence, followed by a nine-step program of moderation, observing recommended limits for drinking. Those who are unable to initiate or maintain moderation are “encouraged to progress to a more radical solution” (Moderation Management, n.d., p. 3), which may include a traditional 12-Step program.

SMART Recovery® offers free face-to-face and on-line mutual help meetings to assist in recovery from all types of addictive behavior. SMART (Self-Management and Recovery Training) Recovery employs cognitive-behavioral techniques in a 4-Point Program that includes (1) enhancing and maintaining motivation to abstain, (2) coping with urges, (3) problem solving (managing thoughts, feelings and behaviors), and (4) lifestyle balance (balancing momentary and enduring satisfactions). While the SMART approach differs from Alcoholics Anonymous and Narcotics Anonymous, it does not exclude them (SMART Recovery, 2006).

LifeRing is “a network of people who support one another in living free of alcohol and other non-medically indicated addictive drugs” (LifeRing, 2005). Members or not required to follow any particular steps or guidelines, other than staying clean and sober.

Religious and spiritual beliefs, or a lack of these, remain a private matter. Foundational beliefs are summarized in the “Three-S” Philosophy of Sobriety, Secularity, and Self-Help, and members are encouraged to develop a personal recovery program, tailored to individual needs.

From Strobbe, S., Finnell, D. S., Piano, M. (in press). Assessment and treatment of alcohol use disorders. In C. E. Savage (Ed.). *A Nursing Education Model for the Prevention and Treatment of Alcohol Use Disorders*. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Humphreys, K. (2003). A research-based analysis of the Moderation Management controversy. *Psychiatric Services*, 54(5), 621-622.

LifeRing. (2005). *Welcome to LifeRing* [Brochure]. Oakland, CA: LifeRing. Retrieved on January 16, 2007 from <http://www.unhooked.com/lifering.com/brochures/Welcome%20to%20LifeRing.pdf>

Moderation Management. (n.d.). *What is Moderation Management?* Retrieved January 16, 2007, from <http://www.moderation.org/whatisMM.shtml>

Secular Organizations for Sobriety/Save Our Selves. (2000). *The sobriety priority* [Brochure]. Hollywood, CA: Author. Retrieved January 16, 2007 from <http://www.sossobriety.org/sobrietypriority.htm>

Secular Organizations for Sobriety/Save Our Selves. (n.d.). *What is SOS?* Retrieved January 16, 2007 from <http://www.sossobriety.org/whatissos.htm>

SMART Recovery. (2006). *Introduction to SMART Recovery*. Retrieved January 16, 2007 from <http://www.smartrecovery.org/intro/>

Women For Sobriety. (n.d.). *Women & addictions: A way to recovery* [Brochure]. Quakertown, PA: Author.

Appendix E

Contact information for mutual-help groups for alcohol problems

Alcoholics Anonymous World Services, Inc.

P.O. Box 459

New York, NY 10163

Phone: (212) 870-3400

Web-site: <http://www.alcoholics-anonymous.org>

LifeRing Service Center

1440 Broadway, Suite 312

Oakland, CA 94612

Phone: (510) 763-0779

Toll-Free: 1-800-811-4142

Fax: (510) 763-1513

E-Mail: service@lifering.org

Web-site: <http://www.unhooked.com>

Moderation Management Network, Inc.

22 West 27th Street, 5th Floor

New York, NY 10001

Phone : (212) 871-0974

Fax: (212) 213-6582

E-mail: mm@moderation.org

Web-site: <http://www.moderation.org>

Secular Organizations for Sobriety

4773 Hollywood Blvd.

Hollywood, CA 90027

Phone: (323) 666-4295

Fax: (323) 666-4271

E-mail: sos@cfiwest.org

Web-site: <http://www.sossobriety.org>

SMART Recovery

7537 Mentor Avenue, Suite 306

Mentor, OH 44060

Phone: (440) 951-5357

Toll-Free: 1-866-951-5357

Fax: (440) 951-5358
E-mail: info@smartrecovery.org
Web-Site: <http://www.smartrecovery.org>

Women For Sobriety, Inc.
P.O. Box 618
Quakertown, PA 18951-0618
Phone: (215) 536-8026
Fax: (215) 538-9026
Web-site: <http://www.womenforsobriety.org>

From Horvath, V. (2005). Alternative support groups. In J. H. Lowinson, P. Ruiz, R. B. Millman, J. G. Langrod (Eds.), *Substance Abuse: A Comprehensive Textbook* (4th ed., pp. 599-609). Philadelphia, PA: Lippincott Williams & Wilkins.

Appendix F

Assumptions from the Theory of Human Relatedness

1. Human growth and development occur within the context of relatedness.
 2. Persons ascribe meaning to their experiences and this is influenced by their sense of self.
 3. Persons are capable of pro-activity in changing their relatedness experiences.
 4. An important aspect of well-being is the affective realm.
 5. Relatedness is a universal phenomenon but its expression, processes and patterns vary according to such factors as gender, race, culture and life-span development.
 6. Persons experience internal and external rhythmic patterns which are interactive.
 7. Persons are capable of exercising both choice and responsibility in their relatedness experiences.
 8. Persons experience sensitive periods during which interventions can influence the nature of their relatedness experiences.
 9. Persons experience relatedness both internally and externally.
-

From Hagerty, B. M., Williams, R. A., Coyne, J. A., & Early, M. R. (1996). Sense of belonging and indicators of social and psychological functioning. *Archives of Psychiatric Nursing, 10*(4), 235-244.

Appendix G

Alcoholics Anonymous Preamble ©

Alcoholics Anonymous ® is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions. A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

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Retrieved January 15, 2007 from http://www.alcoholics-anonymous.org/en_information_aa.cfm

Appendix H

Alcoholics Anonymous affiliation questions

SINCE THE LAST STUDY VISIT:

1. Have you attended any AA meetings?
2. How many AA meetings have you attended?
3. Have you considered yourself to be a member of AA since the last study visit?
4. Have you been to more than five AA meetings in any one week since the last study visit?
5. Have you celebrated an AA sobriety birthday since the last study visit?
6. Have you had an AA sponsor since your last study visit?
7. Have you been an AA sponsor since your last study visit?
8. Have you read AA literature (for example, books, pamphlets, etc.) since the last study visit?
9. Have you called an AA member for help since the last study visit?
10. Have you had a spiritual awakening since the last study visit?
11. Which of the Twelve Steps have you worked SINCE THE LAST STUDY VISIT?
 - _____ 0. I have never worked any of the Twelve Steps
 - _____ 1. I have worked the First Step
 - _____ 2. I have worked the Second Step
 - _____ 3. I have worked the Third Step [etc., through the Twelfth Step].

Scoring: Items 3 and 5-9 were scored as 1 or 0 (zero) for yes or no responses. Values for Item 2 were obtained from the modified Timeline Followback (TLFB). AA meeting attendance and the number of steps worked were recoded to a 0.10-0.90 scale using procedures described by Tonigan et al. (1996). For post-hoc analysis, when examining relationships between spiritual awakening and other affiliation variables, items 10 and 11.12 were eliminated due to their specific mention or direct correspondence to spiritual awakening.