

CONTEMPORARY UTILIZATION OF PROFESSIONAL  
HELP BY ALCOHOLICS ANONYMOUS MEMBERS\*

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This Conference reflects the accelerating involvement of physicians and other professionals in the treatment of alcoholic persons, which is, in turn, related to the increased number of alcoholics knocking on the doors of professionals and professionally directed programs.

Alcoholics Anonymous has also been experiencing an increased growth rate. After averaging an annual growth rate of about 6% during the 1960s, the annual growth rate has more than doubled in recent years.

When these interrelated trends are placed alongside the growing awareness, among persons who deal with alcoholics, of the multifaceted and long-term aspects of the "recovery process," the question of mutual appreciation and cooperative interaction between A.A. and the professional community becomes more relevant than ever.

I have previously described the unfavourable perceptions that have muddied the waters of A.A.-professional relations (1). I found in that exploratory study, conducted in 1963, that the perceptions of A.A. both positive and negative, varied a great deal among individual professionals, as did A.A. members' perceptions of the professionals and professionally directed programs. The range of perceptions and the factors that contribute to misperceptions, often a simple lack of knowledge about each other, need not be reviewed in this context. Rather, I will focus on one aspect of the problem, namely, the perception of A.A. as having among its members a disconcerting strain of antiprofessionalism.

This antiprofessionalism is easily inferred from two ideas with some currency among A.A. members: that only an alcoholic can help another alcoholic (which logically rules out all nonprofessionals) and that the A.A. program is complete in itself (the logic of which suggests that professionals have nothing additional to offer).

One old-time A.A. put it to me this way, in all earnestness: "The A.A. program already has in it the best of psychiatry and religion. What more is there except medical help for withdrawal in severe cases?" His view influenced other A.A.s in his community and the consequent perception of A.A. by the personnel in the local members and the clinic staff members not only had little to do with each other but each also felt more or less aggrieved and hostile.

Well, stereotypes do guide action. Stereotypes are short-handed "pictures in our heads," inevitable in our attempts to

perceive the complex world around us. Stereotypes by definition constitute a mix of reality and distortion; the degree of distortion or reality varies considerably.

It is to be expected, accordingly, that among A.A. members there would be a variety of stereotypes about professionals and, among professionals, a variety of stereotypes about A.A. Each stereotype with its particular mix of reality and distortion has a natural history, analyzable in terms of many factors, such as the group the person belongs to, his personality, and his particular experiences with the subject matter of the stereotype.

It is not easy for most professional persons to have enough personal experience with A.A. groups or members to become well acquainted with what really goes on in A.A. and what A.A. is really like. And, it is very difficult for researchers to obtain the data needed to provide a dependable in-depth perception of A.A. as a whole, of the members, the groups, and the actual dynamics of recovery.

If a researcher could somehow have systematic access to a truly representative sample of all A.A. members, for example, in the United States, he could obtain answers to many of the questions we have about A.A., including the matter of antiprofessionalism among A.A. members. But, such a sample is out of the question. We do, however, now have several sets of fresh data that bear on the extent of antiprofessionalism. Though not giving a definite answer, these limited findings do provide a more dependable view of the actual behavior of A.A. members with regard to utilizing professional help.

The findings come from three sources: A.A.'s own membership survey conducted in 1974 and from two aspects of my current study of A.A.

A.A.'s 1974 Survey (a report on which was presented last December by Norris (2)) was based on an approximate 3% sample of its North American members, drawn from every state and province. For comparative purposes, the short questionnaire repeated the questions asked in A.A.'s first two surveys, conducted in 1968 and 1971. But, among the small number of additional questions was one requested by the Trustees' Committee on Cooperation with the Professional Community, a significant new committee that was created in 1970. The question had four parts, each of which referred to "treatment or counseling other than A.A., i.e., medical, psychiatric, spiritual, etc."

The total number of questionnaires returned was 13,467. The responses to the question on non-A.A. treatment or counseling may be summed up simply: such help was received before coming to A.A. by 46% of the total sample, and of this 46%, more than half (56%) states that this professional help had "played an important part in directing them to A.A." This amounts to 26% of the entire sample.

As for professional help after coming into A.A., 40% reported having had such help, and of this 40%, four of five (79%) stated that this help "played an important part in their recovery from alcoholism." This is 31.5% of the entire sample.

Such are the findings from this large, reasonably representative sample of "meeting-attending" A.A. members (all questionnaires having been filled out in connection with A.A.

meetings). The findings are as close as we can come, at this time, to determining the proportion of all United States and Canadian A.A. members who utilized professional help before (46%) and after (40%) coming into A.A., and the proportion of all members who had found such help important in directing them to A.A. (26%) or important in their recovery (31.5%). It is my impression that these proportions are larger than most observers would have expected.

But, what about the types of professional help utilized by A.A. members? On this point, I have some findings from one aspect of my essentially anthropologic study of A.A., in particular, from intensive taped interviews with 118 A.A. men and women. This is a small purposive sample, selected to include the full spectrum of patterns of participation in A.A. group life and program practice.

Some questions were also addressed to non-A.A. aspects of their total recovery careers, including these two: "Before or upon coming into A.A., did you go to a treatment center? What kind and for how long? More than once?" "Since coming into A.A., which of the following types of non-A.A. help have you used? Individual counseling or therapy? Group therapy? Family counseling? Spiritual counseling? Spiritual retreat? Alcoholism treatment center? Any other?"

Table I is a rank-order presentation of the types of professional help (in this case, not including clergy, church or retreat) utilized by men and women and by two "length-of-sobriety" categories, those with 5 or more years since their last drink and those with less than 5 years since their last drink. Thus, we have four comparison categories.

Table I  
Types of Professional Service Ranked by Percentage of A.A.  
Men and Women, by Time Since Last Drink

5 Years or More Since Last Drink				5 Years or Less Since Last Drink			
				Men			
n=34				n=40			
Type of service	%			Type of service	%		
Detoxification	29.4	(before)*		Treatment center	37.5	(before)	
Psychiatrist	14.7	(before)		Group therapy	32.5	(after)	
Family marriage+	14.7	(after)		Psychiatrist	22.5	(before)	
Psychiatric hospital	11.8	(before)		Family marriage	22.5	(after)	
Treatment center++	11.8	(upon)		Detoxification	7.5	(before)	
				Psychiatric hospital	7.5	(before)	
				Women			
n=14				n=30			
Type of service	%			Type of service	%		
Psychiatrist	21.4	(before)		Psychiatrist	33.3	(before)	
Family marriage	21.4	(after)		Treatment center	23.3	(upon)	
Treatment center	14.3	(before & upon)		Psychiatric hospital	20.0	(after)	
Recovery home	14.3	(after)		Family marriage	13.3	(after)	
Psychiatric hospital	7.1	(before)		Group therapy	13.3	(after)	

\* Indicates during which of the three time periods (before, upon or after coming into A.A.) that the particular service was most used.

+ Family or marriage counseling.

++ Specialized inpatient alcoholism treatment center or unit.

In the upper left-hand quadrant, we note that the 34 "5 year plus" men, a detoxification facility of some kind (a short-term "drying out" place) ranks in first place, because it had been used by 29.4% of the 34 men. Indicated also, in parentheses, is the time period when most of the men were detoxified, namely, before coming into A.A. (The other time periods referred to in this Table are upon and after coming into A.A.) Ranking second are psychiatrists and family or marriage counseling (14.7% each). Psychiatrists were sought out before coming to A.A., family or marriage counseling after. Psychiatric hospitals come next (11.8%), and used by the same percentage was a treatment center, defined as a specialized inpatient alcoholism treatment or rehabilitation center or unit, with a stay of 2-4 weeks or longer. These are the five professional services reported most often, but reported also by these men were hospital (nonpsychiatric), psychologist, group therapy (8.8% each), and physician (5.9%).

Turning to the "under 5 year" men, some significant changes stand out. The rank order is different, and the percentages are larger. Most used was a treatment center, by 37.5% of the 40 men, usually upon coming to A.A. Group therapy is next (32.5%), used after coming into A.A. Going to a psychiatrist were 22.5% of the men, before A.A. The same number entered family or marriage counseling, mostly after coming into A.A. A detoxification facility and a psychiatric hospital were used by only 7.5% of these men.

Before commenting on the significant differences between these "older" and "more recent" A.A. men, let us look at the two categories of women.

Compared to their male counterparts, there are interesting differences in the rank order of the types of professional service sought out by the "5 year plus" women. Psychiatrists (before A.A.) and family or marriage counseling (after A.A.) lead the list (21.3% each). Next, we have 14.3% who used a treatment center (upon coming into A.A.), and the same proportion went into a "recovery home" (a live-in facility with the program based almost exclusively upon the A.A. program) after having come into A.A. Only one woman reported going to a psychiatric hospital, and none went to a detoxification facility (which ranked first with the "older" men).

Among the "under 5 year" women, psychiatrists also ranked first, and they were sought out by a larger proportion (33.3%) than among the "older" A.A. women. The use of a treatment center has moved into second place (23.3%), but group therapy has entered the ranks of the top five types (13.3%).

In addition to the seven most used types of service appearing in the Table, the other professional contacts reported by two or more A.A. members were nonpsychiatric hospital, physician, psychologist, and individual counseling with undesignated therapists.

The seven types of professional services that appear in the Table are, of course, the logical and expected ones. The particular value of the Table's findings is to be found in the percentages of A.A. members who used each type of service within each category and

the rank order and percentage differences among the four categories.

As indicated previously, these findings cannot be construed to be representative of the total A.A. population. However, the Table does point up two trends that, to some degree, are generalizable to the larger A.A. fellowship: the increased utilization of professional help among members both men and women, who have come into A.A. in recent years and the ascending role of the specialized inpatient alcoholism treatment center.

For one thing, there are now more such centers or units than 5 or 6 years ago (twice as many in New Jersey, for example), and they are used by an increasing proportion of A.A. members.

Such units are growing in numbers and acceptance, in my opinion, because they combine in one place several very basic functions: detoxification (some centers require this as a prerequisite to admission), education about alcoholism and help in facing and accepting the realities of the problem, beginning psychotherapy, usually group therapy but often supplemented by individual counseling, education about the multiple and long-term requirements of the recovery process, usually an introduction to A.A. and often a more intensive orientation to A.A., and, finally, the time in residence, in what amounts to an intensive therapeutic community, is long enough for a patient to reassess his life and make a good start in his recovery career. In addition, many treatment centers supply group therapy on an outpatient basis for their "graduates" and sometimes for A.A.s in the local area.

Additional perspective on the contemporary role of treatment centers is provided by another small aspect of my current A.A. study.

In one specific geographic area with a total of 45 A.A. groups, I have succeeded in obtaining reasonably accurate information about treatment center use from 43 groups, which comprise 96% of the area's total membership. The overall finding is that 451 of the 1115 in the 43 groups (40.4%) had gone to a "treatment or rehabilitation center just before or shortly after coming into A.A."

This proportion is larger than that found within any of the four categories of A.A. members described in Table I. And, because this finding is specifically concerned with treatment centers (not just any professional help), we may presume that the proportion of 40.4% is larger in this particular geographic area than in A.A. as a whole. Nevertheless, this 43-group finding adds support to the previously noted trend of an increase in the proportion of A.A. members going to treatment centers.

But, this cluster of 43 groups reveals another aspect about treatment center use by A.A. members, namely, that this phenomenon is not equally distributed within the A.A. fellowship. One might expect to find some overall differences in this respect by larger or smaller geographic regions or areas. But, this sample, composed of 43 neighbouring groups in a relatively small geographic area, points up the differences to be found among the individual groups.

As previously indicated, the members who had been to a treatment center upon coming to A.A. constituted 40.4% of the members in these 43 groups. That is the average. But, the group differences in

the percentage of members who had been to a treatment center are as striking. In 19 of the 43 groups, the percentages were above the average: 50% or above in 14 groups, 60% or higher in 10 groups, 70% or up in six groups. Two groups had percentages in the 8-89% brackets, two in the 90-99% range, and in one small group, all members had been to a treatment center.

However, there were more groups with percentages below the average: eight groups in the 30-39% bracket, eight in the 20-29% bracket, and two in the 10-19% range. In one group, no member had been to a treatment center. Thus, among these 43 groups, the range was found to be from 0 to 100%.

These findings on distribution underscore and illustrate something important about A.A., namely, the variety to be found among individual A.A. groups, not only with regard to treatment center exposure, we may assume, the utilization of other professional services, but also with regard to variety to be found along various other dimensions of A.A. phenomena.

Returning to the question of antiprofessionalism, such attitudes are held by many A.A. members. By what proportion we do not know. But, we may infer from the utilization of professional help data that we have examined that antiprofessional attitudes are less common today than they used to be and that this change is further along in some groups than in others.

## DISCUSSION

In the three sets of data presented, we have evidence of a significant trend within the A.A. fellowship, a trend toward a greater openness to the professional community on the part of an increased proportion of A.A. members. We have noted that A.A. groups vary in their resistance to, or in their expression of, this increased openness. But, as the proportion of members who have favourable experiences with professional persons and services grows within a given group, and within a growing proportion of groups, we will have the basis for generally more productive relations between members of A.A. and members of the professional community.

This does not mean that A.A. will cease to be an independent, free-standing, nonprofessional, mutual-support fellowship. These conditions are among those that appear to be necessary for A.A.'s vitality and effectiveness, as they are with many other lay-run, self-help, or mutual-help groups (3,4). But, a greater openness toward the professional community on the part of a growing number of A.A. members, and the increased recognition of this trend by professionals, should provide a better basis for A.A. members and professionals to understand and appreciate each other's contributions, for them to be more free to perceive each other's roles not as competitive but as complementary, with each contributing skills and strengths to the total, multifaceted, and long-term recovery process. Above all, progress along these lines could mean more effective recovery help and for a greater number of alcoholic persons than would otherwise be the case.

## REFERENCES

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