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THE GROWTH OF ALCOHOLICS ANONYMOUS

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Abstract - This paper outlines aspects of the background the ideas adopted by Alcoholics Anonymous, the growth and development of the fellowship and the argument for a more systematic study of the organization which, to date, has been under-researched.

INTRODUCTION

Mutual aid groups like AA now represent a major feature of contemporary life. In both developed and developing countries, increasing numbers of people with health problems are combining to help each other to help themselves (Newell,1975; Katz and Bender, 1976; Robinson and Henry, 1977).

There are groups for the mentally ill; the mentally and physically handicapped; for people who eat too much and those who are reluctant to eat at all; for the bereaved and the dying; for the blind, the deaf, the worried, the frightened, the lonely and for hundreds more besides, including the delightful Analysands Anonymous, open to anyone who has been in psycho-analysis for twelve years or more and who needs the help of a power greater than their own (or that of their analyst) to terminate the analysis. And then, of course, there is Alcoholics Anonymous which so many other mutual aid groups have unashamedly used as their model.

In this paper I an not directly concerned with the question of what AA is and how it works: this has been described elsewhere (Leach, 1973; Robinson,1979). I want to look briefly at certain aspects of the background and ideas adopted by Alcoholics Anonymous, to outline the growth and development of the fellowship and to stress the need for more systematic study of this world-wide organization which, to date, has been so under-researched.

AA ORIGINS AND BACKGROUND

Of all mutual aid groups AA has perhaps the most well-developed written history. According to the fellowship's major texts, Alcoholics Anonymous (AA, 1939) and Alcoholics Anonymous Comes of Age (AA, 1957) AA originated in a chance meeting in Akron, Ohio, in the summer of 1935 between Robert Holbrook Smith, a local doctor, and William Wilson, a New York Stockbroker. A year earlier, Wilson had been introduced to the Oxford group movement by a friend who said he was staying sober by attending their small discussion group meetings and following their precepts; confession, honesty, talking

out of emotional problems, unselfishness, making reparations and praying to God as personally conceived.

Impressed by his friend's efforts, Bill Wilson attended some Oxford group meetings and after what he terms 'a spiritual awakening' found that he too could remain sober. However, he failed to convert other alcoholics because of what his doctor called 'too much preaching.' So he decided to try to convince them that they had some kind of physical allergy and mental obsession and only to introduce the spiritual aspects later. This was first achieved in Akron with 'Doctor Bob' who had also been in contact with the Oxford group.

The AA Fact File in its brief section on historical data puts it like this:

Doctor Bob's Oxford group membership at Akron had not helped him enough to achieve sobriety. When Dr. Bob and Bill finally met, the effect on the Doctor was immediate. This time he found himself face to face with a fellow sufferer who had made good. Bill emphasised that alcoholism was a malady of mind, emotions and body...Though a physician, Doctor Bob had not known alcoholism to be a disease. Responding to Bill's convincing ideas, he soon sobered up, never to drink again. The founding spark of AA had been struck.

(AA 1956)

Both men set to work with alcoholics arriving on the ward at the Akron City Hospital. Around them they gathered other alcoholics, shared experiences and struggled together with their common difficulties. By the end of 1935 a second group was slowly taking place in New York. A third opened in Cleveland, Ohio in 1939. It had taken over four years to gather together a hundred members of the three founding groups.

In 1939 the fellowship published its basic book Alcoholics Anonymous. The text, written by Bill, explained AA's philosophy and methods which had been developed by trial and error or the preceding four years and contained the case histories of thirty of the early members. The book also contained the now well-known Twelve Steps of Recovery, the first of which contains the core of the fellowship's ideas about the nature of their shared problem: "We admitted we were powerless over alcohol - that our lives had become unmanageable.' From this point AAs development was rapid.

We should not be misled into believing, however, that Alcoholics Anonymous invented the idea of addiction, or loss of control, any more than they invented total abstinence as the only goal of treatment. Nevertheless, AA played a major part in the development of the new disease conception of alcoholism in the post-prohibition period.

This idea that alcoholism is a disease, the chief symptom of which is loss of control over drinking behavior, and the only remedy abstinence from all alcoholic beverages, is now about 200 years old. The following brief discussion of some of the ideas which were adopted by A.A., relies heavily on the article by Harry G. Levine (1978).

During the seventeenth century and for most of the eighteenth, it was assumed that people drank and became drunk

because they wanted to, not because they had to. But at the end of the eighteenth century and in the early years of the nineteenth some people began to report for the first time that they were addicted to alcohol. They said they experienced overwhelming and irresistible desires for liquor.

Throughout the nineteenth century the temperance movement argued that inebriety, intemperance or habitual drunkenness was a disease. But by the last decade of the nineteenth century, the temperance ideology had begun to shift. By the early twentieth century, under the leadership of the Anti-saloon League, the drive was for prohibition. One aspect of this transformation was that the idea of addiction began to occupy a less central role in the ideology of the movement. Levine (1978) points out that prohibition campaigns of the early twentieth century focussed on the broader effects of alcohol: its role in accidents and industrial inefficiency; its cost to workers and their families, and the context of drinking, especially the role of the saloon as a breeding ground for crime, immorality, labor unrest and corrupt politics.

The changed focus of the temperance movement meant that the addiction model of alcoholism was, in Gusfield's (1966), terms,'owned by no-one. There was a vacuum, therefore, that remained unfilled until the appearance of AA immediately after prohibition. Post-prohibition thought about the progressive nature of alcoholism, loss of control over drinking, and the necessity for abstinence is all of a piece with the ideology of the temperance movement. But, stresses Levine (1978), the important difference between temperance thought and the new disease conception is the location of the source of the addiction. The nineteenth-century temperance movement found the source of addiction in the drug itself: alcohol was viewed as an inherently addictive substance, much as heroin is viewed by many people today. Post-prohibition thought, including Alcoholics Anonymous, locates the source of addiction in the individual: only some people, it is argued, for reasons as yet unknown, become addicted to alcohol.

AA GROWTH AND DEVELOPMENT

Alcoholics Anonymous would not have developed as rapidly as it has done if it had not been based on ideas that were compatible with dominant ideas in the American culture. Nineteenth-century U.S.A. was a society which required individuals to regulate their business, family and personal activities in order to survive and succeed. At that time, in both Europe and North America, madness was increasingly being defined as a disease, the chief symptom of which was loss of control.

The asylum was changing from being a place of chains and physical control to becoming a place to restore the power of self-discipline to those who had lost it (Foucault, 1975). It became natural, therefore, to redefine almost all evil or deviance, including alcohol problems, as diseases of will. And, because self-reliance had become such an essential feature of belief

and culture, anything that undermined self-reliance or self-control became a matter of great importance.

Liquor was regarded as important since it could weaken inhibitions in the short run and deprive people of their ability to live restrained, moderate and controlled lives. In AA terms, it AA terms it could make their lives 'unmanageable.'

Just as AA's ideas about the nature of the problem had to be compatible with dominant ideas, thought and culture, so did the principles underpinning its programme aims at transforming the dependent, isolated, drinking alcoholic into an independent integrated, sober alcoholic. At an organizational level AA aims at being self-reliant, self-sufficient, beholden to no-one and dependent on no-one. It remains uninvolved in outside philosophical, political or social issues although it co-operates closely with other bodies in order to bring as many alcoholics as it can to sobriety. A.A. calls this 'being friendly with their friends.'

Given the background of ideas and culture of the nineteenth and early twentieth centuries it is not surprising that AA should have been so well regarded in North America. Certainly the fellowship has grown rapidly from its meagre beginnings in Akron, Ohio in 1935. Although it took four years for the first three groups to establish themselves, growth became much more rapid after the "big book" was published in 1939.

In 1940, AA published its first bulletin which listed twenty-two cities in the United States in which groups were said to be 'well established and holding weekly meetings' (AA, 1940). In 1941 the undated list included information about the day of the week on which the groups met. In the intervening year the number of groups had grown from twenty-two to eighty-six. The 1941 list also noted that isolated AA members were in correspondence with the fellowship's office in New York from twenty-seven additional U.S. cities and three Canadian ones: Toronto, Vancouver and Montreal. This is the first record of AA activity outside the U.S.

The question os often raised whether AA can operate outside the particular socio-cultural context in which it originated. It only requires a glance at the early AA Directories to see how soon the organization began to operate outside the mid-West. It was not long before AA was ubiquitous from the trading towns of Alaska to the slums of Detroit and from the fashionable suburbs of San Francisco to the retirement retreats of Florida. The latest Directory reveals there are now over 30,000 groups in the U.S. and Canada with approximately 600,000 members.

It is difficult to pinpoint exactly when AA established itself in Great Britain. During 1945 and 1946, a few individuals were in correspondence with AA in New York. Since there were so many American servicemen in England during the later stages of the war it is extremely unlikely that there were no ad hoc meetings of members. Nevertheless, the official history in the AA Service Handbook for Great

Britain puts the earliest meeting as having taken place in the Dorchester Hotel, London, in March 1947.

In autumn 1948, the first London group was formed. There were approximately a dozen members. The first provincial meeting was held in Manchester in December 1948. Scotland saw two meetings in 1950 and although Wales' first group met in Cardiff in 1957 and then disbanded, meetings took place in North Wales and began again in Cardiff in 1960. By 1959, the General Service Office in London was able to put out a list of over 100 groups. Ten years later there were over 500 and by 1978 there were well over 1000. There are now over 1600.

It is extremely difficult to plot the growth of AA worldwide, but Trice (1958) calculated that by 1957 the movement had grown to 200,000 members in 7000 groups throughout the world. In addition, there were 1000 seamen and 'lone' members in the remote areas who maintained contact with other AA groups by mail. In its 1972 World Directory, Alcoholics Anonymous gave details of just under 5000 groups outside North America and although acknowledging that 'it is extremely difficult to obtain completely accurate figures on AA's total membership at any given time', felt able to say that 'as the result of a special census survey, total membership is estimated to be in excess of 575,000' (AA, 1972). By 1974 the General Service Board was claiming that world membership had reached 800,000 and by 1977 well over one million.

It is often considered that AA is confined to being a North American organization with British or, at least, English-speaking connections in Australia and New Zealand and a number of other pockets of activity in such places as Scandinavia, Germany and so on. The concept is inaccurate. There are groups now in over a hundred different countries, from Norway to Nicaragua, and from Thailand to Trinidad.

On a worldwide scale Alcoholics Anonymous has groups in Catholic and Protestant countries, in developing countries, in beer-producing and wine-producing countries, in countries with private medical care and in those with state health-care systems. But although AA is widespread, its development has, naturally, been uneven. It is thin in Africa outside South Africa and Zimbabwe. It is also thin in Eastern Europe although there are well-known alcoholic clubs in Yugoslavia and elsewhere which operate on somewhat similar lines to AA. In the Middle East and India many of the members are employees of foreign firms, while in Asia many of the groups were started by the U.S. forces. But in all areas of the world the number of groups is growing. This has been particularly the case over the past decade in Central and South America.

In Mexico, for example, there were AA members meeting sporadically ever since 1941 and a regular English-speaking group was started in 1946. It was not until 1956, however, that a Spanish-speaking group emerged. Thirty-eight groups were operating in 1964 and 181 in 1969 when the national service structure began to function: a central office which could provide literature

for the groups and act as a focus for information and activities and an organisational structure through which members could express their views and work together to in AA's terms, 'carry the message to the still suffering alcoholic.' Since the establishment of this national structure the development of AA in Mexico has been very rapid indeed. The 181 groups in 1969 grew to 928 groups in 1974, 1650 in 1977, 2598 in 1980 and a staggering 3900 groups by the end of last year.

Just to give you some idea of the spread of AA there are now approximately 750 groups in Australia, 250 in New Zealand, 1400 in Germany, 115 in Trinidad, 500 in Finland, 1000 in El Salvador, 270 in Belgium, 650 in Ireland, 120 in Iceland, 700 in Guatemala, 2000 in Brazil, 150 in France, 180 in South Africa and 90 in Italy.

A World Service Meeting started in 1969 and has been held every other year since 1972. At the most recent meeting in Mexico thirty-eight delegates represented the twenty-four countries in which there are well-established national organisational service structures.

Given what we know about how A.A. works and what is required of members in personal and social terms (Robinson, 1979), it is possible to identify certain features of the self-help process which may be more acceptable in some cultures than in others.

Alcoholics Anonymous, like many other mutual aid groups, is based, as was stressed earlier, on a philosophy of independence. The drinking problem, however it arises, is seem to be the property of individuals and, as such, is within their own power to overcome albeit with the support of fellow sufferers. In Mowrer's (1971) terms 'you can't do it alone, but you alone can do it.'

The mutual aid process of Alcoholics Anonymous also demands openness in several crucial ways. First, members have to be open with each other about their past, their activities, their relationships and their emotions, in order to create the necessary common bond of shared experience and understanding. Second, AA operates an open membership policy in which attributes that normally distinguish people from each other are ignored while the one thing which members share, their alcohol problem, is emphasised. Third, members of AA have to be open to the possibility of change, because it is an essential part of mutual aid for members to help each other to modify their self-perception, their network of friends and relationships and even the style and content of their everyday life.

So Alcoholics Anonymous demands that individuals, with the support of the group, take responsibility for their condition, their everyday life and, thus, their destiny. They do this in a mutual aid process which requires them to be totally open about themselves with other members who may be of a different sex and very different in political, racial, socio-economic, age and religious terms. The members must be willing to accept that changes in several aspects of everyday life are not only desirable but essential. So, clearly, any culture which puts a very high premium on privacy

in emotional or social terms, or in which people are tightly fixed in complexes of highly differentiated roles and relationships, will fin it less easy than others to accommodate the core principles and practices of the mutual aid process of groups like Alcoholics Anonymous.

THE QUESTION OF 'SUCCESS' AND THE NEED FOR MORE RESEARCH

Mutual aid is grossly misperceived if it is thought of as merely a temporary expendient or passing fashion. Mutual aid is, of course, as old as human history. People have always banded together to solve their common difficulties and promote their common interests in family networks, clans, tribes, guilds, professions, trade unions, friendly societies, clubs and on street corners. Nevertheless, there has been a rapid and substantial growth of specific mutual aid groups, such as AA, over the past thirty years which, taken together, now represent an important component of primary health care.

Two major themes run through most of the accounts of why mutual aid groups are flourishing today (Caplan and Killilea, 1976; Katz and Bender, 1976; Robinson and Henry, 1977). The first is the disillusionment with existing helping services: the feeling that expectations have not been fulfilled or that services are unable to provide the kind of care that is needed. The second is the recognition that in so many societies the traditional support systems such as the church, the neighbourhood and the extended family are in decline. As a result there is a search for community by people who feel helpless and hopeless and without control over their own lives. For many, the world has moved too fast, is too big and is too indifferent to quality, to individual differences and the basic human needs of understanding, friendship and support. For many people in many countries mutual aid groups like Alcoholics Anonymous provide both help and community.

Alcoholics Anonymous has never been made the subject of an international study. It is not possible, therefore, to say how the fellowship has adapted to various socio-cultural circumstances. But given the well-known variation between groups within the same city it is reasonable to assume that AA in Thailand is somewhat different from AA in Nicaragua. This is one of the strengths of the fellowship: its ability to adapt to the needs of its members, provided always that it maintains the surprisingly few core principles and practices which are the essence of the AA programme of recovery.

Just as there has been no study of the growth and spread of AA worldwide so there has been no study of the success of the fellowship. Not everyone who comes into contact with Alcoholics Anonymous progresses to a life of 'sobriety,' quite apart from those many alcoholics who do not approach AA. The question of the success rate of AA in comparison with other responses to alcohol problems is often asked but never answered (Bebbington, 1976).

This lack of answer is not because of a lack of research

interest, but because of practical difficulties. AA keeps no records of its members. It is not possible to conduct a randomised controlled trial since no-one would be able, technically, to determine the universe of alcoholics from which to draw the samples for comparison, and no-one would be able, randomly, to assign alcoholics to either AA or another 'therapy' since the decision to become an AA member is made by the individual concerned. A further major difficulty is that many people do not just attend AA. In practice they often approach a whole series of therapeutic agencies, including AA, either successively or simultaneously. The simple world of the randomised controlled trial is inappropriate in this situation.

But has the question of 'success,' or rather 'how successful in comparison with other therapies,' taken up too much space in the literature on AA? It could be argued without scientific research that the growth of AA is clearly a 'success story.' Nevertheless, it is important at a time of conflicting views about treatment of drinking problems that the experience and achievements of AA are as fully understood and reported upon as possible.

The only national random sample survey of AA members was conducted in England and Wales in 1976. The study (Robinson, 1979) was conducted with the full support of the General Service Office of Alcoholics Anonymous in London and demonstrated what could be achieved through close co-operation between a university-based researcher and an organisation with understandable concerns for anonymity.

What is now needed is a re-study of AA in England and Wales in order to produce the first systematic account of the changes in AA size, structure, membership, attitudes and activities. If such a study was mounted it would offer the possibility of assembling the first national cohort of AA members for the purpose of follow-up investigation. This would not only produce information of interest to AA but would enable the work and value of the fellowship to be better assessed and scientifically presented than hitherto.

But even without this requisite and feasible research there is no doubt that AA, with its basis of mutual concern and continuing support, together with its record of and public commitment to co-operation with others working in the field has a role to play in the overall response to alcohol-related problems in any country. AA has grown indeed from its beginnings in Akron, Ohio almost fifty years ago.

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