

A CRITIQUE OF A.A. FROM AN ANTI-OPPRESSIVE PERSPECTIVE

A CRITIQUE OF ALCOHOLICS ANONYMOUS FROM
AN ANTI-OPPRESSIVE PERSPECTIVE

By

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Abstract

Substance abuse is a serious and long-standing problem that causes significant personal, social and financial hardship in our society. In response to the difficulties stemming from alcohol problems, Alcoholics Anonymous (A.A.) was formed to help individuals adopt and maintain a goal of abstinence. A.A. is well-known in our society and in fact has been referred to as “the major force dealing with alcoholism today” (Murray et al, 2003: 26) that has shaped society’s view of addiction (Le et al., 1995). While the literature has clearly documented the role that self-help groups such as A.A. can play in assisting people to achieve and maintain sobriety (Burman, 1997), there are fewer studies that take a critical approach, examining A.A.’s limitations. This study provides an important contribution by giving an opportunity for individuals who have expressed some dissatisfaction with A.A. to have their voices heard concerning how A.A.’s practices and beliefs have shaped their experiences. Using an anti-oppressive practice perspective, this study draws attention to issues of power and oppression within the A.A. organization, identifying the structural dimensions that serve to marginalize problem drinkers.

This research project is an exploratory, qualitative study conducted within an interpretive, critical framework. The sample consisted of six Caucasian women, four who continue to attend A.A. and two who attended A.A. in the past. While the participants in this study conceptualized their involvement in A.A. in a variety of ways, for the most part they confirmed the following concerns that have been raised in the critical literature about this organization: A.A. is a patriarchal institution that oppresses women; A.A. promotes the disease model of alcoholism which fosters powerlessness in people’s lives; blaming the individual shifts the focus away from structural issues; labelling increases stigma which contributes to the marginalization of problem drinkers; and A.A. excludes full participation in society. The theme most evident throughout the study was one of powerlessness. Drawing on the participants’ experiences, recommendations are presented in order to develop a model of support that fosters empowerment and self-efficacy, recognizes people’s strengths and abilities, and takes into consideration a diversity of needs.

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Chapter 1: Introduction

Although the majority of people who drink alcohol do so in moderation, a substantial number do not and consequently experience alcohol related problems in their lives. According to the Canadian Addiction Survey, 17% of current drinkers in Canada engage in hazardous drinking behaviour (Adlaf et al., 2005). Hazardous drinking is defined as an established pattern of drinking that increases the likelihood of future physical and mental health problems (Adlaf & Ialomiteanu, 2002). Ontario statistics fare better at 6.9% of drinkers, but it is important to realize that this translates to a staggering number of 501,500 people in Ontario alone (Ibid).

Alcohol abuse results in significant costs to society, estimated in Canada at over fourteen billion dollars (Rehm et al., 2006). In addition to financial costs, there is also great personal suffering and social costs. These costs are often devastating not only for problem drinkers but for those who are impacted by someone else's drinking. Alcohol abuse is associated with homicide, suicide, sexual violence, partner abuse (Buddie, 2004), traffic accidents, crime, family breakdown and fetal alcohol syndrome (Pagano et al., 2004).

In response to the difficulties stemming from alcohol problems, Alcoholics Anonymous (A.A.) was formed to help individuals adopt and maintain a goal of abstinence from alcohol. The following is a description of A.A. appearing in the A.A. literature and cited frequently at A.A. meetings:

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 (Alcoholics Anonymous, 2005).

A.A. is referred to as “the major force dealing with alcoholism today” (Murray et al, 2003: 26) that has shaped society’s view of addiction (Le et al., 1995). Emrick (1989) notes that A.A. has a great stronghold on the treatment of alcohol problems in North America. He states that “the sociopolitical/socioreligious influence of A.A. extends to nearly all efforts to help those who suffer from alcohol problems, making it the norm to recommend that A.A. membership become a central, if not the only component in a person’s endeavor to stop abusing alcohol” (Emrick, 1989: 4). It is also important to note that A.A. is the predominant influence on chemical dependency treatment programs in the United States today (Li et al., 2000; Le et al., 1995).

In the last fifteen years, increasing scientific attention has been directed to understanding and assessing the influence of self-help organizations in the context of substance-use disorders and their treatment (Kelly, 2003). While the literature has clearly

documented the role that self-help groups such as A.A. can play in assisting people to achieve and maintain sobriety (Burman, 1997), there are fewer studies that take a critical approach, examining A.A.'s limitations. As well, studies reveal that substance abusers' attitudes about twelve-step programs have received little empirical attention (Laudet, 2003). Tonigan et al. (2000) recently wrote: "conspicuously absent from the literature has been the measurement of the subjective reactions of individuals to A.A. related practices and beliefs" (cited in Laudet, 2003: 2023). This study will provide an important contribution by giving an opportunity for individuals who have expressed some dissatisfaction with A.A. to have their voices heard concerning how A.A.'s practices and beliefs have shaped their experiences. In turn, it is hoped that this information will be used to generate recommendations that can be implemented when developing support groups for problem drinkers.

A second contribution of this study is that it will present the limitations of A.A. within a theoretical framework that seeks to identify the larger structural forces at play. While the research literature serves to inform readers about the limitations of A.A., existing scholarship (with the exception of some articles grounded in feminist theory) does not generally acknowledge the structural dimensions of power and oppression that serve to marginalize problem drinkers. It is the goal of this research project to offer a critique of A.A. within an anti-oppressive framework.

The research question for this project is: Among problem drinkers who have expressed dissatisfaction with A.A., how did oppressive aspects of A.A. beliefs and practices shape their experiences? A sub-question will be: Among problem drinkers

who have expressed dissatisfaction with A.A., what are the most valued features of a support group? Problem drinkers are defined as those who abuse alcohol, and according to the Diagnostic and Statistical Manual of Mental Disorders, their use results in one or more of the following:

Failure to fulfill major role obligations at work, school or home; continued drinking even in situations where it is physically hazardous; recurrent alcohol-related legal problems; or continued drinking despite persistent or recurrent social or interpersonal problems it may cause (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition).

Being mindful of the importance of researchers locating themselves, that is, making a claim about one's investment and intent to "ensure that those who study, write and participate in knowledge creation are accountable for their own positionality" (Absolon & Willett, 2005), it is necessary that I inform my readers why I have chosen to focus on the oppressive features of A.A. as a topic for this research project. My interest in this area of study began several years ago during my employment as a social worker at the Alcohol, Drug & Gambling Services (ADGS). One reason that I chose ADGS as a place of employment was because it matched my philosophy of respecting clients' choice of goals and methods of intervention. Unlike many addiction agencies, ADGS respects the goal of harm reduction, as well as abstinence. Soon after being hired, I attended intensive training to become a DrinkWise facilitator. DrinkWise is a psychoeducational

program that helps people with mild to moderate alcohol problems learn the skills needed to achieve and maintain a goal of low-risk drinking. This program has been scientifically tested and has shown excellent success in helping people eliminate alcohol-related problems in their lives. My experience as a DrinkWise facilitator confirms the success of this program and has caused me to question the usefulness and validity of the A.A. approach, particularly A.A.'s endorsement of the disease model of alcoholism, which equates recovery with total and lifelong abstinence from alcohol.

The DrinkWise Program is criticized by many in the community who do not endorse programs that support low-risk drinking or harm reduction goals. As the facilitator of DrinkWise, I have been accused of misleading alcoholics into thinking that they can drink in moderation and have been called an 'enabler'. Often times these individuals are not open to hearing what the research has to say in regards to this issue. The literature speaks to my experience stating that "the disease concept of addiction enjoys such wide acceptance in society that anyone who questions it may be regarded as a heretic, misguided or misinformed" (Miller, 1986, cited in Chiauzzi & Liljegren, 1993: 304).

For obvious reasons, my clients who were attempting to maintain a goal of low-risk drinking did not find A.A. to be a viable support group. But I also found that regardless of a client's choice of treatment goal (abstinence or low-risk drinking), many did not get their needs met at A.A. and expressed dissatisfaction with A.A.'s practices and beliefs. Areas of dissatisfaction included: not wanting to label oneself as an alcoholic; not wanting to perceive oneself as powerless; not wanting to 'admit' to having

a disease; and not wanting to commit to lifelong regular attendance at a support group. Listening to this feedback over the years has caused me to question whether or not A.A. should be the major force dealing with alcoholism today and whether it should be the norm to recommend that A.A. membership become a central component in a person's endeavor to stop abusing alcohol.

I am also aware that my location as a social worker influences my perception of A.A.'s practices and beliefs. There are inconsistencies between the philosophies of A.A. and social work that create some tension for me as a social work practitioner, making it more likely that I might question A.A.'s approach. While A.A. promotes the idea of powerlessness, social workers strive to encourage clients to find ways to empower themselves in order to increase their well-being. While A.A. encourages its members to identify their moral defects, social workers encourage clients to identify their strengths so that they can take positive steps in their lives. Clearly, my social work values have influenced me to take a critical look at A.A. and the effect it has on its members.

On a last note, I do believe that it is important to point out that I have seen many people helped by A.A. It has been my experience that A.A. as well as other support groups require a matching process to decide what group modality best suits the needs of different individuals, at different times in their lives and at different points in their recovery. I am not opposed to referring clients to A.A. At the same time, I respect clients' experiences when A.A. is not helpful, and am committed to assisting them in finding alternative supports in the community that may better meet their needs.

Chapter 2: Literature Review

Origins and Current Membership of Alcoholics Anonymous

Alcoholics Anonymous was founded in 1935 in Akron, Ohio, by Dr. Bob Smith and Bill Wilson, two men that the A.A. literature describes as ‘hopeless alcoholics’ (Alcoholics Anonymous, 2005). Both men had been in contact with the Oxford Group, a non-denominational evangelical movement that was in many ways the parent group of A.A. Founded in 1908, the Oxford group was primarily active in the 1920s and 1930s and was comprised of a small group of people who came from a strong Christian background and who hoped to create “a human chain of good relationships based on honesty and moral principles that would change the world” (Kasl, 1992: 139). The Oxford Group stressed the following principles that became part of the twelve step approach that has come to define A.A.: deflation of the ego, humility, confessing one’s defects, and being willing to make restitution.

Wilson’s connection to the Oxford Group was part of a chain of events that led him to form A.A. In December of 1934, he was in the late stages of alcoholism and had been hospitalized on several occasions as a result of his deterioration. One day, he visited with an old drinking buddy who described finding religion through the Oxford Group, a discovery which enabled him to stop drinking. Wilson could not get over how his friend had changed. Shortly after this visit, Wilson was hospitalized with delirium tremens, facing the possibility of death. It is written that Wilson cried out:

I'll do anything... If there be a God, let Him show Himself. He recounts, what happened next was electric. Suddenly my room blazed with an indescribably white light. I was seized with an ecstasy beyond description....There I humbly offered myself to God, as I then understood Him, to do with me as He would.... I admitted for the first time that of myself I was nothing; that without Him I was lost. I ruthlessly faced my sins and became willing to have my new-found Friend take them away, root and branch. I have not had a drink since (Ibid: 140-141).

Wilson attended Oxford Group meetings for a few years, and it was at an Oxford Group meeting that Wilson and Smith met. Though he was a physician, Smith had not conceptualized alcoholism as a disease. Wilson shared with Smith his belief that alcoholism is an illness of the mind, emotions and body, a framework he had learned from Dr. Silkworth of Towns Hospital in New York where Wilson had often been a patient. He also shared with Smith the current twelve steps. Smith, who had not been able to achieve sobriety solely through the Oxford group, responded to Wilson's ideas and beliefs and achieved sobriety, apparently never to drink again. The founding spark of A.A. had been struck (Ibid).

Both men worked diligently with alcoholics at Akron's City Hospital, where one patient quickly achieved sobriety. Though the name *Alcoholics Anonymous* had not been formalized, these three men were the original members of the first A.A. group. In 1939, the Fellowship published *Alcoholics Anonymous*, or what is better known in A.A. circles

as the 'Big Book'. This book, written by Wilson explains A.A.'s philosophy and methods, including the twelve steps and twelve traditions. From this point on, A.A.'s development was rapid (Ibid).

The A.A. group has expanded significantly but because it does not keep formal membership lists, it is difficult to obtain accurate figures on the number of members who attend. It is estimated that there are more than 100,000 groups and over 2,000,000 members in 150 countries (Ibid). The 'Big Book' has been translated into over twenty-five languages (Lile, 2003).

While A.A. is popular with many individuals, it is important to note that many problem drinkers never attend (Laudet, 2003) or drop out at high rates. Approximately 50% of new attendees stop attending meetings within three months (Lile, 2003). A study by Tonigan et al. determined that 50% of substance users seeking treatment had attended A.A in the past year and that an additional 28% had attended A.A. sometime before this. However, 69% of the sample had completed fewer than two A.A. steps, and 50% had attended fewer than five meetings in the past year. Thus, we can conclude that while A.A. attendance is common for problem drinkers, sustained involvement is relatively low (Walters, 2002).

The Twelve Steps

To assist members on the journey to sobriety, A.A. offers a fellowship, as well as its Twelve Steps: "a program of abstinence from alcohol, acceptance of being alcoholic, honest self-examination, atonement for past wrongs, spiritual reflection, and service to other alcoholics" (Humphreys, 2000: 496). A.A. is conceptualized primarily as a

spiritual program, demonstrated by the fact that seven of the twelve steps refer to spiritual transformation, whereas only one mentions alcohol (Ibid). The heart of the program is organized around these steps which describe the experience of the earliest members of the Society:

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.
(Alcoholics Anonymous, 2005)

In addition to the Twelve Steps, there are Twelve Traditions that assure the survival of the informal structure of the Fellowship. (See appendix)

Efficacy of Alcoholics Anonymous

The effectiveness of A.A. has been an issue of controversy that has sparked impassioned debates. Certainly there is considerable personal testimony and reports from thousands who believe that the organization has saved their lives. Some claim that the effectiveness of A.A. has not been scientifically established because A.A. has been insufficiently studied. This particular claim is simply not true; between 1940 and 1992 there were approximately 125 studies on A.A., and between 1993 and 2001, there were 118 empirical studies. Yet other participants in this debate criticize the existing studies on methodological grounds. A review of the literature found mixed results regarding this criticism. Some literature argues that methodologically rigorous research in the past ten years has come to similar conclusions as prior research that was not as methodologically sound (Zemore et al., 2004; Kelly, 2003). Other researchers state that methodology

continues to be a problem. For instance, Peele argues that the research base in A.A. is primarily cross-sectional and correlational in nature, raising the possibility that there is no causal connection between A.A. participation and better outcome (McKellar et al., 2003). Walters, a critic of A.A., states that research on A.A. has proven inconclusive. He states “whereas Emrick et al. uncovered a modest relationship between A.A. involvement and decreased drinking in 16 studies, several of the more methodologically sound attendance-outcome studies have failed to discern a relationship between A.A. attendance and follow-up outcome” (Walters, 2002: 57). He further argues that the anonymity of A.A. membership, the voluntary nature of A.A. participation and difficulties in attaining comparable groups makes conducting research on A.A. extremely difficult (Ibid). Valliant agrees with this, stating that empirical information on the efficacy of A.A. is hard to come by. He identifies three problems in this area. First, A.A. as an organization is not interested in participating in research. Second, “because of ideological differences and unconscious rivalry, medical researchers sometimes have difficulties in assessing A.A. without bias” (Vaillant, 2004: 433). Finally, due to the chronic nature of alcoholism, alcoholics encounter many different kinds of interventions, often simultaneously, making it difficult to do a truly controlled study (Ibid). That said, I will attempt to provide a summary of the most recent research on the effectiveness of A.A.

A summary of the research

Many reviews consistently conclude that twelve-step participation can enhance treatment outcomes (measured in terms of reduced alcohol consumption) among

problem-drinkers (Zemore et al., 2004; Laudet, 2003; Kelly, 2003; Morgenstern et al., 1997). Treatment refers to addiction-specific out-patient or in-patient counselling provided by substance abuse treatment providers. It is important to note that this research shows that it is the *combination* of A.A. attendance and treatment that is associated with *optimal* outcomes. A.A. attendance without professional treatment does not routinely result in better outcomes (Taleff, 2003), nor does treatment alone without A.A. result in better outcomes (Moos & Moos, 2004). This does not mean that A.A. alone offers less than treatment alone. A well known study, Project MATCH, compared the effectiveness of A.A. and two treatment protocols with almost 2000 alcoholic patients and arrived at several interesting conclusions. It revealed that during the first year, A.A. alone was as effective as the two most effective professional alternatives: cognitive behavioural and motivational enhancement therapies. Second, the study showed that regardless of the original protocol (cognitive behavioural, motivational, or Twelve Steps) the more A.A. meetings attended the better the outcome (Vaillant, 2004).

Higher intensity of involvement with A.A. has been associated with a reduction in alcohol consumption. Individuals who attend A.A. regularly experience better alcohol-related outcomes than do individuals who attend infrequently or irregularly (Moos & Moos, 2004).

Research suggests that A.A. is more effective for some people than others. Project MATCH found that twelve-step programs were especially effective among individuals with severe alcohol problems and among those without persistent and severe psychiatric illnesses (Buddie, 2004).

Although most studies have found A.A. to be modestly effective, other studies have found that positive outcomes associated with A.A. attendance often decline after six or twelve months (Gossop, 2003).

Watson et. al (1997) note that findings from studies of twelve-step interventions range from highly successful to potentially harmful for certain clients. Other researchers state that some studies have found no significant benefit from twelve-step interventions (Lile, 2003).

Clearly, the literature reflects the on-going controversy of the efficacy of A.A. It is not my intent to come to a firm conclusion about this debate. While it may be reasonable to state that A.A. is modestly effective for some people, I am interested in examining the negative impact that A.A. has on people, outside of effectiveness. This critique will be from an anti-oppressive practice perspective.

Anti-oppressive Practice – what is it?

Anti-oppressive practice is a framework that draws upon several approaches such as feminist, critical, anti-racist, post-structural, and post-modern theories of practice. It is concerned about issues of power and oppression within the delivery of social work services as well as within the lives of individuals who have been marginalized and oppressed. An anti-oppressive framework strives to deindividualize clients' problems in order to understand them within a wider social context. As well, this framework seeks to move away from an expert model of service delivery towards one that is inclusive of individuals' experiences and strengths. Central to this approach is a commitment towards

changing relationships and institutions that perpetuate the exclusion of marginalized groups of people (Pollack, 2004).

It is important to note that this paper does not conceptualize members of A.A. as an oppressed group in the traditional sense. They are not subject to inhuman or degrading treatment brought about by the dominance of one social group over the other. Although class, race and gender do not predict addiction, many people joining self-help groups such as A.A. are from disempowered groups: women, people of colour, unemployed and underemployed people and poor people (Morell, 1996). Oppression operates through social institutions, and A.A. is one such institution that reinforces structures of oppression such as sexism and racism that further perpetuates the marginalization of people. A.A. as an institution, regardless of its intentions, exercises oppression in that it limits the lives, experiences, and opportunities of its members (Lee et al, 2005). It also adds to the oppression of individuals who are already disadvantaged by the label ‘alcoholic’. A.A. in effect contributes to the on-going marginalization of problem drinkers.

Young provides a framework incorporating five forms of oppression that explains how inequality is maintained. Three of these forms are relevant to the critique of A.A. “Marginalization” excludes whole groups of people from useful and meaningful participation in society which can lead to the inability to secure material needs. Even when material deprivation is not present, marginalization may still occur when individuals are “excluded from meaningful participation and cannot exercise their capacities in socially defined and recognized ways” (Mullaly, 2002: 43-44).

“Powerlessness” consists of inhibitions in the development of one’s capacities, a lack of decision-making power in one’s life, and exposure to disrespectful treatment because of the status one occupies. “Violence” is experienced by oppressed groups simply because they are members of a particular group (Ibid).

The next section of this literature review will examine Alcoholics Anonymous with an anti-oppressive practice lens, and will attempt to identify facets of oppression within this institution.

Alcoholics Anonymous is a patriarchal institution that oppresses women

Alcoholics Anonymous was developed by two white males (Abbott, 1994), and initially was a program run by men for men. One of the titles considered for A.A.’s Big Book, was *One Hundred Men*. In the early days of A.A., women were not allowed to attend this Fellowship because of the stereotype “nice women don’t become drunks”. Four years after its conception, A.A. opened its door to the first female member, Marty Mann (Berenson, 1991). Since then the percentage of women has grown to 35% of the total membership (Alcoholics Anonymous, 2005). In spite of this increase in membership, studies indicate that women continue to feel out of place at A.A. meetings. In one study of almost 600 attendees of Women For Sobriety, a self help group based on the philosophy of empowerment, women reported several reasons for not attending A.A including: feeling that they never fit in, finding A.A. too negative and focused in the past and finding that it was driven by the needs of men (Kaskutas, 1994, as cited in Buddie, 2004). Sonia Johnson (1989) agrees that A.A. contributes to patriarchy stating:

Alcoholics Anonymous is simply another male institution, different in neither quality nor kind from the churches or schools or political parties or from any other group dedicated to maintaining men's oppressive and destructive value structure and hierarchy. There are no new values there, nothing that is recognizable as nonparadigmatic to patriarchy.... Recovery groups – particularly when they center around the Twelve Steps of A.A. – often have the same self-abasing, powerless external focus, an ultimate rejection of responsibility inherent in male religion and politics (Berenson, 1991: 68).

The fact that A.A. started out as a men's group and continues to be patriarchal in nature fits with Mullaly's belief that "when a hierarchy becomes established, a dynamic of superiority-inferiority or domination-subordination is inevitable, and there is difficulty maintaining the conceptualization of the lesser (inferior) person having as much intrinsic worth or value as the superior person. Once a group is defined as inferior, the label tends to become permanent" (Mullaly, 2002: 31). Because of A.A.'s male dominated approach, some feel that although this fellowship works with many problem drinkers, it may be relatively unlikely to help women (Galaif & Sussman, 1995).

This dynamic of superiority-inferiority, marked by differences in power and status (Mullaly, 2002) has made it difficult for women to question A.A.'s practices and philosophy. Kasl, in her critique of the twelve steps states that it is not surprising that it

has taken women nearly fifty years to start questioning the A.A. model due to the fact that women have been socialized to be loyal to male institutions and protect male egos.

The tenth A.A. tradition also serves to erect a barrier to questioning A.A.'s practices and beliefs by reinforcing a silence around criticisms generally. It states:

No A.A. group or member should ever, in such a way as to implicate A.A., express any opinion on outside controversial issues – particularly those of politics, alcohol reform, or sectarian religion. The Alcoholics Anonymous groups oppose no one. Concerning such Matters they can express no views whatever (Alcoholics Anonymous, 2005).

Kasl reports that many women have been criticized for questioning the twelve-step approach, especially in settings dominated by men or women who are rigidly attached to the model. She writes about one woman in a training program for chemical dependency counselors who questioned the program's male God-language, and was told that if she "kept that up" she would be asked to leave the training program. Another woman reported that in order to keep her job as a counselor, she had to keep quiet about her disagreement with the A.A. philosophy. Kasl argues that this "perpetuates oppression – dutiful obedience at the cost of honesty and self-affirmation" (Kasl, 1992: 10-11).

The dynamic of superiority-inferiority is evident in A.A. meetings. Studies indicate that when people with varying degrees of power come together in groups, the language patterns of the members who hold more status and power predominate (Reed,

1987 as cited in LaFave & Echols, 1999). Thus, in mixed-sex groups, both women and men adopt traditional patterns of interaction. Women may not discuss topics that are important to them because they feel that they are not relevant to men. This problem is exacerbated when men outnumber women in a mixed-sex group, as is the case with A.A. (LaFave & Echols, 1999). The fact that A.A.'s philosophy and practices reinforce traditional gender-roles should not be taken lightly. Studies show that having a traditional gender-role orientation has been associated with higher rates of depression, lower self-esteem, and lower self-confidence for women (Wilke, 1994), creating further oppression in women's lives.

A criticism of A.A. over the years is that it pushes powerlessness on people who are already powerless in the dominant culture (Davis & Jansen, 1998). Kasl notes that A.A.'s initial members were argumentative, self-willed men who needed to change their behaviour and make amends for the damage they had caused (Berenson, 1991). Wilke states that men are socialized to be powerful and dominant and may need an experience of humility to achieve recovery from problem drinking. Women, however, are socialized to be passive and dependent and may need to be empowered to develop and maintain a positive self-image (Wilke, 1994). The first A.A. step – admitting to powerlessness – may be problematic for some women who have been feeling powerless all of their lives (Zilberman et al., 2002).

A.A.'s practice of understanding alcoholics as individuals with character defects serves to increase powerlessness in the lives of women struggling with problem drinking. A.A. maintains that alcoholism is rooted in self-centeredness and grandiosity, as

evidenced by behaviours such as not acknowledging shortcomings, and ignoring the needs of others (Humphreys, 2000). The fourth A.A. step states “we made a searching and fearless moral inventory of ourselves” (Alcoholics Anonymous, 2005). The object of this step is explained by way of a business analogy: “A business which takes no regular inventory usually goes broke. Taking a commercial inventory is a fact-finding and a fact-facing process... one object is to disclose damaged or unsalable goods, to get rid of them promptly without regret” (Alcoholics Anonymous, 2005). The expectation of removing immoral or unwanted aspects of the self can result in an individual experiencing exaggerated shame and guilt and a feeling of failure if the defects cannot be removed (Le et al., 1995). Step six states “we were entirely ready to have God remove all these defects of character” (Alcoholics Anonymous, 2005). Now that shame has been produced, members prepare to have their defects removed by a higher power. The person is first discredited, then left dependent on outside forces to make changes in the self (Le et al., 1995).

Focusing on one’s defects is particularly a problem for substance-abusing women. Studies show that they experience higher levels of guilt, shame, depression and anxiety about their addiction than men (Nelson-Zlupko et al., 1995; Angove & Fothergill, 2002). Other studies show that women alcoholics have significantly lower self-esteem than male alcoholics and women in general (Van Den Bergh, 1991). In addition to this, women are socialized to internalize problems making them more likely to see themselves as the sole cause of a problem, rather than take a more balanced ecological view (La Fave & Desportes Echols, 1999). Dominelli states that “the bottom line is that oppressive

relations target people's sense of self, that is, who they are" (Dominelli, 2002: 9). Similarly, Mullaly (2002) notes that oppression interferes with the development or maintenance of a healthy identity – the very thing that is needed to tackle one's oppression and oppressors. A.A.'s practice of stripping away power, and focusing on defects serves to not only produce oppression in women's lives, but also undermines women's abilities to resist this process.

A final example of oppression of women in A.A. is found in the practice of '13th stepping'. This is a term used in the A.A. fellowship to describe the practice of members (usually men), who try to "pick up" more vulnerable members (usually women) for dates or sex (Bogart & Pearce, 2003: 43). A study by Bogart and Pearce found that 13th stepping behaviours amongst A.A. members are fairly common. Out of a sample of 55 participants, at least half had reported such behaviours which included feeling intimidated, receiving unwanted hugs, being asked for phone numbers, receiving unwanted calls, hearing sex-related comments, experiencing "passes" and feeling pressured to have sex (Ibid). It is noteworthy that in a study with 55 women, two reported being raped by men from A.A.

Bogart and Pearce discuss the connection between childhood sexual abuse and 13th stepping. They found that many survivors of childhood sexual abuse have had their capacities to resist sexual advances compromised. This makes them particularly vulnerable to becoming victims of sexual abuse within the A.A. community (Ibid).

The slogan, "13th-stepping does not happen to victims, but only volunteers" reiterated by some A.A. members, further perpetuates the oppression of women. This

attitude reflects rape myths such as “many women have an unconscious wish to be raped, and may then unconsciously set up a situation in which they are likely to be attacked” (Ibid: 47).

From an anti-oppressive perspective, it is disconcerting that the practice of sexual harassment in A.A. is sufficiently widespread as to have been incorporated into the organizational jargon. Thus it appears to be part of the A.A. culture. Referring to this oppressive behaviour as one of the ‘steps’ validates its occurrence and further oppresses women (Ibid).

Alcoholics Anonymous promotes the disease model of alcoholism which fosters powerlessness

According to Young, powerlessness is a form of oppression consisting of inhibitions in the development of one’s capacities, marked by a lack of decision-making power in one’s life, and exposure to disrespectful treatment because of the status one occupies (Mullaly, 2002). A vast amount of research evidence demonstrates that powerlessness is a significant health risk factor, and conversely, having power and control in one’s life contributes to health and wellness. This research points to the importance of the social environment in determining one’s overall physical and mental health (Bergsma, 2004).

This theme of powerlessness is central to the disease model of alcoholism which is supported by the Fellowship of Alcoholics Anonymous. This critique will provide examples of how powerlessness plays out in the lives of problem drinkers. Before these examples are provided, it is important to clarify a point of confusion in the literature.

Some writers attempt to separate the disease model of alcoholism from the Fellowship of A.A. (Kurtz, 2002), and in fact A.A.'s tenth tradition of having no opinion on outside issues is often cited in this regard. But one only has to look at A.A.'s written material to conclude that A.A. supports this model. The following quotes from A.A. information found on their web site demonstrate this allegiance:

We in A.A. believe alcoholism is a disease that is no respecter of age, sex, creed, race, wealth, occupation, or education. It strikes at random (Alcoholics Anonymous, 2005).

All available medical testimony indicates that alcoholism is a progressive illness, that it cannot be cured in the ordinary sense of the term, but that it can be arrested through total abstinence from alcohol in any form (Ibid).

What is the disease model of alcoholism?

This model is characterized by the following five beliefs:

1. **Alcoholism is a unitary disease** – this assumption is based on the belief that there are two kinds of people: alcoholics and nonalcoholics. Alcoholism is seen as a binary condition that is qualitatively, not quantitatively distinct from normality. As with pregnancy, either one is an alcoholic or one is not, and there are only stages of development, not continuous gradations (Miller, 1993).

2. **Alcoholism is caused by physical abnormalities** – proponents of the disease model believe that the causes of alcoholism are purely physiological and are found in genetically determined factors such as abnormal metabolism and brain chemistry. These physiological factors are identified to account for the racial differences in alcohol problems. Asserting that somewhere around 80-90% of Native Americans have alcoholism, Milam and Ketcham in their review of the disease model (1983) confidently state that “physical factors – not psychological, social, or cultural factors – explain these different ethnic susceptibilities to alcohol” (Ibid: 130). Psychological and social factors are simply seen as resulting from alcoholism, and the belief that psychosocial factors contribute to alcohol problems has been dismissed as a myth (Ibid).
3. **Alcoholism is marked by a loss of control and insatiable cravings** – it is believed that one sip of alcohol is catastrophic and is likely to lead to a full blown relapse (Buddie, 2004; Heather, 1992). Loss of control is usually presented as common sense in light of the belief that alcoholism is a physiological deficit, rather than a psychological problem. Within the disease model, it is firmly believed that the alcoholic is powerless to control his reaction to alcohol (Miller, 1993).
4. **Alcoholism is irreversible** – this assumption states that once an alcoholic, always an alcoholic, implying that abstinence from alcohol must be a life long goal (Ibid). If drinking is continued, the belief is that it will lead to further deterioration, insanity and death. A.A. slogans, such as “once an alcoholic,

always an alcoholic” and “one drink, one drunk” describe the spirit of the disease model (Heather, 1992).

5. **Denial of the severity and consequences of drinking is a symptom of the disease** – anyone suspected of having an addictive disease who insists that they do not have the disease is guilty of being in denial. In this way, the disease label is like a web that traps a person more firmly the harder the person tries to get out of it (Peele & Brodsky, 1991).

Based on the above beliefs, the implication for treatment is obvious: abstinence from alcohol must be total and lifelong.

Critique of the Disease Model of Alcoholism

Every major assumption of the disease model of addiction has been refuted by scientific research (Peele & Brodsky, 1991). Distributions of alcohol consumption, problems, and dependence reflect continuous variation, rather than a binary pattern, indicating that alcoholism is indeed not a unitary disease (Miller, 1993). Among the most important references regarding genetic factors are the studies on twins, genetic markers, adoption and the neuro-biological and neuro-behavioural theories (Suijsa, 1993). Most of these studies focus on the transmission of and the vulnerability to genetic factors of alcoholism, ignoring research related to the environmental, psychological, and social factors influencing the development of alcohol problems (Ibid; Heather, 1992). A summary of the literature indicates that because of numerous methodological problems,

the results confirming a genetic transmission as opposed to a multi-factorial model of addiction are weak. For example, there are North American aboriginal communities with high rates of alcoholism that show no signs of genetic markers of alcoholism (Suissa, 2003).

Two important bodies of literature pertaining to controlled drinking and spontaneous recovery also provide evidence that the disease model is flawed. Despite the widely held notion that for the recovering alcoholic “one drink equals one drunk”, data on long term outcomes following treatment for an alcohol problem suggest that moderation is an achievable goal (Marlatt & Witkiewitz, 2002). Studies report that between 5 and 20% of patients treated in abstinence-oriented programs were found to be drinking without problems at follow up (Crandell, 1987). The Rand Report that was published in 1976 drew attention to this finding. This study reported what had been found in more than one hundred other studies: at an eighteen month follow-up, a small proportion of patients treated in abstinence-oriented treatment centres were drinking moderately without experiencing problems (Miller, 1983).

It is important to note that the above studies are not relevant when discussing the outcome for treatment that is designed to instill moderation. The Rand study reported cases of “accidental” moderation outcomes – patients received no counseling toward this goal. If anything, patients were told that attempting to drink moderately would lead to failure (Ibid). Studies indicate that when patients receive training in moderation, about 65% maintain successful outcomes at one year follow-ups (Ibid). These successful

outcomes have remained consistent across a wide range of clinics, geographic locations, professional counselors and patient populations (Ibid).

The belief held by A.A. that problem drinkers have a disease that is progressive and irreversible is inconsistent with the results of longitudinal studies showing that many people ‘mature out’ of problematic drinking (Walters, 1992). Studies have found that over 75% of individuals recover from alcohol problems without any treatment (Buddie, 2004).

Proponents of the disease model argue that attributing alcoholism to physiology and genetics rather than moral or character deficiencies, serves to decrease guilt and stigma (Davis & Jansen, 1998; Le et al., 1995). Viewed as a disease, alcoholism is often compared to diabetes, cancer or pneumonia. In the same way as a diabetic inherits the carrier diabetic genes, the alcoholic receives a genetic predisposition at birth. In theory, we can then blame the disease, not the person (Suissa, 2003). There is some evidence to suggest that removing the stigma of alcohol abuse encouraged some people to enter substance abuse treatment programs who previously would have avoided treatment for fear of being labeled weak and immoral (Walters, 1992; Suissa, 2003). But does the disease model actually reduce stigma in the wider community? Heather argues that the alleged benefits of the disease model for a compassionate response to alcohol-related problems are illusory. Research by Crawford and Heather clearly showed that whether or not members of the general public believed alcoholism to be a disease had no effect on the level of compassion they had for alcoholics (Heather, 1992). A study by Mulford and Miller indicates that although 65% of their sample regarded the alcoholic as “sick”, most

added that the alcoholic was also “morally weak” and “weak willed” (Dean & Poremba, 1983). As well, Dean’s study indicates that a greater public acceptance of the disease concept has not decreased the stigma associated with the term ‘alcoholic’.

The disease model is not only conceptually flawed, it also serves to foster powerlessness in the lives of problem drinkers. Clearly, the belief that alcoholism is caused by physical abnormalities serves to oppress problem drinkers. Mullaly in his discussion of oppression states that the inferior capacities of members of subordinate groups are considered innate and that this resurgence of attempts to define human nature as the product of biological inevitability has been evident in the last few decades. This thinking which is referred to as biological determinism supports the assumption that deficits are biologically determined, natural and fixed (Mullaly, 2002). The disease model fosters powerlessness because it sets people up for failure by convincing them that they are powerless over alcohol and that it is a delusion for them to believe that they can have any control over a biologically determined deficit (Peele & Brodsky: 1991). As Gergen in his article *The Diffusion of Deficit* points out, “the result of deploying this kind of mental deficit term is to inform the recipient that the problem is not circumscribed, limited in time and space to a particular domain of his/her life, but that it is fully general. He or she carries the deficit, like a cancer, from one situation to another” (Gergen, 1990: 360). Gergen notes that the problem becomes “inescapable as their own shadow... the sense of enfeeblement becomes complete” (Ibid: 360).

This enfeeblement is maintained by A.A.’s twelve steps. The first step states “we admitted that we were powerless over alcohol, that our lives had become

unmanageable”. A.A. believes that the admission of powerlessness is the first step towards sobriety. Individuals learn that they are “passive victims resting at the mercy of the greater power of alcohol” (Le et al., 1995: 604). The second step states “we came to believe that a Power greater than ourselves could restore us to sanity”. Having accepted powerlessness, this step introduces the idea that change is only possible if a power external to oneself can come to the rescue. Bufe (1991) points out that this step promotes the idea of individual helplessness and encourages dependency which contradicts the usual goals in therapy to increase self-direction and independence (Ibid). Step three states “We made a decision to turn our will and our lives over to the care of God as we understood Him”. Having completed the first and second step, individuals turn to a powerful force to take control over their lives. A quote found in the A.A. Big Book states “any life run on self-will can hardly be a success” (Ibid: 605). Clearly, these steps revolve around themes of powerlessness and dependency (Ibid). This belief in powerlessness unfortunately can undermine the exercise of power in daily life. Gilliam in her book *How Alcoholics Anonymous Failed Me* states “my belief in my powerlessness actually made it a self-fulfilling prophecy. Too many times when confronted with a craving, I felt, why even resist?” (Gilliam, 1998: 102).

Powerlessness is also evident in A.A.’s slogan “one drink one drunk”. Addiction experts refer to this phenomenon as the “abstinence violation effect”. Rigidly adhering to a strict philosophy of abstinence is believed to encourage relapse by making continued involvement in a prohibited act seem inevitable after a slip (Walters, 1996). Gilliam states:

It sets people up to completely throw in the towel if they have made one small slip. It does not give us hope in the power to stop ourselves anywhere along the line. It doesn't even indicate that we have the ability to stop when we wish. The expectation that one can't stop contributes to drinking too much (Gilliam, 1998: 102).

Ojehagen and Berglund's study of alcohol-dependent Swedish outpatients also demonstrates the abstinence violation effect. They found no difference in the number of abusive drinking days per month among patient groups who had an abstinent goal, a controlled drinking goal, or a drinking goal that changed during a two year follow-up period; all groups averaged about two abusive drinking days per month. However, patients who had a goal of abstinence drank significantly more on those abusive drinking days than did the other two groups (Rosenberg, 1993).

Anti-oppressive practice frameworks encourage us to recognize that many of the problems people experience have their sources external to the self, in oppressive social structures. While recognizing the significant power of these structures, AOP encourages resistance. In A.A., on the other hand, problem drinkers are encouraged to locate the possibility of change external to themselves, relying on a higher power. Much of the literature has shown that control beliefs play an important role in recovery from alcoholism and can influence treatment participation and treatment outcomes in alcohol dependent individuals (Murray, 2003). A study by Murray et al. explores the relationship between control beliefs and treatment outcome in an alcoholic population. They found

that only the individuals who endorsed control attributions consistent with being self-directed showed significantly longer sobriety than those in the less empowered group. They concluded that A.A. could obtain better results by focusing their efforts on promoting a sense of personal control (Ibid).

Taking on the identity of ‘alcoholic’ also adds to one’s powerlessness. In addition to the stigma associated with this (which will be discussed later), it leads to a personal transformation for problem drinkers. A.A. is known for using storytelling within the Fellowship as a means of self-teaching and leading members to incorporate the A.A. worldview (Humphreys, 2000). The ‘drunk-a-log,’ the most important story form, is a term members use to describe their personal story of their descent into alcoholism and their recovery through A.A. (Ibid). Each time a members says “I am an alcoholic” and tells a story about his or her alcoholism, that identity becomes more firmly incorporated. This incorporation is gradual for some and dramatic for others, but it is almost always experienced as a personal transformation (Ibid). Powerlessness, as understood in terms of giving up one’s identity is evident as members learn to construct their drunk-a-logs to fit A.A.’s philosophy about alcoholism. Over time, the drunk-a-logs of members become more and more similar to the stories found in the Big Book which support the ideology of A.A. “This process of construction brings the member’s life story more fully into harmony with the A.A. community narrative, and is one of the more dramatic examples of how a community-level phenomenon influences individual-level phenomenon in mutual help groups” (Ibid: 499).

Sociologist David Rudy also observed the practice of individuals taking on the alcoholic role. In his book *Becoming Alcoholic*, he discusses his work which involved observing A.A. meetings. He found that most people had to learn their role as alcoholics and in doing so actually reinterpreted their experiences to fit this role. At A.A. meetings when members talked about their experiences as alcoholics, the group “homogenized them through interpretation and clarification” (Peele & Brodsky, 1991: 33). For example, most people who go to A.A. have not had blackouts, a symptom of severe alcoholism. But blackouts are taken as a badge of alcoholism and according to Rudy “members learn the importance of blackouts as a behaviour that verifies their alcoholism, and an indeterminable number of members who may not have had blackouts report them” (Ibid: 33). Rudy states:

When newcomers to A.A. claim that they cannot remember if they had any blackouts or not, other members use this claim as evidence of the event in question. As one member put it to a newcomer: “The reason you can’t remember is because alcohol fogs your brain. If it fogs your brain now after not drinking for a few days it must have fogged your brain before. See, you must have had blackouts then” (Ibid: 33).

Steffen in her work on illness narratives also discusses this phenomenon. She states that A.A. may be seen as a local moral world where experience is shaped through social interaction. “Already at the stage of being introduced to A.A. by someone telling his life story, the listener seems to be integrated into a process of shaping experience, so that it fits into a superior narrative context” (Steffen, 1997: 106).

This process of adopting an alcoholic identity and shaping one's experience can be seen as a form of oppression according to Mullaly's framework. Individual A.A. members have no say about the identity given to them. It is imposed on them, marking them different and inferior and there is no escape from it because the behaviour and reactions prescribed and encouraged by the institution are constant reminders of it (Mullaly, 2002). Dominant ideologies (in this case, A.A beliefs) are "transmitted to the individual through interactions with others... persons develop and internalize a picture of themselves, in large part, according to how society views them, which, in turn, is determined largely by ideology, stereotypes and myths" (Ibid: 50).

Blaming the individual shifts the focus away from structural issues

One's propensity to develop an alcohol problem can be directly related to experiences of invalidation, oppression and abuse (Van Den Bergh, 1991) stemming from structural inequalities such as sexism, racism, and socioeconomic class (Morell, 1996; Williams, 2000; Gibson et al., 2004). Unfortunately, A.A. does not support such a view. Life problems experienced before joining A.A. are accounted for in terms of the disease of alcoholism. In addition to the disease explanation, A.A.'s ideology informs members that defects of character are partly responsible for the development and maintenance of alcohol problems (Emrick, 1989). It purports that the core of alcoholism lies in a person's character. "Selfishness—self-centeredness! That, we think, is the root of our troubles," reads a key passage from A.A.'s 'Big Book' (Miller and Kurtz, 1994: 161). The vocabulary of faults used by A.A. members clearly reflects their belief that problems

partly stem from individual deficits. Words such as grandiosity, resentment, defiance, dishonesty and obsession with control are commonly used (Ibid). Steps four through eight of A.A. emphasize the importance of doing a personal inventory to recognize that the individual is responsible for himself or herself and cannot blame others or inequalities in social conditions for their plight (McCrary, 1994). This reflects a view called “recovery thought” often perpetuated in self-help groups that assumes that current social and economic arrangements work for the general good; therefore, the addicted person must change (Morell, 1996).

The focus on changes that the problem drinker must make reveals an interesting paradox in A.A. On one hand, A.A. teaches that a problem drinker is powerless and must rely on a higher power outside of him or herself to make changes. On the other hand, it insists that the individual is responsible for him or herself. It appears that A.A. reconciles these opposing threads by insisting that change occurs if the alcoholic “works the program”, an act that requires individual choice and determination. Attending meetings on a regular basis, obtaining and maintaining a close relationship with a sponsor, becoming actively involved in A.A. activities, and working through the steps (McCrary, 1994) are individual behaviours that according to A.A. ideology will result in the development of a relationship with a higher power which will ultimately be the saving grace for the alcoholic. Once an individual has accepted responsibility for his or her own character defects and is working the A.A. program, the higher power will provide the necessary transformation required to maintain a lifelong goal of abstinence from alcohol (Ibid).

It is the position of this paper that this tendency to reduce complex problems to individual deficits, biological determinism and the need to rely on a higher power detracts needed attention from social and political factors that shape the oppression of marginalized groups, and undermines possibilities for resistance (Chiauzzi & Liljegen, 1993). Three of these factors – sexism, poverty and racism will be examined highlighting their role in the development of alcohol problems in our society.

Sexism and poverty: Links to alcohol use

Numerous studies indicate that women use alcohol as a means of escape from the alienation, loneliness and physical and emotional pain in their lives (Lundy, 1988) that stem from social, political and economic forces associated with patriarchy (Van Den Bergh, 1991). In this context, problem drinking can be viewed as a manifestation of the oppression experienced by women. In contrast to how A.A. individualizes this problem, some researchers argue that alcohol dependence is essentially socially constructed (Lundy, 1988). Marian Sandmaier, who supports this view states:

A woman's experience with alcoholism cannot be separated from the realities of sexism in our culture. Every dimension of a woman's addiction – its causes, its consequences, its subversive hidden quality, its treatment – are shaped by her subordinate and devalued status. To a large degree, the depth of this connection stems from the sheer pervasiveness of sexism. Women are driven to all kinds of self-destructive escapes from their powerlessness and their conflicted visions of

themselves: depression, compulsive eating, other drug addiction, suicide...
alcohol is only one escape of many (Ibid).

Sexual, physical and emotional abuse are forms of oppression experienced by many women in our society. Studies show that an estimated 75% of women with substance abuse problems have histories of physical and sexual abuse as children and are likely to have been involved in an abusive relationship as adults as well (Lafave & Echols, 1999). This is in sharp contrast to the estimated 12% of substance abusing men who have been victims of childhood sexual abuse (Bogart & Pearce, 2003).

Sexual discrimination does not limit itself to the most vulnerable in our society. A study by Ames and Rebhun examined the issue of sexism in medical training and found that sexual discrimination among residents led to the use of alcohol as a coping mechanism. Abusive experiences that were significantly more likely to be reported by females were unfair treatment due to gender, gender-related exclusion from informal settings, discomfort from sexual humour and unwanted sexual advances. This study found that women who experienced at least one of these abuses were more likely to become problem drinkers in order to cope with this discrimination (Ames & Rebhun, 1996).

Not only do women struggle with the aftermath of sexual, physical and emotional abuse, they are impacted by economic inequalities that serve to oppress them. The “feminization of poverty” is a phrase used to describe the reality that women are more likely to be poor than men. Households headed up by women have a greater likelihood

of living in poverty for many reasons including occupational segregation, household structure involving parenting responsibilities, and failure to receive child support (Pressman, 2003; Van Den Bergh, 1991). The Canadian Addiction Survey found that income inadequacy is a risk factor for hazardous levels of drinking (Adlaf et al., 2005). Other studies show that compared to substance abusing men, chemically dependent women have less education, fewer marketable skills, fewer work experiences and fewer financial resources (Nelson-Zlupko et al, 1995). Not only is poverty a risk factor for developing an alcohol problem, it creates a barrier to being successful in substance abuse treatment. Studies assessing alcohol treatment success have consistently found that women at lower socioeconomic levels did less well than middle or upper class women. An interpretation of this may be that hopelessness and despair come about when an individual finds it impossible to raise her standard of living. It is understandable then, that a person would turn to alcohol in order to escape a feeling of helplessness, despair and powerlessness (Van Den Bergh, 1991).

It is important to note that while poverty affects more women than men, it is a structural issue deserving attention for both sexes. Khan et al. studied 795 community residents with equal representation of males and females and found that increased poverty caused increased alcohol use and alcohol problems. They also found that long periods of unemployment led to alcohol related problems (Khan et al., 2002). Blaming the individual, whether male or female, serves to direct attention away from structural forces that need to be examined in the role of alcohol problems in our society.

Layered on top of abusive relationships and poverty, women also face the stress associated with performing dual roles in society. In addition to filling positions of unpaid domestic labour and caring for children without remuneration (Nelson-Zlupko et al, 1995), many women participate in the work force in order to meet the needs of their families. This coupled with a lack of adequate child-care provisions and reduced rates in benefits pushes many women into chemical solutions in order to cope (Angove & Fothergill, 2002).

Not only does A.A. ignore these important structural factors that affect the lives of women, they discourage any discussion of oppression through their use of slogans. A.A. slogans such as “Get off the pity pot” are used to stifle the discussion of emotionally laden topics often raised by women. Since these matters are not addressed at meetings, women tend to discuss them with A.A. sponsors and mentors, who sometimes turn out to be 13th steppers who further the cycle of oppression (Bogart & Pearce, 2003).

“Hitting bottom” is a slogan used in A.A. to reflect the belief that people stop drinking when they reach their bottom – an individual level of existence that becomes intolerable and acts as a motivator to stop drinking. In the case of women, it is important to note that just because they find their situations intolerable does not mean that they have alternatives. Many women ‘hit bottom’ and stay there indefinitely due to the many inequalities they face in society. The possibility of achieving and maintaining sobriety will depend on factors other than subjective or psychological ones. Decent employment and the elimination of sexism will tear down barriers making it more likely for women to overcome substance abuse problems (Lundy, 1988).

Racism and poverty: Links to alcohol use

Numerous studies have found higher rates of heavy drinking and alcohol related problems among members of racialized people compared to whites. A central theme that has arisen from this research involves the influence of stressors related to adjusting to, and living within, the dominant white culture. These stressors include: 1) acculturative stress which is experienced by immigrants who are faced with the turmoil of leaving their homeland and adjusting to a new society; 2) socioeconomic stress which is experienced by people of colour who are oppressed because of inadequate financial resources and limited social class standing and 3) minority stress which refers to the tensions emerging from racism (Caetano et al., 1998). The political identity, access to political power, economic opportunities and social integration of various communities affects their alcohol related behaviours and attitudes (Ames & Rebhun, 1996). To illustrate this reality, I will briefly discuss the issue of alcohol problems of African Americans and Native people – two groups who experience oppression resulting from their minority class.

The drinking patterns of African Americans who make up the largest minority group in the United States are significantly influenced by historical and continuing economic and social discrimination. The advancements that resulted from the 1960s Civil Rights movement opened opportunities for some African Americans to advance to higher-paid, more prestigious jobs but a large percentage were left behind “mired either

in rural poverty or the urban underclass, increasingly beset by violent crime, drug and alcohol abuse, and other social manifestations of despair” (Ibid: 1653).

Some studies (Grant, 1997; Herd 1994) have found that African Americans report significantly higher number of alcohol related problems and alcohol dependence symptoms than do whites, whereas other studies (Kandel et al. 1997; Lozina et al, 1995) have reported no significant differences between the two groups (Jones-Webb, 1998). Longitudinal studies have explored changes in problem drinking indicators and alcohol-related mortality among African Americans and whites. One study found that alcohol-related mortality rates decreased among African Americans and whites from 1979 to 1989; however rates of alcohol-related mortality were consistently higher among African Americans compared to whites over the ten year period (Stinson et al., 1993 as cited in Jones-Webb, 1998). Thus, although African Americans and whites report similar rates of frequent heavy drinking, African Americans are more likely to die of alcohol-related injuries and illnesses, such as cirrhosis of the liver and accidents. Some studies indicate that compared to whites, African Americans may have longer histories of heavy drinking, which may account for the increase in alcohol-related problems (Jones-Webb, 1998). Studies also show that belonging to a higher social class appears to be a protective factor for African Americans against the effects of race on drinking problems (Ibid). Although this literature focuses on African Americans, many of these issues resonate for people of colour in Canada.

An enormous body of literature speaks to the prevalence of drinking problems among Native people but it is important to recognize that the severity of the problem

varies from community to community and by social environment. For example, in the United States, the Hopi and Navaho have very different drinking patterns, with the Hopi tending to be abstainers and the Navaho tending to be heavy binge drinkers (Ames & Rebhun, 1996). The drinking patterns of Natives are influenced by their history of oppression, relocation and confinement to reservations. Lurie has characterized Native drinking as “the world’s oldest on-going protest demonstration” (Ibid: 1656) in reference to their current living conditions. These conditions include poverty (27.5% lives below the poverty line), high infant mortality rate, low life expectancy and high unemployment (Ibid). Holmes and Antell in their discussion of the social construction of Indian drinking in the United States concur with this view stating: “Alcohol use may stem from anomie due to blocked opportunities, social disorganization from the breakdown of traditional cultural and familial relations, and powerlessness and lowered self-esteem from economic deprivation” (Holmes & Antell, 2001: 152).

The dominant approach to addressing social marginalization calls upon the oppressed to alter their identity, ‘try harder,’ and more fully assimilate to the dominant culture. This individualistic mode of understanding does nothing to confront the social and economic inequalities that are to blame for oppression, or for the behaviour of excessive drinking. Yet, blaming victims as A.A. does, and attempting to change the individual “neutralizes the underlying political issues and maintains the status quo” (Conrad, 1975 as cited in Holmes & Antell, 2001: 169).

Labelling increases stigma which contributes to the marginalization of problem drinkers

In A.A. meetings, members introduce themselves by stating their first name and identifying their drug of choice: “Hi, my name is George and I’m an alcoholic”. The rationale for labelling oneself as an alcoholic is to cut through the denial that is believed to be central to the disease of alcoholism. While there may be good intentions associated with this practice, the reality is that it can be very damaging to a person’s self image and level of confidence (Walters, 2002; Chiauuzzi & Liljergren, 1993; Davis & Jansen, 1998) due to the stigma attached to alcoholism.

Goffman (1963) defines alcoholism as a “stigma – a deeply discrediting attribute” (Thomassen, 2002: 180). Forty years later, there is plenty of evidence indicating that individuals struggling with alcohol problems continue to be stigmatized. In a survey of alcoholism treatment providers, Moyers (1991) found endorsement of items such as “alcoholics are liars who cannot be trusted” and “alcoholism is, in part, a spiritual deficit” (Miller, 1993: 131). The general public also holds negative views of alcoholism. In Dean’s study, he assessed among the general public the level of stigma associated with the label ‘alcoholic’. He found that the label ‘alcoholic’ is a stigmatizing term associated with end stage alcoholism of the skid row drinker. He suggests that the term is so stigmatized that continued attempts to reconstruct it are futile. Other organizations support this view, as evidenced by The World Health Organization Expert Committee that recommended that the term be abandoned. As well, the Diagnostic Statistical

Manual eliminated the term *alcoholism* and replaced it with *alcohol dependence* (Dean, 1983).

Substance users themselves are aware of the stigma attached to problem drinking. Studies have found that a point of resistance for individuals attending an A.A. meeting is that they do not want to be thought of as a “skid-row drunk” (Laudet, 2003; George & Tucker, 1995).

Marginalization in the form of being shunned from one’s peers results from being labeled an alcoholic. One study showed that students receiving a heavy-drinker label from peers were more frequently shunned by other adolescents and restricted from opportunities for social interaction even after their status changed from heavy drinking to non-drinking (Downs, Flanagan & Robertson, 1986 as cited in Walters, 1996). This is in keeping with Dominelli’s view that identity is socially constructed and is presented in *fixed* oppressive terms (Dominelli, 2002).

Within the A.A. community, individuals who fail to accept the label ‘alcoholic’ are thought to be “in denial”, “unmotivated”, “not ready” and “uncooperative”. These attributions clearly mark a negative characterologic model (Miller, 1993). Dean offers an alternative view on the issue of denial. He states that it may be that the denial is not in response to the alcohol problems, but may be an attempt to avoid the negative stigma attached to the alcoholic label (Dean, 1983). He questions whether or not the use of the term ‘alcoholic’ is imperative in treatment. If it is not, he believes that the term should be abandoned along with its pejorative connotation (Ibid). Gergen in his discussion of the impact of using mental deficit language would likely agree with this recommendation.

He argues that mental deficit language such as ‘alcoholic’ creates social hierarchies that lead to rituals of degradation. Like Dean, he would argue for language that would reconstruct problem drinking in a way that would erase present hierarchies (Gergen, 1990).

It is important to note that certain groups such as women and racialized minorities are much more sensitive to labelling. Although male problem drinkers experience judgmental attitudes, women are reproached to a greater extent. “Stereotypically, those of the ‘fairer sex’ are supposed to be society’s moral guardians” (Van Den Bergh, 1991: 18). Our gender-related rules regarding the use of alcohol leads to women being doubly oppressed: not only are they ‘alcoholics’ they are ‘women alcoholics’, a term that is highly stigmatized in our society (Angove & Fothergill, 2003).

As discussed earlier, the founder of A.A. was concerned with the need to deflate a rigid, over-blown ego as an important component of treatment. Generally, this worked well for the white, upper-middle-class alcoholic men he knew. But it does not fit the needs of most women and many underprivileged people who already face discrimination in our society. Deflating their egos only leads to further disempowerment (Kasl, 1992). Results from Project MATCH support this view. This study indicates that compared to white participants, few African American and Hispanic clients attended the A.A. sessions during the later follow-up periods. They found that racialized minorities who have received many degrading labels over the years view the A.A. labelling process as an invitation to further self-denigration (Walters, 2002). It is evident that the practice of

labelling individuals as alcoholics contributes to oppression in the lives of those who are already marginalized.

Alcoholics Anonymous excludes full participation in society

Many people in recovery report that they only feel comfortable with others in exactly the same situation as themselves. They find that they cannot form healthy relationships outside the circle of treatment and that they are constantly driven to talk about their alcoholism. This is a frequent problem for recovering alcoholics who attend A.A. so religiously that they cannot maintain life outside of the group (Peele & Brodsky, 1991).

Dominelli (2002) states that oppressive relations are about limiting the range of options that subordinated individuals can readily exercise. One of the pitfalls of individuals spending a great deal of time at twelve step meetings is that this is where they often meet potential partners. Their range of options for meeting a significant other narrows from a broad array of social contexts to the social environment of A.A. Meeting one's partner at A.A. can be disastrous due to the fact that both individuals are struggling with major issues. What often happens is that the relationship ends in bitterness and recriminations (Peele & Brodsky, 1991), adding to the complexity of the problem drinker's life.

The phenomenon of habitual attendance at A.A leads to the question: "Is there such a thing as addiction to treatment?" (Ibid). Some critics believe that A.A. encourages dependence upon the program itself which can lead to a lack of involvement in other

social organizations (Galaif & Sussman, 1995). Just as alcohol can become a preoccupation and can decrease the quality of life, treatment can also become a preoccupation that decreases the quality of life. Walnut contends that A.A. promotes dependency by serving as a substitute addiction, an argument that is supported by the fact that many A.A. members attend meetings on a daily basis for a number of years (Walters, 2002). This practice of regular attendance stems from A.A.'s belief that "working the program" by attending meetings on a regular basis will be the addict's only hope of sobriety. People who are new to the program are encouraged to attend A.A. daily for the first three months. This practice is referred to as "90 in 90" (McCrary, 1994). Caldwell & Cutter found in their study of A.A. attendees that while many attended 90 meetings in 90 days, those who did not went to more than one meeting on some days in order to complete their commitment to the "90 in 90" goal (Caldwell & Cutter, 1998). Not only are A.A. members encouraged to attend regularly, they are expected to maintain a life long commitment if they hope to maintain sobriety (McCrary, 1994). This belief is reflected in the following quote from Alcoholics Anonymous:

It may take the alcoholics themselves some time to admit their own illness. They may protest that their problems are "different" and that A.A. is not necessary or desirable for them. Such drinkers often point out that they are a long way from the bottom of the ladder, and what they consider "the bottom" keeps getting lower and lower. Or they may simply continue to insist that they can stay sober on their own. Unfortunately, they cannot and do not (Alcoholics Anonymous, 2005).

Story-telling in A.A. also serves to indoctrinate its members regarding the importance of regular attendance. Some stories, referred to as legends, are tales of miracles worked by the program and the disasters of people who have left the program. An old-timer told one such legend at an A.A. meeting as a warning to those who think they no longer need to attend:

I knew a guy who sobered up with A.A. and came to meetings for 20 years. A real old-timer. Then he decided he had his problem licked and he didn't need A.A. anymore. The next time anyone saw him he was as drunk as he had ever been. I always try to remind myself of that. I need to, even though I've been sober for 23 years (Humphreys, 2000: 503).

Walnut states that while A.A. may provide valuable social support in the beginning, the expectation of a life-long commitment stands in the way of long-term growth. Thus, continued involvement in A.A. beyond a certain point may become life-limiting rather than life-enhancing (Walters, 2002). Emrick notes that while A.A. provides a "social cocoon", individuality is sacrificed as total allegiance is given to this greedy organization" (Emrick, 1989: 6).

It is interesting that A.A. is not only aware of this issue of a substitute addiction, but legitimizes it by naming it and encouraging it. In the literature provided to family members and significant others, A.A. informs those affected by someone's drinking that:

The drinker may plunge into such a constant round of A.A. meetings and calls to help other alcoholics that they have little time to spend with you.... often this interest in A.A. will seem just as self-centered as the alcoholic's drinking was... this period when the recovering alcoholic has such high enthusiasm for A.A. that other concerns fade – is often referred to in the Fellowship as “living on a pink cloud” (Alcoholics Anonymous, 2005).

According to Mullaly we could also call this oppression. He states that oppression occurs when a person is blocked from opportunities to self-development and is excluded from full participation in society (Mullaly, 2002). As the above examples demonstrate, the philosophy of A.A. clearly leads to a narrowing of opportunities and participation in society.

Chapter 3: Methodology

Design

This research project is an exploratory, qualitative study conducted within an interpretive, critical framework. An interpretive approach is concerned with what is meaningful or relevant to the people being studied. It provides a research report that reads more like a novel or biography providing a “thick” description of people’s experiences. A critical approach involves conducting research in order to critique and transform social relations. Critical researchers do this by revealing the underlying sources of social relations and empowering people, especially less powerful people. This is done by uncovering myths, revealing hidden truths and helping people make changes for themselves (Neuman, 1997). Some of the questions that participants were asked served to uncover sources of social relations and provided opportunities for me to increase consciousness regarding the oppressive nature of A.A. For example, participants were asked about their understanding of the disease model and if this impacted them in any way. With some participants, this led to a discussion of how A.A. in its support of the disease model has fostered powerlessness in their lives. This may have led to an increased consciousness which in turn may have helped the participants re-conceptualize their situation – for example seeing themselves as powerful, rather than powerless. It is reasonable to think that this re-conceptualization may have served as a catalyst for participants to make positive changes in their lives. In keeping with a critical approach,

this research project went beyond identifying the oppressive aspects of A.A. and sought out ideas that can be used to develop non-oppressive support groups in our community.

Conducting research within an interpretive, critical framework required a qualitative approach to gathering data. Qualitative methods are typically used to obtain information about feelings, thoughts, processes and emotions that are difficult to get at with other types of research (Strauss & Corbin, 1998). Compared to quantitative methods, a qualitative study is much more likely to be effective in gathering information on sensitive topics, such as addiction (Padgett, 1998). Qualitative methods also made room for ongoing alteration as the research proceeded, allowing me to address issues that were brought to light by previous interviews – this flexibility served to enhance the richness of this study (Bouma & Ling, 2004). As noted above, this study is also exploratory in nature. Exploratory studies are typically used when a researcher examines a new interest or when the subject of study itself is relatively new (Babbie & Benaquisto, 2002). While A.A. is not new to the research field, applying an anti-oppressive framework to the focus of this study is new. This study can also be considered exploratory as it was conducted on a small scale, drawing tentative conclusions to be further explored in future studies (Ibid).

Sample

This research project used a purposive sample so that participants could be selected to represent some explicit predefined traits or conditions (Luborsky & Rubinstein, 1995) – in this case, problem drinkers who have expressed some dissatisfaction with A.A. As well, I attempted to include women and people of colour, as

sexism and racism are implicated in addiction and relevant to the critique in the literature about A.A. The sample consisted of six Caucasian women, four who continue to attend A.A. and two who attended A.A. in the past. While I made a conscious effort to recruit men for this study, no volunteers came forth. As well, no people of colour volunteered, most likely due to their low representation in the agencies that the sample was drawn from.

Instrumentation

A semi-structured interview process utilizing an interview guide with pertinent topics and probes was used to allow for spontaneous, relevant information to be disclosed (Burman, 1997). Interviews were 60-90 minutes in duration during which time the participants were asked to give a personal narrative of their experience as a member of A.A. Areas that were explored through the narrative included: how A.A. was helpful or not helpful in their recovery process; and the level of satisfaction or comfort with specific A.A. ideology and practices. Using this type of interview allowed me to explore the experiences of participants in a focused way while allowing for a conversational manner (Fossey et al., 2002) and flexibility to pursue issues that may not have been anticipated (Babbie & Benaquisto, 2002). In keeping with an interpretive schema, this approach ensured that the participants' voices were heard and their knowledge privileged (Fossey et al., 2002). See appendix for Interview guide.

The interviews were audio taped for two reasons. First, it eliminated the need to take notes, allowing me to concentrate on the interview process, and secondly, it was

more inclusive than note taking. Audiotapes capture laughter, sighs and sarcasm – aspects of the interview that vividly add to the participant’s story (Padgett, 1998).

Recruitment and Data Collection

Recruitment sources included: Alcohol, Drug & Gambling Services (ADGS) where I have been employed for the past eight years (but am presently on a leave of absence in order to conduct this research project) and Women for Sobriety (WFS), a community based support group dedicated to helping women overcome alcoholism and other addictions.

The following is a description of the recruitment process that was used at ADGS:

When a social worker became aware of a client who fit the purposive sample for this project, she:

1. Introduced the research project to the client by reviewing the letter of information with him or her. The client was given this letter for further review.
2. Asked if it was permissible to pass on contact information to me so that I could contact the client to provide further information to help him or her decide whether or not to participate.
3. Documented (for reasons of confidentiality) any particular process required in the contact (for example, calling at a certain time, or only speaking with the person directly).

I asked the social workers not to do anything that could be interpreted by the client as pressure to participate. The social workers informed their clients that agreeing or

declining to participate would in no way affect the service that they were receiving from ADGS.

Upon receiving contact information, I contacted these individuals and further explained the study, as well as answered any questions they had. The individual then informed me of his or her decision to participate or not. It was left to the participant to decide whether or not to inform their social worker of their involvement in this research project.

The interviews were arranged with the participants' confidentiality in mind, as well as my comfort and safety. The participants were asked to select the interview site (ADGS, an office at McMaster University, or other location suggested by the participant) that was private, safe and comfortable for both parties. The interviews took place in a variety of settings: four at ADGS, one in the participant's home and one at McMaster University.

For the two participants recruited from WFS a parallel process was used with the exception that they were not screened by a social worker. The facilitator of WFS distributed the letter of information at a WFS meeting and encouraged the women to call me if they were interested in participating in this research project.

The above recruitment plan was carefully thought out in regards to ethical considerations. The threat of coercion is a genuine concern in social work research, especially when members of vulnerable populations are studied (Padgett, 1998). It is for this reason that former clients of mine were not approached to participate, as they may have felt a sense of obligation to do so as a way of showing appreciation for past services

received. Also, to reduce any pressure clients may have felt, ADGS social workers did not ask clients directly if they wished to participate in the research project.

Another ethical issue that I considered in the recruitment phase related to informed consent. Following Padgett's guidelines, the following information was given to potential participants to aid them in making a decision to participate or not:

1. a brief description of the study and its procedures as they involve participants
2. full identification of the researcher's identity and of the sponsoring organization, including an address or telephone number for future contacts
3. an assurance that participation is voluntary and the respondent has the right to withdraw at any time without penalty
4. any risks or benefits associated with participation in the study

(Padgett, 1998)

Potential participants were advised to consider the risk of discussing their experiences with problem drinking, as this can be a challenging and emotional experience. They were informed that I have extensive experience interviewing problem drinkers and responding to the associated emotional difficulties. As well, they were informed of their right to choose not to answer some of the interview questions.

Participants were assured that their participation would be kept confidential and that no identifying information or quotes would be included in any of the written reports. However, they were warned of the possibility that someone who knows them might be able to guess who said what in the research report. They were advised to keep this in

mind when deciding what to disclose. In keeping with ethical guidelines, I only guaranteed confidentiality, not anonymity. A participant may be guaranteed anonymity only when *both* the researcher and the people who read the research report cannot identify a given response with a given participant (Babbie & Benaquisto, 2002; Padgett, 1998).

See letter of information and consent form – in appendix.

Analysis of Data

This research project drew on a model of qualitative data analysis developed by Connolly (2003) that has been influenced by Strauss & Corbin's grounded theory method of social research. It was chosen because of its congruency with an interpretive critical framework, which privileges the voices of the participants and allows for an analysis of oppression.

The analysis of the research data included three phases: 1) The generative phase involved a careful examination of the data sentence-by-sentence, and sometimes word-by-word. Examining the data involved listening to each tape in its entirety in order to get an overall sense of the participant's experiences with A.A. Listening to the tapes enabled me to draw on the tone of the discussion to increase the accuracy of the interpretation of the data. 2) The interpretive phase involved listening to the tapes a second time, while matching the data with the five areas of oppression that were identified in the literature review. Any information that did not fit into these categories was then grouped into other themes that in my opinion best represented the participants' experiences. As a result of

identifying new themes that emerged in later interviews, I listened to all of the tapes for a final time in order to identify content that may not have been identified earlier in the process. I then confirmed the accuracy of this matching process by returning to the data, re-examining the categories in the light of this. The aim of this exercise was to increase the grounded validity of the findings – or in other words, to ensure that the findings were indeed grounded in the data. 3) The theorizing phase involved formulating theories derived from the themes and presenting them in an anti-oppressive framework (Connolly, 2003).

As I analyzed the data I was aware of the critical role that I play in creating, interpreting and theorizing the research data, and made an effort to be cognizant of my own personal, political and intellectual autobiography in this process (Mauthner & Doucet, 1998). The use of quotations juxtaposed with my description and interpretation will enable the readers to evaluate the authenticity of my claims about the data (Fossey et al., 2002).

Limitations of the Study

This particular study took place in a large urban Canadian city in southern Ontario where there are numerous addiction agencies and support groups available to assist individuals in their recovery process. The experiences of the participants in this study may be quite different than those who live in smaller communities with fewer resources. Participants who have been able to attend ADGS and WFS are able to compare different philosophies and thus may be able to more readily identify oppressive aspects of A.A.

For example, a woman who attends WFS who has been encouraged to identify herself as a competent woman may be more likely to question A.A.'s practice of identifying herself as powerless. Someone who has attended ADGS and has benefited from addressing the underlying issues of her addiction may be more cognizant of the importance of addressing these issues than someone who has only had the opportunity to attend A.A. Thus, the geographic location of this study has likely shaped the participants' experiences as well as their conceptualization of oppression in A.A. and may not reflect the experiences of A.A. members in other geographical areas.

A second limitation occurred as a result of not having people of colour included in the sample. The difficulty in finding a person of colour to interview was most likely due to the fact that both ADGS and the specific WFS group that I contacted have a low participation of visible minorities – a reality that may well reflect systemic barriers. Not having a diverse sample prevented me from exploring the implications of racism as related to the critique in the literature about A.A.

A third limitation is that due to time constraints I was not able to conduct member checks – a process where participants review the analysis in order to ensure that the researcher's interpretation of the data is correct (Fossey et al., 2002). To compensate for this limitation I followed Campbell and Gregor's (2002) suggestion and checked my understanding of issues from time to time, asking participants questions such as: "am I getting this right?" or "what am I missing here?" I also attempted to avoid ordinary conversational etiquette where people assist each other in making meaning. As well, I conceptualized the interviews as more than a set of questions and began the analysis

during the interview. I checked my understanding as it developed and offered it up to the participants for confirmation or correction (DeVault & McCoy, 2003).

Finally, it must be recognized that this research project can only generate tentative generalizations due to the small sample size (Bouma & Ling, 2004). With a sample size of six participants, saturation – the point when patterns are recurring and no new information emerges (Fossey et al., 2002), may not have occurred. Regardless, studies indicate that rich, detailed information can be obtained even with one participant (Babbie & Benaquisto, 2002). This is particularly true when the sample is purposive in nature, allowing the researcher to seek out “information-rich cases whose study will illuminate the questions under study” (Patton, 1990, cited in Thomas, 2005: 247). Thus, I am confident that the findings generated from this study are relevant to understanding how oppressive aspects of A.A. beliefs and practices shape the experiences of problem drinkers.

Chapter 4: Findings

Using an anti-oppressive framework, the following problematic features of Alcoholics Anonymous were identified in the literature review:

- A.A. is a patriarchal institution that oppresses women
- A.A. promotes the disease model of alcoholism which fosters powerlessness in people's lives
- Blaming the individual shifts the focus away from structural issues
- Labelling increases stigma which contributes to the marginalization of problem drinkers
- A.A. excludes full participation in society

The following is a summary of the participants' observations and experiences in relation to the above oppressive aspects of A.A. All participants' names have been changed to protect their confidentiality.

A.A. is a patriarchal institution that oppresses women

Although there has been an increase in the membership of women in A.A., the majority of the participants found that A.A. continues to be male dominated. Most participants reported that the speakers at meetings are generally men and that they often talk about issues that are of interest to men. Diane commented: "the majority of the

time, they are men over 60 talking... and you know what, I can't relate.... I am so tired of hearing about World War 1". Linda, who identified her group as male dominated also had difficulty relating: "I didn't necessarily relate to the men's hard core drinking stories that they had and didn't think it really fit me". She spoke of the difficulty she experienced in opening up to the group:

... I'm very fragile, like the first month, and you're really insecure and you're full of shame and guilt and all this and you might want to hide yourself in a little hole uh so to be ... a little bit forceful and saying, 'you know I really want to know this answer to my question,' I just sat back and listened. I didn't feel secure enough in myself to maybe interject and say, 'I've got something to say here or I want a question answered' because there were people who monopolize.

Not only did some of the women have difficulty relating to the men in the group, they also expressed discomfort in discussing certain issues such as relationships and feelings in a mixed gender group. Clara commented that she did not like to talk about relationships, while Beth commented that men would not understand her. This experience led her to join Women For Sobriety.

Karen challenged the above, stating that women in her group talk as freely and as often as the men. But she noted that her particular group has equal numbers of men and women. It may be that the persistent gender imbalance in numbers of participants in A.A.

supports male dominance of both the topics of discussion and the ‘air time’ available to each member.

This persistent gender imbalance also results in women having difficulty finding a female sponsor to support them. The majority of the participants noted this as a concern. Diane commented that women who are considered to be “good sponsors” are overwhelmed with the number of sponsees that they have to support. This in turn adds to the complexity of their lives, having to respond to the needs of a large number of women. Other implications of A.A. lacking a critical mass of women include: less mutual support among the women; as noted above, due to discomfort in mixed gender groups, women’s voices within the A.A. rooms are not heard; and any energy that is available is used to support each other rather than utilized to resist the male-dominated practices of A.A.

A.A.’s patriarchal nature is also evident in Diane’s experience of women being slotted into traditional roles. She commented that in her experience, women do not often get to chair the meetings: “They’re door greeters or they make the frickin coffee”. Julia disagreed that women are put into traditional roles, but stated that she carefully chooses which A.A. group she attends (from several available in this city) in this regard.

One of the most blatant manifestations of men’s power over women is sexual violence and abuse. 13th stepping is a practice (albeit unofficial) of A.A. members (usually men) who try to “pick up” more vulnerable members (usually women) for dates or sex (Bogart & Pearce, 2003). Julia described her experience as a victim of 13th stepping. She states that a man in A.A. led her to believe that he was abstaining from alcohol when in reality he continued to drink. She reports being a victim of abuse in this

relationship which caused her to relapse. She stated: “I talked to some other people about this and basically there are people out there... who count on exploiting vulnerability... because they know they can”.

A characteristic of dominance is its resistance to challenge. Three of the participants in this study spoke of their difficulties questioning A.A.'s beliefs and practices. Diane commented on the reaction that members receive when they try to question A.A.'s practices: ‘Shut up and do as you’re told.’ I have heard that so many times its not even funny... the other words are, ‘your best thinking got you here so don’t think, shut up and do as you’re told.’ Karen also received the message not to think too much and to simply follow the program: “I’ve got a scientific analytical mind which gets me into trouble and I’ve been told that... initially at A.A., it’s, ‘don’t think too much.’ Julia commented that she met with resistance when she questioned the program in order to make changes to better meet the needs of women with young children. She stated:

There’s arguments for keeping the program exactly as it was because that’s the way it was written and that’s the way it works and if you’ve got a problem that’s your problem. If it’s not related to alcohol, we don’t want to hear about it. Suck it up. Deal with it.

Karen described A.A. as a ‘union’ based on her perception that “there’s a doctrine, there’s a message... and you *better* get these 12 steps and you’d *better* follow that book.” These findings support the literature indicating that the dynamic of superiority-inferiority,

marked by differences in power and status (Mullay, 2002) has made it difficult for women to question A.A.'s practices and philosophy (Kasl, 1992).

The literature on women and A.A. raises particular concerns about A.A.'s fourth step. This step requires members to make a "searching and fearless moral inventory of themselves" and to "disclose damaged or unsalable goods, to get rid of them promptly without regret" (Alcoholics Anonymous, 2005). Critics argue that this step contributes to women's powerlessness.

In this study two participants, Diane and Julia, did not perceive A.A.'s fourth step as problematic. Diane explains that initially her understanding of this step was that she would have to list her alcoholic defects and identify the people she harmed through alcoholism. But then it occurred to her that she had not harmed anyone: on the contrary, she quickly identified a drinking problem and took steps to address it. While A.A. members might inform her that she was in denial, she felt confident about this assessment and received support from her husband and children in this regard. Julia stated:

The fourth step hopefully is going to help me to see a little bit more clearly into who I am and how I came to be who I am and compare that with who I want to be, who I see my potential as being as a healthy functioning person, look at why there's these discrepancies and then through the rest of the steps I'm going to start making changes in how I think now that I understand why I do the things I do.

Both Diane and Julia are able to conceptualize this step in ways that did not make them feel powerless. Julia, in fact, turns the fourth step into a positive exercise, taking it as an opportunity to confirm her potential and plan for positive change.

Karen, Beth and Linda, on the other hand, all perceived this step to be problematic. Karen discussed how A.A. members are encouraged to “pick themselves apart” by identifying their moral defects. She explained that the result can be a poor feeling when leaving a meeting. In pondering her dissatisfaction with A.A. she stated: “I don’t think I’m defective... maybe that’s the problem and I was told, ‘your arrogance will stop any progress...’ Do I feel empowered there? No I don’t. I don’t feel empowered at all”. Linda, who left A.A. to join another support group discussed her thoughts about the practice of identifying your defects:

...humiliating yourself – that was uncomfortable to me because I thought if I continue to humiliate myself I can’t get the self-esteem and the image that I want myself to have to say, ‘I can beat this’... because you’re constantly hearing people telling you stories about all the crap they’d done in the past, and we’ve all gone through that – any addict has gone through that and that’s in the past, and I don’t want to be constantly reminding myself of that.

Karen and Linda reveal ways that A.A.’s understanding of alcoholics as individuals with character defects can serve to increase powerlessness in the lives of women struggling with problem drinking. Karen was explicit that the ‘fearless moral inventory’ was

disempowering. Linda identified the practice as a form of self-humiliation. She described how the practice interfered with her capacity to see herself as someone able to overcome problems with alcohol.

Beth was not familiar with the fourth step but indicated some resistance to it when the object of the step was revealed to her. She stated that when she attended A.A. she did not identify people she had harmed as a result of her drinking because “it was the other way around... I’ve been harmed”. It appears that conceptualizing her drinking as a coping response to a difficult situation, rather than a moral defect that resulted in harm to others was useful to her.

A.A.’s reliance on the notion of character defects to explain alcohol problems also affects women’s understandings of their discomfort with A.A. Karen and Diane, for example, conceptualized their disenchantment with A.A. as another personal defect rather than seeing this as the first step in resisting domination – that is, identifying oppression. Diane commented: “I was talking about being disenchanted [with A.A.] and I was actually beating myself up like I’m not doing something right”. Karen expressed similar comments: “I do feel like a failure sometimes that I haven’t got it [A.A.’s philosophy]... it evokes a little child in me sometimes... its like I’m not in the group, in the gang – that’s always been my biggest battle in life...”. It is evident that women are socialized to internalize problems making them more likely to see themselves as the sole cause of a problem rather than taking a more balanced ecological view (La Fave & Desportes Echols, 1999). This in turn contributes to their subordinate position in society. Julia succinctly commented on the similarities between the oppression that women face in

society and the oppression they experience in A.A.: “I mean a lot of it is just this is the world that we live in and women are not equal and why should A.A. be any different?”

A.A. promotes the disease model of alcoholism which fosters powerlessness

The strength of the disease model was very apparent in this study. Julia articulated it clearly:

[A.A.] is not a gathering of healthy, sane people. We're sick, every last one of us and I don't care how many years of sobriety you have, you're a drink away from a drunk. We're not there because we're healthy.

Among participants in this study, only Julia perceived no negative implications of conceptualizing alcoholism as a disease. Most participants expressed both benefits and disadvantages of defining alcoholism as a disease. Karen, Diane and Julia all noted that accepting alcoholism as a disease legitimized their struggles and reduced the guilt and shame that they felt. Diane, recalling this benefit in the early stage of her recovery prior to adopting a goal of moderation stated:

Well when I first heard about that [alcoholism as a disease] I kind of thought – okay, that makes a bit of sense and in one sense it made me feel better... in the sense that I didn't feel as much shame... it made me feel okay, this is little more legitimate than I just don't have any willpower.

Clearly participants benefited from some aspects of the disease model. Deriving some benefits from this model makes it less likely that it will be rejected in its entirety.

Regardless of the benefits that these participants perceived however, they were also keenly aware of the negative implications of the disease model. One of the criticisms of the disease model is that it fosters powerlessness because it sets people up for failure by convincing them that it is a delusion for them to believe that they can have any control over a biologically determined deficit (Peele & Brodsky: 1991). Diane, who left A.A. in order to pursue a goal of moderation, resisted this belief and spoke of the importance of having the choice to abstain or drink in moderation. It is no surprise that members of A.A. did not support this goal, and in fact made comments that could be perceived as an attempt to sabotage her efforts. They informed her that she ultimately would fail: ‘yes, you may be able to go back out there for a year but you’ll eventually end up worse off than you were in the first place’. This kind of feedback operates to support the self-fulfilling prophecy which serves to convince individuals that they cannot control their drinking, making them believe that it is only a matter of time before they succumb to the disease of alcoholism. Diane cleverly noted the narrowness of the belief “one drink equals one drunk” by responding “then I also say one smoke equals one stroke”. Clearly, Diane experienced negativity in her life as a result of the disease model. Her effort to maintain a goal of moderation was sabotaged by the very existence of the disease model and its popularity in the addiction community. She was fighting against a concept of addiction that “enjoys such wide acceptance in society that anyone who

questions it may be regarded as a heretic, misguided or misinformed” (Miller, 1986, cited in Chiauzzi & Liljegren, 1993: 304). Karen also experienced the pressure to accept the belief that alcoholism is a disease: “I know I’m *supposed* to say it because it’s the word of the time and we’re *suppose* to say that its [a disease]... the easy thing was to say I have a disease, its controlling me, but I don’t know if I totally believe it’s a disease”.

Karen also talked about the discouragement that can occur when thinking about never being free from the disease of alcoholism: I look around [in A.A. meetings] and think the stories are so horrendous and I think – wow this disease is horrible and will we ever be clear of it?”

Critics of A.A. argue that the powerlessness engendered by the disease model is maintained by A.A.’s twelve steps, which instructs individuals to rely on a higher power external to themselves. Most of the participants struggled with the concept that change is only possible by relying on a higher power. Even Julia who endorsed the disease model, when reflecting on her education which stressed feminist based values commented:

[My teachers] were saying ‘you are in charge of your life, you are in control... and you let the world know that you’re a force to be reckoned with,’ then I’d go to a meeting and they’d say ‘you are powerless over people, places and things.’ And it’s a real mind bender...

Diane also struggled with the dichotomy between seeing herself as having power and the ability to make good decisions in her every day life, and being told by A.A. members that she needed to rely on her sponsor for direction:

There was this whole concept that I couldn't do anything without asking my sponsor. And if I did anything without first clearing it with my sponsor then I was taking back my will. And I was having trouble with that because I've always been a very pro active, determined high achiever.

Diane also questioned the role of a higher power in her life. While she believes in a higher power, which she defined as “something bigger than ourselves”, she had difficulty “drawing the line” in terms of knowing how much control to give to the higher power. She stated: “Like do I just sit back and say ‘okay higher power, take control of my life,’ or do I [take control myself]... I’m a person who gets things done you know [in every other aspect of my life]”. Karen was able to state that she has power within herself but wondered if she might be deluding herself in this regard: “Maybe I am tricking myself... sometimes [I believe this] if I have a certain conversation with some people in the group... and I avoid conversation with certain people because of what I feel”. The struggle with the role of a higher power demonstrates the sociopolitical / socioreligious influence of A.A. and the stronghold it has on individuals (Emrick, 1989). A.A. members are encouraged to locate their power within a dimension narrowly defined by A.A.’s ideology. Karen suggests that at meetings, *A.A. itself* is conceptualized as the higher power that rescues people from the disease of alcoholism: “It’s like if you don’t rely on A.A. and if you don’t come to realize that their doctrine is *the way*, you’ll relapse... that makes me feel powerless”.

Clearly the belief that change is only possible when control is handed over to a higher power causes women to feel powerless and causes them to question their own self-efficacy which is not conducive to maintaining long term sobriety. Perhaps we can learn from Linda who has been able to maintain long-term sobriety since leaving A.A. She stated:

Mine was my self-motivation, not God or anybody else. If I wanted to do it, I was going to do it on my own power not on God's power or anybody else's power. I feel if I'm going to do it [abstain from alcohol], I'm going to do it on my own. I'm not going to have some other being tell me how to do it... I know what works for me.

Blaming the individual shifts the focus away from structural issues

At A.A., life problems experienced before joining A.A. are accounted for in terms of the disease of alcoholism. In addition to the disease explanation, A.A.'s ideology informs members that defects of character are partly responsible for the development and maintenance of alcohol problems (Emrick, 1989). A.A.'s steps emphasize the importance of doing a personal inventory to recognize that the individual is responsible for himself or herself and cannot blame others or inequalities in social conditions for their plight (McCrary, 1994). This in turn serves to draw attention away from the reality that alcohol problems can be directly related to experiences of invalidation, oppression and abuse (Van Den Bergh, 1991), stemming from structural inequalities such as sexism,

racism, and socioeconomic class (Morell, 1996; Williams, 2000; Gibson et al., 2004).

All the participants in this study with the exception of Clara clearly stated that underlying issues are not addressed at A.A. meetings. (Clara stated that members can talk about these issues but noted that they do not receive feedback... because “cross talk is not allowed”. So while these issues may be raised, there is little opportunity to adequately address them). Not only were these issues not addressed, but women were made to feel that they were to blame for their drinking. When I asked Karen if A.A. addresses *why* women drink, she responded: “No...[You are informed] ‘You drink because you’re an alcoholic and you need to do the work on yourself first, getting over your issues and your ego’. When I pointed out to Karen that her ego might be conceptualized as one of her strengths which enables her to claim her own power in order to take positive steps, she replied: “I do know when I go there [A.A.] I don’t try to act that way too much because I’ve been told I’m arrogant”. So not only did A.A. not recognize the underlying issues of her drinking, they attempted to pathologize her power by labelling it as arrogance.

Some of the women explained how A.A. members respond to comments pertaining to underlying issues. They are told ‘don’t drink, go to meetings and all will be well’. In discussing her history of depression, Diane stated: “A.A.’s answer to that is well ‘if you didn’t drink you wouldn’t get depressed’.... “A.A. is more of, ‘you’ve got this disease and its causing everything else...’ the only solution is ‘don’t drink, go to meetings’. She explained that she was able to prove this thinking wrong – after a significant period of sobriety, she “crashed with depression”. It was only with the

assistance of those outside of A.A. that Diane was able to address the issue of depression. Diane was not alone in her experience – Linda, Karen, Julia and Beth all discussed how they had to go outside of A.A. to get help for the underlying issues that triggered their drinking. It is quite evident that A.A.'s practice of not addressing the underlying issues in women's lives serves to mask the pain and oppression that led them to use alcohol as a coping mechanism.

Another way that A.A. discourages any discussion of oppression is through their use of slogans, such as "Get off the pity pot". Karen discussed how this slogan was used to stifle any discussion about emotions: "They don't really want to talk about the cravings and they don't really want to hear how crappy you feel"... "Sometimes we need pity... Self-pity sometimes is a very worthy [thing]". Karen not only felt that women's emotions and experiences were not being recognized, she perceived that A.A. wanted the credit when success was achieved. She noted:

I feel sometimes that they don't want to hear about all the struggles and the cravings; they want you to talk about A.A. being wonderful and the reason you stay sober... [Karen noted that A.A. offers little opportunity to talk about why you're drinking]... it's very much about why you're *not* drinking and how you're staying sober and A.A. has saved everyone there. I almost need to break down, and say 'you're just the best and this is why I stay sober'. But I can't say that... I'd be lying.

Clearly, A.A. not only masks the structural inequities and emotional turmoil in women's lives by explaining their drinking in individualistic terms, but strips away any power they might attempt to claim by taking the credit for their success.

Labelling increases stigma which contributes to the marginalization of problem drinkers

A.A. members are required to label themselves as alcoholics. The rationale for this is to cut through the denial that is believed to be central to the disease of alcoholism. While there may be good intentions associated with this practice, the reality is that it can be very damaging to a person's self-image and level of confidence (Walters, 2002; Chiauzzi & Liljergren, 1993; Davis & Jansen, 1998) due to the stigma attached to alcoholism. Many studies indicate that both alcoholism treatment providers and the general public hold negative views of alcoholics (Miller, 1993). Diane, Karen, Beth and Linda all found this to be true in their experiences. Linda described her perception of how the general public views alcoholics:

You know, people still look at alcoholism as people who are down and out, and you know drinking from a paper bag and sitting on the streets and grubby and dirty...

Beth disclosed that she has been judged by members of the medical profession for being an alcoholic. As a result, she has learned to only use the label 'alcoholic' with her closest

friends and family who understand who she really is. Similar to Beth, Karen observed that her co-workers had judgemental attitudes towards alcoholics. She explained that she does not like this label due to the negative stigma attached to it:

An alcoholic is defeatist. There still is the connotation... we know its not just the ruffian down the street – we know that it's the CEOs... When I used to hear my parents, [use the word] 'alcoholic' it was always a negative connotation.

While Diane states that she is fine with calling herself an alcoholic, she explained that her children are not comfortable with this label. When she informed them that she was an alcoholic they responded: 'Oh my God, don't say that word'. The experiences of these women confirm for us that the term 'alcoholic' continues to have a negative stigma attached to it, as evidenced by the reactions of family members, co-workers, the medical profession and the general public.

It is also important to look at how the participants themselves experienced being labelled an alcoholic. It is interesting that Diane states that she is fine with calling herself an alcoholic, but then goes on to say that "I was just admitting my weakness". So while she accepts the label she continues to associate it with a negative characterologic descriptor. Karen in her discussion of accepting the label 'alcoholic' said this:

I just know I am [an alcoholic] because I've been told I am and because I've decided that I am. But sometimes I just want to say 'I'm a woman who is dependent upon a chemical'.

This quote brings to light a few observations and questions: Karen admits to accepting the alcoholic label because she has been "told" that this is who she is. It is unknown what led her to also 'decide' this to be true. Could this have happened as a result of the indoctrination of A.A.? It is obvious that she does not fully endorse the alcoholic label, in that she states that she sometimes would rather identify herself as a woman who is dependent upon a chemical and as noted above, does not like the negative stigma attached to the alcoholic label.

Like Karen, Linda (who no longer attends A.A.) accepts the label 'alcoholic' but talks about how A.A. used this label in a way that denied the existence of her whole being:

I always felt as if I was an alcoholic first...I didn't like to say 'hello my name is Linda and I'm an alcoholic.' I didn't like to say that. I might be an alcoholic but that's not all I am... I'm a woman, lots of things but I don't want to identify myself as an alcoholic and that's what they do every week, 'hello I'm so and so and I'm an alcoholic,' I didn't want to say that every week.

Linda explained that her preference is to introduce herself as a competent woman, rather than an alcoholic. She believes that “the more you say it [competent woman] the more you’ll believe it”. This exercise of affirming one’s positive traits may be even more important to women, being that the literature informs us that women are much more sensitive to labelling. Although male problem drinkers experience judgmental attitudes, women are reproached to a greater extent (Van Den Bergh, 1991). Linda found this to be true stating:

....people don’t look upon it [drinking] favourably, especially with women. Men and their drinking days and going partying with their buddies and getting loaded is acceptable... like even now a guy can go out and get drunk [but] if a women is falling down drunk in a bar its not looked upon as favourably as men... the term women and alcoholic is not looked favourably upon.

Linda’s experience reflects our society’s gender-related rules regarding the use of alcohol which leads to women being doubly oppressed: not only are they “alcoholics”, they are “women alcoholics”, a term that is highly stigmatized in our society (Angove & Fothergill, 2003).

A.A. excludes full participation in society

The practice of regular attendance at A.A. stems from A.A.’s belief that “working the program” by attending meetings on a regular basis will be the addict’s only hope of

sobriety. People who are new to the program are encouraged to attend A.A on a daily basis for the first three months. This practice is referred to as “90 in 90” (McCrary, 1994). Just as alcohol can become a preoccupation and can decrease the quality of life, it has been suggested that attendance at A.A. can also become a preoccupation that decreases the quality of life (Walters, 2002).

Of the six participants, only two expressed no concern about this practice of daily attendance. Linda (who no longer attends A.A.) attended on a daily basis for a one month period of time, then found another support group that was better able to meet her needs. She stated that during the time that she belonged to A.A. she appreciated the fact that she could attend every day: “I needed to get out of the house and be in a safe place”. She noted that attending on a daily basis was possible for her due to not being employed at that time in her life. Julia was the only participant who commented that she attends A.A. as often as she can – typically three to seven times a week. There appears to be two factors that may account for this decision. First, she states that she “does not have an awful lot of other things to be doing”, making it possible to attend on a regular basis. Secondly, as noted above, it appears that Julia has accepted A.A.’s ideology of the disease model which supports the idea of regular involvement with A.A. When discussing her belief in the importance of regular attendance, she stated that her understanding is that if she does not go to meetings on a regular basis that her thinking will change which will cause a relapse. When one endorses the disease model of addiction, it follows that one will abide by the program and its direction.

The other participants provided explanations for their unwillingness to attend on a regular basis. Beth, who is retired, stated that although she is familiar with the “90 in 90” expectation, she chose not to follow this because she has learned to keep a balance in her life: “I have learned not to overwhelm myself, so I don’t go to meetings all the time because that can get me into trouble [feeling overwhelmed], and I won’t allow it”. Clara cited more practical issues regarding daily attendance stating that fulfilling this expectation is impossible if you do not own a car. Both Karen and Diane who are employed and married with children, cited time management issues as a barrier to regular attendance. Diane who at one time attended A.A. three times a week and an aftercare meeting once a week, described this time in her life as “horrendous”. Both Karen and Diane felt that A.A. did not recognize the complexity of their lives. Diane stated: “People couldn’t necessarily grasp the level of stress I work under... my other time commitments... there was no ‘take a look at my life and the balance thing’. Karen commented that many of the members in her A.A. group are retired, or work part time or are independently wealthy and do not understand why at times she is too tired or too busy to attend.

Not only does A.A. not take into account the complexity of women’s lives, but their advice to increase involvement when things are not going well actually serves to increase this complexity. Diane noted that when A.A. members assessed that she was ready to relapse they advised her to “start working the steps stronger” and to “attend more meetings”. There was no discussion pertaining to the possibility that managing multiple roles and feeling overwhelmed and guilty for not meeting all of her obligations

may have been the cause of some of her difficulties. She stated: “three meetings a week, and that’s really still not good enough... so I was always feeling like I should be doing more”. She also commented that at times when she did attend, she felt like it was an obligation without meaning: “You’re basically being lectured and literally it was putting in your time... ‘okay, I’ve done a meeting’. Clearly for the majority of the women in this study, the expectation of attending A.A. on a regular basis was problematic. It is enlightening that they were able to resist the expectation of regular attendance and find ways to get their needs met – whether it was by finding the confidence to “do it their own way” or by finding a different support group altogether.

In addition to the expectation that members attend A.A. on a regular basis, A.A. encourages dependence upon the program by neglecting to offer its members other avenues of support and therapy. Linda and Karen were cognizant of this criticism and shared how A.A.’s aim to be exclusive affected their experience. Karen commented that her sponsor was very negative about Women For Sobriety and formal treatment. As well, her general sense was that A.A. members did not want her to give too much credence to treatment: “‘Don’t bring up treatment too much’... ‘just talk about how wonderful A.A. is and what it is doing for you’.” Linda found that A.A. attempted to exclude her from full participation in society by not providing resources outside of A.A. that may have been helpful. She stated:

There was no mention of ADGS, Women For Sobriety... you can talk to your doctor, there’s the Centre for Native Women down on the east end, there’s

COAST if you need it, there's a detox centre... there's all of these things... I was not offered anything at A.A. – no other options other than A.A.

When asked why she felt A.A. did not encourage members to utilize other avenues of support, she replied:

I think maybe... people who are members of A.A. really believe in their group... and really believe that this is the way to go and no other group is going to help you... and I think they feel loyal to their group and maybe they don't feel as if it can be shared and you could actually do two or three things or whatever works for you.

Linda did not agree with this reasoning and stated that it is possible to attend different support groups and agencies to get the help that is needed. She commented that “while you might not accept 100% of the advice from any one group, you can take what is helpful and leave the rest”. This flexibility seems to have served her well. With the help of different support groups and therapy modalities, Linda has been able to maintain long term sobriety. It is these kinds of experiences that challenge the belief that A.A. is the only hope of sobriety for those struggling with problem drinking.

What are the most valued features of a support group?

In addition to speaking about their experiences with A.A., the participants offered information regarding what they value in a support group.

Group Composition

All of the participants talked about the importance of meeting with people with whom they could relate. Diane liked the idea of meeting with people in a similar age bracket, as well as the idea of a support group for professionals so that issues specific to this group could be addressed. There was no consensus on the preference of attending a mixed gender or gender specific group. Some of the women strongly prefer a women's only group, while others enjoy the company of men and women. Diane and Julia agreed that a mixed gender group that provides some separate sessions for men and women might be ideal.

The majority of the participants talked about the importance of providing an inclusive group, welcoming all individuals whether they are problem drinkers, drug users or problem gamblers. Several of the participants observed quite the opposite of this in A.A. stating that they have seen many drug users either turned away or discouraged from attending this support group. All participants who discussed this issue took exception to this practice, noting that "an addiction is an addiction" and denying someone a service based on their drug of choice is not acceptable. None of the participants voiced opposition to being part of a group comprised of individuals addressing different addictions. They all recognized the fact that they would be dealing with similar issues and supported the idea of inclusivity.

Julia, Beth and Clara all talked about the importance of having members at different stages in their recovery in the same group. Julia talked about the hope that she receives when she interacts with people with fifteen or more years of sobriety: “They are the ones who have the serenity”. When I asked Beth what has most helped her to stay sober, she informed me that having the opportunity to receive inspiration from other members *and* having the opportunity to support others has been central to her recovery. This is supported by the literature that provides compelling evidence that recovering alcoholics who help other alcoholics maintain long-term sobriety are better able to maintain their own sobriety (Pagano et al., 2004).

Regarding the size of the group, it was recommended by Beth and Linda that the membership not exceed 12-15 people so that everyone has the opportunity to participate. The other participants were not asked about their opinion regarding the ideal size of a group.

Frequency and Timing of Meetings

Julia stressed the importance of offering meetings at times that are suitable for mothers of young children. She suggested that an ideal time would be in the daytime or at 8:00 in the evening. While the participants who are employed did not comment about the timing of meetings, it can be assumed that a variety of times would be needed to meet their needs depending on their hours of work.

There were a significant number of comments made by the participants regarding the frequency of meetings. Both Diane and Linda commented on the importance of being able to attend meetings often during the first few months of recovery when the need for

support is high. Diane and Beth both reflected on the importance of flexibility in terms of attendance noting that if members need to attend often, this should be an option. On the other hand, they felt that if a member only feels the need to attend on a sporadic basis, this should be respected.

Structure

Various recommendations were given regarding the structure of the group. Some participants noted the importance of having a professional facilitator to lead the group. Julia who attends a support group led by a professional noted the following benefits: the facilitator is able to keep the discussion focused while encouraging the members to share relevant information based on their experience as problem drinkers or drug abusers. Julia noted that a support group that is guided by a facilitator but enriched with the experience of people “who have been there” is most effective.

Karen talked about the importance of being provided with knowledge and “concrete information” during meetings. Diane and Linda recommended that coping skills be part of the information that is shared. Linda felt strongly that information be given in meetings about resources outside of the support group that may be beneficial to its members. As well, she recommended that resource materials be made available to the participants at no cost.

Comfort

All participants except one talked about the sense of belonging and connection that they felt at A.A. meetings. The following quotes capture the sense of this:

I felt welcome... I felt like they say you're not alone...I had been struggling with my thoughts for so long in isolation. So again I felt like these were people I could relate to and they understood what I was talking about.

The most helpful aspect, it's an anchor. It's always there. I'm always welcome... you can refer to other people's experience and you can see similarities...

You feel you're at home when you're with other alcoholics. They know what the struggle is...There is that connection and that's why it works, that's why it will continue to work.

The above quotes point to the importance of creating a support group that is welcoming and comfortable and one that provides a sense of belonging. Linda, Beth and Julia shared ideas that might be helpful in this regard. They all talked about the importance of not feeling judged in a support group. Beth commented:

Not being judged [is important]... that feeling of being accepted...I belong here... I will speak my mind. It's a safe place to go...

Beth also commented on the importance of having the option to speak or not in a group. She recommended that the facilitator not put anyone "on the spot". Linda spoke of the

importance of giving positive reinforcement to people rather than humiliating them as a way of motivating them to make positive changes in their lives.

Philosophical Position

Due to the negative stigma attached to the label ‘alcoholic’, Karen suggested that members introduce themselves by name only at meetings, and not as an alcoholic. This would eliminate a barrier for those who are opposed to identifying themselves as an alcoholic. Linda recommended that the focus in the group be on positive thinking and behaviour:

Like changing your attitude that I can do it and I am a capable person and I have learned from my past but that’s not where my life is right now. I’m a new person and my life is all about something different.

She states that members should not only be given the opportunity to talk about what is going well in their lives, but that this should be actively encouraged:

Rather than encouraging them to dwell on all of the facts of that horrible thing that happened... they should be encouraged to talk about something good that came out of it and how they’re coping well or that they got through that without the use of alcohol.

She explains that this helps people focus on the positive events in their lives which in turn will help to increase their self-esteem – a critical element in being able to maintain long term sobriety.

Chapter 5: Discussion

While the participants in this study conceptualized their involvement in A.A. in a variety of ways, for the most part they confirmed concerns that have been raised in the critical literature about this organization. Participants offered examples, for instance of ways that A.A. supports domination of men over women and how it operates to draw attention away from the structural forces that give rise to problem drinking. They also identified ways that A.A.'s philosophy leads to a narrowing of opportunities, creating dependency upon the A.A. organization. While the participants were affected differently by their understanding of the disease model and by A.A.'s practices that support this model, it was evident that these beliefs and practices in many ways fostered powerlessness in their lives and limited their participation in society.

As discussed in greater detail in the findings, in some instances participants did not experience features of A.A., cited as oppressive in the literature, as problematic. Indeed, sometimes these features were experienced as supportive. These counter-findings can be accounted for in terms of variability among the participants, variability in circumstances and / or as an indicator that they had found ways to creatively adapt A.A.'s practices and beliefs for their own purposes – a form of resistance.

Powerlessness was the most significant and recurring theme in this study. The disease model fosters powerlessness because it sets people up for failure by convincing them that they are powerless over alcohol and that it is a delusion for

them to believe that they can have any control over a biologically determined deficit (Peele & Brodsky, 1991). Not only does this thinking cause people to conceptualize their problem drinking as a disease that is “inescapable as their own shadow” (Gergen, 1990: 360), it eliminates the option of choosing moderation as a goal. Dominelli (2002) points out: “oppressive relations are about limiting the range of options that subordinated individuals and groups can readily exercise” (p. 9).

Powerlessness is also fostered in the lives of problem drinkers by A.A.’s fourth step which encourages members to identify their defects which can result in feeling humiliated rather than empowered. As Mullaly points out, these types of oppressive acts “interferes with the development or maintenance of a healthy identity – the very thing that is needed to tackle one’s oppression and oppressors” (Mullaly, 2002: 61). A.A.’s practice of stripping away power and focusing on defects serves to not only produce oppression in women’s lives, but takes away one’s ability to resist this process. This inability to resist was evident in the difficulty that women in this study had in questioning A.A.’s practices and beliefs.

Powerlessness is also encouraged in the lives of problem drinkers by teaching them to locate the possibility of change external to themselves by relying on a higher power. Furthering this oppression, when individuals try to claim their own power, as one of the participants in this study did, A.A. attempts to pathologize this claim, taking away any ownership of self-efficacy and control.

The fact that A.A. insists on problem drinkers labelling themselves as alcoholics is yet another example of how they contribute to the powerlessness of those who are

already oppressed in our society. As Gergen points out – mental deficit language such as ‘alcoholic’ creates social hierarchies that lead to rituals of degradation. These social hierarchies and rituals of degradation were definitely experienced by the participants in this study leading them to be quite cautious about using the label ‘alcoholic’ in social or professional circles outside of the A.A. rooms.

As this study makes clear, blaming individuals for their drinking problems while ignoring the structural issues underlying this behaviour is also not conducive to maintaining long term sobriety and contributes to the powerlessness in the lives of problem drinkers. Not only does placing the blame on the individual serve to further demoralize them, it detracts from the necessity of addressing issues such as sexism, racism and socioeconomic class that contribute to problem drinking. Blaming victims as A.A. does “neutralizes the underlying political issues and maintains the status quo” (Conrad, 1975 as cited in Holmes & Antell, 2001: 169).

It is evident that the fostering of powerlessness in problem drinkers’ lives is problematic. Powerlessness according to Young, is a form of oppression consisting of inhibitions in the development of one’s capacities, marked by a lack of decision-making power in one’s life, and exposure to disrespectful treatment because of the status one occupies (Mullaly, 2002). One can only conclude that feeling powerless and being treated as powerless is not conducive to maintaining long term sobriety. Gilliam (1998), author of “How Alcoholics Anonymous Failed Me” provides support for this stating:

If I had to single out the most important component of my ability to break the chains of my addiction, it would be learning to become empowered; learning to connect with my inner power. Recognizing that I wasn't powerless but was, in fact, powerful was one of the most defining moments in my journey toward healing. Later, I saw how debilitating my insistence on powerlessness was and I also understood exactly why I had struggled for so long! (p. 242)

Recommendations and Implications for Practice

In this section I discuss recommendations for support group composition, frequency and timing of meetings, structure, and ensuring comfort of support group participants. These recommendations emerge from interviews with participants and my own practice experience in the field. I then consider the implications of the study in a broader way, drawing from interviews, the literature review and my own practice knowledge to suggest ways an anti-oppressive framework can and should shape services for people with alcohol problems.

Group Composition

In order to meet the diverse needs and preferences of problem drinkers, there needs to be available women-specific and mixed-gender groups as well as groups geared to meet the needs of specific groups, such as professionals or individuals in a particular age bracket. As well, support groups should be available for those who wish to pursue a goal of moderation or harm reduction. Due to the philosophical divide that is quite

common between these groups, it is advised that these groups be separate from each other.

Mixed-gender groups should strive to have equal representation of men and women in order for both men and women to have equal opportunity to participate and to engage in topics that are of interest to them. Groups should be inclusive, comprised of individuals with alcohol, drug and gambling problems. As well, the group should be comprised of individuals at different points in their recovery. This will be a benefit to all members – individuals in early recovery will benefit from members who have longer periods of sobriety, and in turn these more experienced individuals will benefit from being able to inspire others.

The issue of the size of the group was not adequately addressed in this study. While two participants recommended that the group not exceed 12-15 members, literature on this topic suggests that for a weekly ongoing group of adults, about eight people with one leader may be ideal. A group of this size is big enough to provide interaction and small enough for everyone to be involved and to feel a sense of the group (Corey & Corey, 1992).

If an agency or individual commits to developing a support group, it is evident that it may not be possible to implement all of the above recommendations. For example, it may not be possible to offer a group for individuals in a specific age bracket, and at the same time have people in the group that are at different stages in their recovery. Many members with long periods of sobriety are likely to belong to an older age bracket. As well, it is impossible to offer both a gender specific group and a mixed gender group if

the agency's resources are limited to offering one group. It will be important for the agency to weigh out the costs and benefits of each option and more importantly to assess what is available in the community and to offer a service that is presently not available or limited in availability.

Frequency and Timing of Meetings

A variety of meeting times should be available to meet the needs of all problem drinkers, including parents of young children and those who are employed. It is important to remember that many people in the City of Hamilton work shifts. This will require that meetings be available during the day as well as the evening. Similar to the difficulty of being able to satisfy everyone's needs when deciding on group composition, it will not be possible to select a meeting time that will meet everyone's needs if only one group is offered. Again, it will be important to assess what is offered in the community in order to meet a need that is presently not met or met in a limited way.

Regarding frequency of meetings, they should be offered at least once a week in order to provide on-going support for its members. To meet the requirements of those who need a safe place to go on a daily basis, it may be useful to provide a safe environment such as a drop in centre, for those who need a high level of support early in their recovery.

The issue of encouraging regular attendance in support groups is not straightforward and very much depends on the structure and nature of the group. If the group is educational in nature and is designed to run over the course of a specific time period, encouraging regular attendance makes sense. On the other hand, if the structure of the

support group is open-ended and designed to provide support and feedback in response to issues as they arise, this may lend itself to more flexibility regarding attendance. In an open-ended group, it is important that members feel respected in their decision to attend sporadically or on a regular basis. When groups are offered to individuals, it is important that the nature of the group be defined, clearly specifying whether or not regular attendance is expected and the reasons for this.

Again, while the above suggestions are excellent and grounded in the participants' experience, there are barriers to seeing them come to realization. For instance, it may be difficult for a small agency to provide a support group more than once a week, or on a continual basis throughout the year. This once again points to the importance of the community working together as a whole to provide for the needs of individuals struggling with addictions.

Structure

If possible, support groups should be facilitated by a professional who is able to lead the group in a way that will provide maximum benefit to its members. Facilitators need to draw on the expertise of the group members who have personally struggled with alcohol, drug or gambling problems to help all members in the group.

Members should be offered concrete information during meetings, including information on coping skills, and community resources that may be useful in their recovery. If possible, resource materials should be made available to the members at no cost.

Comfort

The following recommendations which stem from the participants' experiences provide direction in creating an environment that fosters a sense of belonging and comfort.

1. Members should not feel judged for their opinions or appearance.
2. Members should have the option to speak or not speak in a group. Facilitators should not put anyone "on the spot". This will allow members who may not have the confidence to speak to feel comfortable in the group.
3. Members should never be humiliated. Rather, they should receive positive reinforcement for what they are doing well in their lives. The purpose of this approach is to facilitate growth and healing.
4. Members should be informed that entering into an intimate relationship with another group member is not advised while both individuals are participating in the group. This is to prevent members from becoming victims of individuals who may try to take advantage of their vulnerability to engage in a relationship that may compromise their recovery and well-being.
5. Members should be provided with a comfortable, non-threatening way of giving both positive and negative feedback regarding the support group's beliefs and practices. A focus group format facilitated by someone outside of the agency is one way to provide this opportunity.

Integrating an anti-oppressive perspective

Based on the findings of this study it is imperative that a model of support be created that fosters empowerment and self-efficacy, recognizes people's strengths and abilities, and takes into consideration a diversity of needs.

While there may be some discussion in support groups of how addictive behaviours have impacted people's lives, this should not be the focus. In other words, drunk-a-logs should not be encouraged. The focus should be on the "here and now" and on skills that can help individuals maintain their goals.

It is imperative to recognize that a focus on the "here and now" includes addressing the underlying issues that have contributed to the members' addictive behaviours. While recognizing the importance of this, facilitators must be mindful that some members may not want to discuss certain issues in a group setting due to the sensitive nature of these issues. This should be respected. But at a minimum, the group facilitator should discuss the fact that substance abuse and problem gambling can be directly related to experiences of invalidation, oppression and abuse (Van Den Bergh, 1991) stemming from structural inequalities such as sexism, racism, and socioeconomic class. Any comments regarding underlying issues should be validated and encouragement should be given to seek further assistance outside of the group if needed.

Due to the significant and prolonged impact that these underlying issues have in members' lives, they should not be told "if you don't drink, all will be well". It is often during periods of abstinence that emotional pain stemming from underlying issues such as sexual abuse will increase (Harrison, 1997). Again, members' experiences in this area

should be validated and referrals to appropriate services in the community should be offered.

While the issue of powerlessness is complex and understood in a variety of ways, it is imperative that the philosophy of a support group validate the power and capabilities of individuals while at the same time respecting those who rely on a higher power for guidance and support. Studies indicate that many people have a belief in God or some spiritual force (Stewart & Nash, 2002) and find that spirituality is fundamental to their sense of being (Hodge, 2003). While being sensitive to this, it is also important to realize that a significant number of people do not know what is meant by the word spirituality, or disagree with the suggestion that their lives have a spiritual dimension (McSherry & Draper, 2002). A philosophy of empowerment should embrace both personal power and a higher power, respecting both positions and recognizing that an endorsement of a higher power does not negate the importance of personal power.

In keeping with a philosophy of empowerment, it should not be a requirement for members to label themselves as alcoholics. Again, in response to the variability in how people conceptualize this term, there needs to be respect for both positions. If members choose to call themselves an alcoholic and find this to be helpful, this should be supported. On the other hand, if members choose to not call themselves alcoholics, this should be respected and understood in the context that many people do not use this term in order to avoid the negative stigma attached to the alcoholic label.

It was evident in this study that while the disease model in many ways fostered powerlessness in people's lives, it was helpful in terms of providing a way of combating

stigma associated with alcoholism. The philosophy of newly developed support groups should offer an equally powerful resource to people – one that will provide a pathway for healing, and provide an explanation for the cause of addictive behaviour that is not stigmatizing. The biopsychosocial model of addiction may be able to provide such a pathway. From this perspective, a substance use disorder is conceptualized as having biological, psychological, sociological and behavioural components (Donovan & Marlatt, 1988, cited in Soden & Murray, 1997). Within this perspective, addictive behaviours can be viewed as an outcome of: 1) oppression stemming from structural inequalities such as sexism, racism, and socioeconomic class; 2) habitual behaviours; 3) sociological factors such as the level of acceptance of substances in society and the availability and costs of alcohol and drugs; or 4) a combination of all three factors (Ibid). Like the disease model, the biopsychosocial model provides an explanation for addictive behaviours, but is able to do so in a way that is empowering.

It is a common practice for addiction treatment programs to mandate their clients to attend A.A. meetings while in the program. Furthermore, they are encouraged to continue to attend A.A. as part of their recovery plan upon discharge from the program. This practice stems from the belief that “working” the A.A. program is the addict’s only hope of sobriety (McCrary, 1994). As previously mentioned, “oppressive relations are about limiting the range of options that subordinated individuals and groups can readily exercise” (Dominelli, 2002: 9). Making A.A. a focus of recovery while in treatment is unfortunate in light of the fact that sustained involvement in A.A. is relatively low (Walters, 2002). When individuals drop out of A.A. they are often unaware of other

resources that may be helpful. This points to the need of informing individuals in treatment programs of the various resources that are available and encouraging them to choose the one that best meets their needs. If clients assess that a support group is not meeting their needs or is not a good match philosophically, rather than being told that they are not working hard enough or are in denial, their opinion should be respected and assistance should be offered to find resources that are more appropriate.

The time has come to loosen the stronghold that A.A. has on alcohol problems in North America and to respect the wishes and experiences of a diverse group of problem drinkers.

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Appendix A

The Twelve Traditions

Our A.A. experience has taught us that:

1.—Each member of Alcoholics Anonymous is but a small part of a great whole. A.A. must continue to live or most of us will surely die. Hence our common welfare comes first. But individual welfare follows close afterward.

2.—For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience.

3.—Our membership ought to include all who suffer from alcoholism. Hence we may refuse none who wish to recover. Nor ought A.A. membership ever depend upon money or conformity. Any two or three alcoholics gathered together for sobriety may call themselves an A.A. group, provided that, as a group, they have no other affiliation.

4.—With respect to its own affairs, each A.A. group should be responsible to no other authority than its own conscience. But when its plans concern the welfare of neighboring groups also, those groups ought to be consulted. And no group, regional committee, or individual should ever take any action that might greatly affect A.A. as a whole without conferring with the trustees of the General Service Board. On such issues our common welfare is paramount.

5.—Each Alcoholics Anonymous group ought to be a spiritual entity *having but one primary purpose*—that of carrying its message to the alcoholic who still suffers.

6.—Problems of money, property, and authority may easily divert us from our primary spiritual aim. We think, therefore, that any considerable property of genuine use to A.A. should be separately incorporated and managed, thus dividing the material from the spiritual. An A.A. group, as such, should never go into business. Secondary aids to A.A., such as clubs or hospitals which require much property or administration, ought to be incorporated and so set apart that, if necessary, they can be freely discarded by the groups. Hence such facilities ought not to use the A.A. name. Their management should be the sole responsibility of those people who financially support them. For clubs, A.A. managers are usually preferred. But hospitals, as well as other places of recuperation, ought to be well

outside A.A.—and medically supervised. While an A.A. group may cooperate with anyone, such cooperation ought never go so far as affiliation or endorsement, actual or implied. An A.A. group can bind itself to no one.

7.—The A.A. groups themselves ought to be fully supported by the voluntary contributions of their own members. We think that each group should soon achieve this ideal; that any public solicitation of funds using the name of Alcoholics Anonymous is highly dangerous, whether by groups, clubs, hospitals, or other outside agencies; that acceptance of large gifts from any source, or of contributions carrying any obligation whatever, is unwise. Then too, we view with much concern those A.A. treasuries which continue, beyond prudent reserves, to accumulate funds for no stated A.A. purpose. Experience has often warned us that nothing can so surely destroy our spiritual heritage as futile disputes over property, money, and authority.

8.—Alcoholics Anonymous should remain forever nonprofessional. We define professionalism as the occupation of counseling alcoholics for fees or hire. But we may employ alcoholics where they are going to perform those services for which we might otherwise have to engage nonalcoholics. Such special services may be well recompensed. But our usual A.A. “12 Step” work is never to be paid for.

9.—Each A.A. group needs the least possible organization. Rotating leadership is the best. The small group may elect its secretary, the large group its rotating committee, and the groups of a large metropolitan area their central or intergroup committee, which often employs a full-time secretary. The trustees of the General Service Board are, in effect, our A.A. General Service Committee. They are the custodians of our A.A. Tradition and the receivers of voluntary A.A. contributions by which we maintain our A.A. General Service Office at New York. They are authorized by the groups to handle our over-all public relations and they guarantee the integrity of our principal newspaper, the A.A. Grapevine. All such representatives are to be guided in the spirit of service, for true leaders in A.A. are but trusted and experienced servants of the whole. They derive no real authority from their titles; they do not govern. Universal respect is the key to their usefulness.

10.—No A.A. group or member should ever, in such a way as to implicate A.A., express any opinion on outside controversial issues—particularly those of politics, alcohol reform, or sectarian religion.

The Alcoholics Anonymous groups oppose no one. Concerning such Matters they can express no views whatever.

11.—Our relations with the general public should be characterized by personal anonymity. We think A.A. ought to avoid sensational advertising. Our names and pictures as A.A. members ought not be broadcast, filmed, or publicly printed. Our public relations should be guided by the principle of attraction rather than promotion. There is never need to praise ourselves. We feel it better to let our friends recommend us.

12.—And finally, we of Alcoholics Anonymous believe that the principle of anonymity has an immense spiritual significance. It reminds us that we are to place principles before personalities; that we are actually to practice a genuine humility. This to the end that our great blessings may never spoil us; that we shall forever live in thankful contemplation of Him who presides over us all.

Appendix B

Interview Guide

Topics to be included in the semi-structured interview are listed below:

1. Can you tell me about your experience with Alcoholics Anonymous?
2. Are there ways that A.A. was helpful to you?
 - a. If yes, probe for examples of how it was helpful.
3. Are there ways that A.A. was unhelpful?
 - a. Probe for examples of why it was not helpful.
 - b. Probe (here or later) for any time that they raised questions or objections to A.A. ideas or practices, and the response they received from others.
4. A.A. encourages daily attendance at meetings for the first 3 months (90 in 90”). Did you attend on a daily basis? If so, was it helpful? Not helpful? How/ in what ways?
 - a. Probe for information regarding the impact that regular attendance had on their day-to-day life.
5. For female participants: I’ve heard that A.A. sometimes doesn’t work well for women; and I’ve also heard that some women find it supportive. Did you ever feel that being a woman ‘mattered’ in your A.A. experience?
 - a. Probe for sense of exclusion, discomfort
 - b. Probe for examples or critical incidents
6. For people of colour: Some people think A.A. works better for white people, than it does for people of colour, or visible minority people. Do you have thoughts on this?
 - a. Probe for sense of exclusion, discomfort
 - b. Probe for examples or critical incidents
7. The first step of A.A. is admitting powerlessness. What does this mean to you? What impact if any did this step have on you?
 - a. Probe for negative and positive impacts.
8. I’ve heard that the fourth step – made a searching and fearless moral inventory of ourselves – encourages members to identify defects in their character. If so, what impact did this have on you?
 - a. Probe for positive and negative impacts.

9. The idea that alcoholism is a disease is supported by A.A. Do you understand alcoholism as a disease? Is it helpful to you personally to understand alcoholism in this way?
 - a. If yes, probe for an understanding of why it is helpful. If no, probe for an understanding of why it is not helpful.

10. A.A. encourages members to identify themselves as an alcoholic. Is this something that you are comfortable doing? Is it something you find helpful/not?
 - a. Probe for an understanding of the basis of comfort or discomfort with this.

11. I know this might be a difficult question, but if you had to say what the source or cause of your struggle with alcohol is, or in other words, the reason behind your drinking, what might you say it is?
 - a. Do you feel that A.A. addressed this issue? Do you think it would have been useful to you if they did?
 - b. If this issue was not talked about, did this impact your ability to make changes to your drinking?

12. One thing that I would like to learn about is what makes a support group work well. I think that based on your experience you probably have some really good ideas about this. What ideas do you have about what would make a support group effective as well as welcoming?

Appendix C

Project Title: Exploring Experiences with Alcoholics Anonymous

Letter of Information

I am a student in the Masters of Social Work program at the McMaster University School of Social Work. To complete the program, I will be conducting a research project.

The purpose of this research project is to learn about the experiences – both positive and negative – of men and women who have attended the Alcoholics Anonymous (A.A.) support group. If you agree to take part, I will ask you questions about how A.A. was helpful and not, and about your experiences and feelings about specific A.A. ideas and steps.

As with any research there are potential risks and benefits. I recognize that talking to someone about substance abuse can be a challenging and emotional experience. You may choose not to answer some of the questions. During the interview, I will remind you of this, so that you will not feel obligated to discuss anything that you do not wish to speak about. It may be helpful to know that I have worked as a social worker at the Alcohol, Drug & Gambling Services for the past eight years, and have experience talking to individuals who are struggling with alcohol problems. If the interview process is difficult, I will provide support as well as information about further support that you can access in the community. The potential benefit of participating in this research is that you will have the opportunity to have your voice heard and your experience validated. I hope to use what I learn from this research to make a positive difference in support for people with alcohol problems.

If you choose to participate in this study, you will be asked to meet with me for one session that will last approximately 60-90 minutes. You can choose one of the following locations to meet: McMaster University, Alcohol, Drug & Gambling Services, or a public place that provides privacy that is agreeable to both of us.

Your participation in this research is voluntary. It is also confidential. Every care will be taken to respect your privacy. The interview session will be tape-recorded; when I type it up it will not have any identifying information. No identifying information or identifying quotes will be included in any of the written reports. However, it is possible that someone who knows you might be able to guess who said what in the research project. You should keep this in mind in deciding what to reveal. All information will be kept in a locked filing cabinet to which only I have access. Upon completion of the study, the audio tapes will be destroyed. You may choose to withdraw from the study at any time without consequences. If you choose to withdraw, all information you have provided will be destroyed.

A summary of my research will be available at Alcohol, Drug & Gambling Services. You are welcome to read it.

MSW Thesis – Jo-Anne Fleming
McMaster – School of Social Work

This project has been reviewed and received ethics clearance by the McMaster Research Ethics Board. Should you have any concerns or questions in regards to your participation in this study, you may contact:

The McMaster Research Ethics Board Secretariat
c/o the Office of Research Ethics
Telephone: 905-525-9140 ext. 23142
E-mail: ethicsoffice@mcmaster.ca

Dr. Chris Sinding is supervising my work. She can be contacted at sinding@mcmaster.ca or by phone at 905-525-9140 ext. 22740.

I will be conducting interviews in February and March 2006. For more information or to arrange an interview, please contact Jo-Anne Fleming at jo-anne@fleming.net or you may simply leave your name with your ADGS social worker and I will be pleased to contact you.

Thank you!

Appendix D

Note: This letter was modified for participants recruited from Women For Sobriety.

Project Title: Exploring Experiences with Alcoholics Anonymous

Letter of Information

I am a student in the Masters of Social Work program at the McMaster University School of Social Work. To complete the program, I will be conducting a research project.

The purpose of this research project is to learn about the experiences – both positive and negative – of men and women who have attended the Alcoholics Anonymous (A.A.) support group. If you agree to take part, I will ask you questions about how A.A. was helpful and not, and about your experiences and feelings about specific A.A. ideas and steps.

As with any research there are potential risks and benefits. I recognize that talking to someone about substance abuse can be a challenging and emotional experience. You may choose not to answer some of the questions. During the interview, I will remind you of this, so that you will not feel obligated to discuss anything that you do not wish to speak about. It may be helpful to know that I have worked as a social worker at the Alcohol, Drug & Gambling Services (ADGS) for the past eight years, and have experience talking to individuals who are struggling with alcohol problems. If the interview process is difficult, I will provide support as well as information about further support that you can access in the community. The potential benefit of participating in this research is that you will have the opportunity to have your voice heard and your experience validated. I hope to use what I learn from this research to make a positive difference in support for people with alcohol problems.

Following the direction of the McMaster Research Ethics Board, I am not permitted to interview individuals who were former clients of mine at ADGS. For anyone who has not been a former client, if you choose to participate in this study, you will be asked to meet with me for one session that will last approximately 60-90 minutes. You can choose one of the following locations to meet: McMaster University, Alcohol, Drug & Gambling Services, or a public place that provides privacy that is agreeable to both of us.

Your participation in this research is voluntary. It is also confidential. Every care will be taken to respect your privacy. The interview session will be tape-recorded; when I type it up it will not have any identifying information. No identifying information or identifying quotes will be included in any of the written reports. However, it is possible that someone who knows you might be able to guess who said what in the research project. You should keep this in mind in deciding what to reveal. All information will be kept in a locked filing cabinet to which only I have access. Upon completion of the study, the audio tapes will be destroyed. You may choose to withdraw from the study at any time without consequences. If you choose to withdraw, all information you have provided will be destroyed.

A summary of my research will be available at Alcohol, Drug & Gambling Services. You are welcome to read it.

This project has been reviewed and received ethics clearance by the McMaster Research Ethics Board. Should you have any concerns or questions in regards to your participation in this study, you may contact:

The McMaster Research Ethics Board Secretariat
c/o the Office of Research Ethics
Telephone: 905-525-9140 ext. 23142
E-mail: ethicsoffice@mcmaster.ca

Dr. Chris Sinding is supervising my work. She can be contacted at sinding@mcmaster.ca or by phone at 905-525-9140 ext. 22740.

I will be conducting interviews in March and April 2006. For more information or to arrange an interview, please e-mail me at jo-anne@fleming.net

Thank you!

Jo-Anne Fleming

Appendix E

Project Title: Exploring Experiences with Alcoholics Anonymous

Consent form

I understand that the purpose of this study is to explore the experiences of men and women who have attended the Alcoholics Anonymous support group.

I understand that Jo-Anne Fleming is the principle investigator of this study, and that her work is being supervised by Dr. Chris Sinding who is a faculty member of the McMaster School of Social Work.

I am willing to take part in one interview that will last approximately 60-90 minutes and agree to have the interview audio-taped and transcribed. No identifying information will be included in the transcripts. I understand I may choose not to answer any particular question and/or may choose to withdraw from participating in this study at any time without consequence. I understand if I choose to withdraw, any information I have provided, including audiotapes, transcripts or notes will be destroyed.

I understand that there are potential risks attached to participating in this project. I understand that talking to someone about substance abuse can be a challenging and emotional experience, and that I will receive the appropriate support if needed. As well, I recognize that this project will provide an opportunity for my voice to be heard, and that the researcher hopes to make positive change in substance abuse support groups in my community.

I understand that my responses will be kept confidential and that I will not be identified in any report. However, it is possible that someone who knows me might be able to guess who said what in the research project and I understand that I should keep this in mind in deciding what to reveal.

I understand that this project has been reviewed and received ethics clearance by the McMaster Research Ethics Board, and that if I have further concerns and questions regarding my rights as a research participant, I can contact:

The McMaster Research Ethics Board Secretariat
c/o the Office of Research Ethics
1280 Main Street West, GH-306
Hamilton, ON L8S 4L9

Telephone: 905-525-9140 ext. 23142
E-mail: ethicsoffice@mcmaster.ca
Fax: 905-540-8019

Or

The principle Investigator: Jo-Anne Fleming
Sinding
E-mail: jo-anne@fleming.net

The Faculty thesis supervisor: Chris
Sinding
E-mail: sinding@mcmaster.ca
Phone: 905-525-9140 ext. 22740

I agree to take part in this study.

Name and signature of Participant

Date

Name and signature of Investigator

Date