Twelve Reasons Why We Need to Find Alternatives to Alcoholics Anonymous

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Abstract

Alcoholics Anonymous (AA) and its professional analog, the Minnesota Model, are often the only options available to persons looking for assistance in overcoming an alcohol abuse problem. Twelve reasons why alternatives to the Twelve Steps must be identified, developed, and implemented are outlined in this article. These reasons include AA's high rate of attrition; views on motivation; religious connotations; external orientation; affiliation with the disease model; emphasis on character defects, powerlessness, loss of control, abstinence, and dependence; labeling practices; and weak operationality. In short, 12-step programs may be inappropriate and ineffective for a certain portion of people who misuse alcohol. Alternatives that more closely approximate the belief systems of clients who find AA principles or practices objectionable are consequently required.

Key Words: Alcohol, Alcoholics Anonymous, alternatives, choice.

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Alcoholics Anonymous (AA) was conceived by two individuals within the context of their own personal struggles with alcohol. The self-help format these two individuals invented in 1935 soon catapulted into a social movement with adherents across the globe. As of January 1, 2001, there were 100,766 active chapters of AA with 2,160,013 members worldwide, with 51,735 chapters and 1,162,112 members in the United States alone.[1] While AA does not directly employ the services of mental health professionals, there are professional-led groups and programs that rely extensively on the traditions and steps of AA. The Minnesota Model is an example of a professional-run program allied with AA.[2] In the United States, if not elsewhere, AA and programs affiliated with the Minnesota Model are often the only option available to alcohol-abusing clients. The present article outlines and describes 12 reasons why alternatives to AA and the Minnesota Model must be found if we are to effectively deal with the problem of alcohol abuse in the United States and abroad.

Reason 1: Attrition

It is apparent that a majority of people who attend AA terminate their involvement shortly after beginning. Chappell,[3] in one of the few empirical studies on attrition from AA, determined that half of all new members to AA drop out within the first 3 months. In norming their Alcoholics Anonymous Involvement scale on a group of 1,625 problem drinkers, Tonigan et al.[4] determined that 50% of the treatment-seeking drinkers they interviewed had attended AA in the past year and that an additional 28% had attended AA sometime before this. However, 69% of the sample had completed fewer than two AA steps in their lifetime, and 50% had attended fewer than five sessions in the past year. Hence, whereas AA attendance is common in alcohol-abusing populations, involvement is relatively low.

Alcoholics Anonymous supporters often attribute high rates of attrition to denial or lack of motivation on the part of those who drop out of the fellowship. Be this as it may, it is also possible that people leave AA for reasons other than denial and poor motivation. In some cases, attrition from AA may be prompted by practices and procedures that make AA unacceptable to a portion of the problem-drinking population. For this reason, the cookie-cutter approach traditionally employed in United States chemical abuse programs, whereby everyone who walks through the door is treated as having the "disease of alcoholism," is in need of revision. Identifying alternatives to AA and the Minnesota Model, in fact, can be an effective means of pinpointing issues requiring attention as part of a comprehensive program of assisted change.

Reason 2: Motivation

The belief that high attrition from AA is a consequence of denial and weak motivation reflects the dispositional as-

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sumptions that define AA and the Minnesota Model. Opting for an alternate perspective on motivation, Miller[5] argues that motivation is a dynamic interpersonal process rather than a static client trait. Hence, motivation can be nurtured and facilitated within the context of the helping relationship. Employing a procedure known as motivational interviewing, Miller and his colleagues seek to enhance motivation for change by administering to substance-abusing clients a battery of physical and mental tests, the results of which are then shared with the client. Rather than directly confronting the client about his or her drinking behavior, Miller recommends that helpers nonjudgmentally discuss with their clients apparent discrepancies between the client's current level of functioning, as measured by the physical and mental tests, and where the client would like to be functioning. Research designates that motivational interviewing can augment the effectiveness of other forms of intervention in people who misuse alcohol,[6,7] although its utility with severely alcohol-dependent clients may be more limited.[8]

Proponents of AA often insist that a person must "hit rock bottom" before realizing the motivation to do anything about a serious alcohol problem. Besides the methodological challenge of measuring this construct, the notion that one must "hit bottom" before changing lends itself to procrastination by serving as an excuse for postponing change: "I'm not ready for change at this point; I haven't hit rock bottom yet." More to the point, only 4.2% of people spontaneously remitting from alcohol and other drug abuse listed "hitting bottom" as important in stimulating their decision to desist from alcohol in a meta-analysis of the self-change literature.[9] Motivating events for initial desistance more popular than "hitting bottom" were drug-related medical problems (18.9%); extraordinary events, like watching a drug associate die from an overdose (9.8%); pressure from family and friends (9.0%); changes in values and goals (7.8%); drug-related financial problems (6.6%); increased responsibility created by marriage or birth of a child (6.1%); and drug-related social problems (4.9%). Conceptualizing motivation as a dynamic process subject to environmental effects in the form of both positive (birth of a child) and negative (ultimatum from spouse) crises may be more acceptable to some clients than the dispositional views espoused by AA.

Reason 3: Religious Connotations

The Twelve Steps of AA were originally borrowed from five procedures established by a nondenominational Christian movement known as the Oxford Group. The five procedures held by the Oxford Group were Giving in to God, Listening to God's Direction, Checking for Guidance, Achieving Restitution, and Sharing.[10] Proponents of AA assert that their approach is spiritual rather than religious in nature. However, God is directly mentioned in 5 of the 12 steps and implied in several others. Another commonality between AA and religion is that some members approach recruitment with missionary zeal. In the late 1980s, an AA veteran journeyed to the Caribbean in what eventually became known as the Caribbean Crusade, and several delegations of AA members, under the auspices of AA-affiliated sponsors, set up chapters in the Soviet Union.[11] Even many supporters of AA acknowledge its religious overtones and appeal.[12]

Research denotes that God-consciousness correlates strongly with AA attendance and involvement in AA-related activities, like finding a sponsor and working the Twelve Steps.[13] What happens, then, to individuals who have trouble relating to AA or who actively reject the religious connotations of the Twelve Steps? The truth is that some individuals who drop out of AA after only a few sessions cannot relate to the religious tenor of the meetings. Alternatives that do not demand allegiance to a religious philosophy of God-consciousness and restitution are therefore required if we are to afford clients the full range of services needed to construct a broad and comprehensive approach to substance misuse. Otherwise, those individuals who find unacceptable the atmosphere of revivalism that marks many AA meetings will be left without a viable, alternate, non-AA program of assistance.

Reason 4: External Locus of Control

There is more than one path to spirituality. Even religious mythology fails to conform to a single pattern. The spirituality championed by AA is external in nature and aligns more closely with Western versions of religion, like Christianity, than Eastern religions, like Taoism and Buddhism. With an emphasis on finding a higher power, AA promulgates the belief that spirituality must be found outside oneself.[14] All the same, there are many expressions of spirituality not addressed by AA, in particular the spirituality that lies within the person. As a result, AA has traditionally been more acceptable to externally oriented individuals than internally oriented ones. The single most powerful correlate of AA membership in one large-scale survey was prior use of external support mechanisms to stop drinking.[15] In adolescents, the most commonly reported concomitant of affiliation with AA is an external orientation or attributional style.[16–18] Locus of control, therefore, may be another factor to consider in determining the appropriateness of various models of alcohol abuse for clients with a substance misuse problem.

Research on locus of control and alcohol abuse is mixed. Some studies find greater externality in alcohol abusers,[19] while other studies detect no such relationship between alcohol misuse and locus of control.[20] There is evidence, however, that externally oriented problem drinkers are more apt to relapse compared to internally oriented drinkers[21] and that over the course of a psychological intervention, alcohol-abusing clients become more internally oriented.[22] Thus, whereas alcohol abusers display a range of

attributional styles and persons with an external locus of control may benefit from externally oriented approaches like AA, internally focused individuals may be more favorably inclined toward cognitively based alternatives. Research indicates that persons affiliated with AA are more externally oriented than clients enrolled in cognitively based programs, like Rational Recovery[23] and Smart Recovery.[24] An even more important question is whether internally and externally oriented individuals experience differential outcomes when enrolled in internally and externally oriented programs.

Reason 5: Disease

Alcoholics Anonymous was instrumental in bringing about acceptance of the disease concept of alcoholism. Since 1935, AA has maintained that some people are "allergic" to alcohol and unable to use it in any form.[25] In 1956, the American Medical Association embraced a medical version of the disease concept, and in 1960, Jellinek[26] lent the concept scientific credibility with the publication of his book *The Disease Concept of Alcoholism*. Whether the disease of alcoholism is conceptualized as spiritual (AA) or medical (AMA) in nature, all versions of the disease concept propose that alcohol misuse is a chronic disorder, progressive in nature, which if not arrested will inevitably lead to death. Research to be reviewed later in this article on alcohol expectancies,[27] unassisted change,[9] and controlled drinking[28] by contrast indicate that alcohol abuse can be as situational, variable, and subject to moderation as it is chronic, progressive, and intractable. Alternatives need to be found and implemented in order to address the disparate circumstances that can contribute to an alcohol abuse problem.

The disease concept is grounded in internal, global, and stable attributions for alcohol misuse. Huselid et al.[29] note that women attending an AA-based program for chemical dependency more often remained in the program if they attributed recent negative events to stable and global causes. Concluding that I drink because of a generalized condition within myself that does not change over time or across situations is akin to treating alcohol abuse as a personality trait. This can create two problems. First, it may foster hopelessness in the sense that psychologists generally agree that personality traits are difficult to change. Second, it can become an excuse for continued drinking: "It's not my fault, my disease got the best of me." Even though AA states that a person is not responsible for the development of his or her disease but is responsible for doing something about it, such subtleties tend to get lost on clients who view the disease concept as an excuse for personal irresponsibility.

Reason 6: Character Defects

Step 6 of the Twelve Steps holds that "We were entirely ready to have God remove all these defects of character."[25] Seeing oneself as broken and defective can lead to feelings of guilt or shame, while asking an outside force to remove these defects of character can promote dependency.[14] Rather than concentrating on a person's weaknesses and limitations, a more productive approach, at least with some clients, is to shift the focus to personal strengths. The behavioral model of intervention, in which skill building is emphasized, would appear to be a viable alternative to AA for clients who consider admission of deficits and dependence on a higher power incongruent with their own belief systems and who drop out of AA in large numbers when forced to attend by a spouse, employer, or probation officer.

Reason 7: Powerlessness

The first step of the Twelve Steps is to acknowledge one's powerlessness over alcohol, the second step is to find a higher power, and the third step is to surrender one's will to one's higher power. This just said, it should be noted that powerlessness can derail the helping process.[30] Likewise, viewing oneself as the passive recipient of outside assistance rather than an active initiator of self-help can impede the personal growth process.[31] Hohman and LeCroy[32] remark that in their group of adolescent alcohol abusers, those with the strongest allegiance to AA had been involved with treatment programs in the past, associated less with other teenagers who used alcohol and drugs, and expressed greater hopelessness than adolescent drinkers with the weakest affiliation to AA. In some instances, overcoming alcohol abuse may mean overcoming hopelessness, which can probably be more effectively addressed through skill development and empowerment training[33] than by focusing on low self-efficacy in situations involving alcohol.

Willpower is often denigrated in AA circles as ineffective in the fight against alcohol abuse. Even so, Walters[9] discerned that 17.4% of the individuals participating in studies on spontaneous remission from alcohol and other drugs mentioned willpower as critical in maintaining their desistance from drugs, as opposed to the 2.5% who reportedly used self-help groups like AA to maintain their newfound sobriety. Part of the problem appears to be inattention to the role of choice in substance misuse. An early study conducted at the National Institute of Mental Health, in any event, showed that "chronic alcoholics" learned to increase the time span between drinks to the point of near abstinence when the cost requirements of earning beverage alcohol in a laboratory setting were increased.[34] In addition, heavy-drinking subjects asked to sign a pledge to abstain from alcohol for 1 week were significantly more likely to achieve abstinence and reduce their alcohol intake (by 74%) than a control group of heavy drinkers who simply monitored their intake.[35] Willpower alone does not always work, but with some clients, it may be integral to the change process.

Reason 8: Loss of Control

The assumption that a person with a drinking problem will lose control in the presence of alcohol, in its various forms, is central to the AA philosophy. There are three sets of research findings, nonetheless, that argue against the loss of control postulate. First, studies on counterregulation indicate that contrary to predictions made by the loss of control hypothesis, problem drinkers classified as "restrained" do not drink more than "nonrestrained" drinkers when presented with a priming dose of alcohol.[36] Second, research using the balanced placebo design to assess alcohol expectancies demonstrates that it is the belief that one has consumed alcohol rather than the pharmacological properties of the beverage that has been ingested (alcohol vs. placebo) that determines the amount of alcohol imbibed in a single session and the behaviors displayed during the session.[37] Third, research on controlled drinking indicates that nearly one in five problem drinkers proceeding through a traditional abstinence program was consuming alcohol and experiencing no adverse effects 4 years later[38] and that it is possible to teach people who have previously experienced serious alcohol problems to drink in a controlled manner.[28]

There is a need for alternatives to the loss of control concept that underpins most theories of addiction to include the disease concept of alcoholism. One such alternative is Edwards'[39] dyscontrol concept, which views control as falling along a continuum that is marked by time, person, and situation and is modifiable by training and skill development. There is empirical support for this conceptualization of control[40] and evidence that expectancies may also play a role in determining a person's overall level of dyscontrol. Oei et al.[41] ascertained that experimental induction of a "high-dependence" expectancy or cognitive set (i.e., "I drink to make me less inhibited") engendered significantly higher levels of alcohol consumption than a "low-dependence" expectancy or cognitive set (i.e., "alcohol is not necessary to get full enjoyment out of life"). It would seem likely that for at least a portion of the alcohol-abusing population, the dyscontrol concept and an emphasis on skill development and expectancy modification would be more helpful than a belief in the inevitability of losing control in the presence of alcohol.

Reason 9: Abstinence

A key tenet of AA is that total abstinence is the only reasonable goal for someone with a drinking problem, which is based on lore that would have us believe that "one drink is too many and a hundred is not enough."[25] Just to mention the possibility of controlled drinking in someone who had problems with alcohol in the past is an anathema to those who follow the path forged by AA and the Minnesota Model. The fact that someone could engage in controlled drinking is, according to AA, prima facie evidence that the person was never a "true" alcoholic in the first place. However, when Walters[28] conducted a meta-analysis of research on behavioral self-control training for alcohol abuse, he discovered that controlled drinking could be taught equally well to persons labeled problem drinkers and alcoholics. Furthermore, when controlled drinking and abstinence programs were directly compared in this meta-analysis, the results favored the controlled drinking approach, although the difference fell short of statistical significance. Despite the fact younger individuals often prefer moderate drinking and harm-reduction goals to total abstinence in dealing with an alcohol problem, many such individuals eventually become abstinent, even though they resisted abstinence initially.[42]

With its rigid adherence to abstinence as the sole criterion for success in alcohol-abusing clients seeking change, it is easy to see why some clients reject AA. There are several factors to keep in mind when selecting goals for change. First, strict adherence to a philosophy of abstinence may cultivate what Marlatt[43] calls the Abstinence Violation Effect, whereby the individual responds with guilt and shame to an initial lapse, which may then precipitate a full-blown relapse. Four of six studies reviewed by Walters[44] in which Marlatt's Abstinence Violation Effect hypothesis was directly tested supplied evidence that abstinence beliefs enlarged a person's vulnerability to relapse. Second, some individuals are better candidates for controlled drinking than others. Younger drinkers with less extensive histories of alcohol abuse[38] and individuals who have successfully moderated their drinking in the past[45] appear to have a greater chance of controlling their use of beverage alcohol than older individuals with more extensive alcohol abuse histories and little past success in moderating their drinking. This may be why there are so many more participants above the age of 40 in AA than participants below age 40.[46]

Reason 10: Labeling

In meetings, AA members identify themselves by their first names and their substance of misuse: "Hi, my name is Glenn and I'm an alcoholic." The rationale for labeling oneself an addict or an alcoholic is to cut through the denial and focus on the problem. The good intentions of this approach notwithstanding, self-labeling can be highly damaging to a person's self-image and confidence level to the point that it limits what a person believes he or she is capable of achieving. Besides the self-handicapping that accompanies acceptance of the sick role subsumed by the labeled alcoholic,[47] labeling has the power to become a self-fulfilling prophecy, which might then rule a person's life.[44] Lacking a strong sense of life purpose can place a person at risk for experimenting with alcohol and drugs as a means of securing an identity,[48] whereas a robust and complex self-image can serve a protective function in an otherwise vulnerable individual.[49]

Certain groups may be more sensitive to labeling than other groups and so may be differentially motivated to

elude or escape AA, not because they are racked with guilt, denial, or weak incentive for change, but because they wish to avoid the labeling rituals that are practiced routinely in AA. Results from Project MATCH indicate that compared to white participants, fewer African-American and Hispanic clients attended the AA sessions during the later follow-up periods. Minorities have received more than their share of uncomplimentary labels over the years and may view the AA labeling process as an invitation to further self-denigration.[50] Hence, just as adolescents and young adults may be drawn to harm reduction and controlled drinking alternatives, minorities may be differentially receptive to alternatives that instead of labeling the individual, label the drinking behavior[51] or drug-using pattern.[44]

Reason 11: Dependence

Step 11 of the Twelve Steps states that one must maintain continued dependence on a higher power to remain sober.[14] Lifelong commitment to AA is implied to the extent that failure to return to AA is interpreted by many AA advocates as proof that the person has relapsed, whether or not he or she returns to drinking. Walant,[52] on the other hand, contends that AA promotes dependency by serving as a substitute addiction, an argument that finds support in the observation that some members attend daily meetings for years. It may well be that AA provides an invaluable social support function for some alcohol abusers shortly after they make the decision to stop drinking but that expectations of life-long commitment stand in the way of long-term growth. In this way, continued involvement in AA beyond a certain point may become life-limiting rather than life-enhancing.[53]

Just as controlled drinking may be more appropriate for some individuals than others and labeling may have a more devastating effect on one group than another, some clients may find the dependency engendered by AA less appealing than the AA affiliates who find comfort in the regularity of meetings. Jarvis[54] writes that many women prefer one-on-one counseling to the group format employed by AA. We might then speculate that women benefit less from AA then men, a possibility bore out by research showing a stronger correlation between AA involvement and abstinence in men than in women.[50] Feminists are particularly concerned with AA's interpretation of powerlessness and surrender as liberating given the traditional subservient position held by women in this country.[55] As such, many women may prefer and respond better to an alternative that encourages autonomy and independence through skill- and confidence-building rather than an approach that demands dependence on an outside force.

Reason 12: Operationality

Research on AA, in the few instances in which it has been conducted, has proven inconclusive. Even the most fundamental of questions, such as the relationship between AA attendance and outcome, remain unanswered. Veteran's Administration outpatients randomly assigned to AA or a control condition exhibited no significant group differences in outcome 12 months later.[56] Whereas Emrick et al.[15] uncovered a modest relationship between AA involvement and decreased drinking in 16 studies, several of the more methodologically sound attendance–outcome studies[57,58] have failed to discern a relationship between AA attendance and follow-up outcome. The anonymity of AA membership, the voluntary nature of AA participation, and difficulties in attaining comparable control groups makes conducting research on AA extremely difficult and challenging. However, research is necessary to determine the relative cost effectiveness of alternate programming. Options more amenable to empirical scrutiny are therefore required if we are to offer clients the full range of services necessary to assist people in overcoming alcohol-related problems.

Conclusion

If we view models of change promotion as stemming from belief systems, similar in kind to the belief systems that people use to construct their personalized versions of reality, we can see that one goal of change programs is to match the belief systems of the individual client with the belief systems of the model being employed. In situations in which the match is good, change is more apt to occur. In situations in which the match is poor, attempts to alter the individual's thinking take on the appearance of brainwashing techniques.[59] Project MATCH randomly assigned clients from nine research units to one of three interventions (12 sessions of Cognitive-Behavioral Therapy, 12 sessions of Twelve-Step Facilitation, or 4 sessions of Motivational Interviewing Enhancement) and examined such matching variables as level of alcohol consumption, conceptual level, and psychiatric severity.[60] Matching had virtually no effect on outcome in this study, although the results may have been different had the investigators matched on belief system variables, like religious ideology, internal–external locus of control, attributional style, alcohol expectancies, confidence level, abstinence attitudes, and identity-seeking. The next logical step for programs like Project MATCH is to examine whether matching a client's belief systems to the belief systems of the change model being utilized has an effect on compliance and outcome in the service of understanding the circumstances under which AA is optimal and when alternate approaches should be considered.

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