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Linking Treatment Centers with Alcoholics Anonymous

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ABSTRACT. Research has explored professional relationships with mutual-help groups but has not paid attention to professional coordination with Alcoholics Anonymous. This study surveyed by mail and by means of personal interviews professionals and members of A.A. Thirty-six centers reported good relationships with A.A., although some professionals evaluated cooperation as better than did A.A. members. Six centers refrained from cooperating with A.A. Respondents shared methods of coordination and recommended linking practices. Good relationships with A.A. existed when professionals interacted frequently with the fellowship and where these interactions followed certain patterns of activity.

Most of us who have worked with alcoholics have felt the frustration of seeing them return to drinking shortly after completing a course of treatment. The social worker in a substance abuse setting knows that successful treatment requires follow-up after professional efforts end. This means linking the alcoholic to a support system in the community. Often that support system includes Alcoholics Anonymous (A.A.). Because social workers identify by training and tradition with the linking role, it is one that many treatment centers will expect them to perform. This article reports the findings of a study that explored linking between alcoholism treatment centers and A.A. members in one southeastern state.

Researchers have not examined the role of professional/A.A. relationships separately from relationships between professionals and other mutual-aid groups (Hermalin, Melendez, Kamarck, Klevans, Ballen & Gorden, 1979; Knight, Wollert, Levy, Frame & Padgett, 1970; Levy, 1978; Powell, 1979; Toseland & Hacker, 1982: Wollert, Knight & Levy, 1980). This investigation examined only the ways that A.A. professionals worked together. A sample of professionals and A.A. members responded to a mail survey. Following that, the author interviewed A.A. members and center personnel in three communities where surveys showed that relationships between the two ranged from highly cooperative in one, through unsuccessfully cooperative in another, to antagonistic in the third.

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Studies of mutual aid groups have been atheoretical. This researcher applied the balance theory of coordination proposed by Litwak and Meyer (1966), in order to investigate whether their propositions clarified the nature of professional/A.A. relationships. The balance theory of coordination proposed that formal organizations and informal community groups must keep some distance in their interactions so that the powerful bureaucracy would not subvert the care that the more informal groups could give its members. Yet, the distance must not be so great that the two cannot relate to each other (Litwak & Meyer, 1966, 1974).

Litwak and Meyer saw a difference between formal organizations and informal groups in the way members relate to help-seekers. Within the bureaucracy professionals respond to clients in order to help them attain objectives. In a mutual-aid group the key ingredient is mutuality. "By sharing my experience with others when they ask for it," wrote one A.A. member on his questionnaire, "I have a chance to stay sober one more day."

Litwak and Meyer suggested ways in which professionals can involve themselves constructively with such groups. For example, a professional person might move out from the organization and become a trusted friend within an informal group. Another method, the settlement house approach, is to provide a place within the organization for the group to meet (1966, p.40). In the author's experience as a former mental health administrator, the approaches by Litwak and Meyer characterized the ways that A.A. members and professionals worked with each other. Some A.A. groups meet in treatment centers, an example of the settlement house approach. Some professionals attend A.A. meetings.

Descriptions of professional relationships with other self-help groups have concluded with suggestions for more directive interactions between them, e.g., consultation, facilitation, initiation of groups (Powell, 1979; Toseland & Hacker, 1982; Woolert, Knight & Levy. 1980). Small and Goldhamer (1979-80), for example, described how a professional administrator assisted the coordination and maintenance of a widow-to-widow program. The professional role included screening of members, supervision of and consultation to bereaved women who counselled others who had lost a husband. Organizers of widow-to-widow see their close involvement with the program as insuring its survival when individual widows graduate after their mourning period ends (Small & Goldhamer, 1979-80).

Coplan and Strull told how they helped physically handicapped adults and single parents to establish mutual-aid groups (1983). They began by forming the groups. They remained in and facilitated the initial meetings, although their assistance differed from that of a traditional group therapist. Later on they separated from the groups, which continued without them. They noted that group members passed through a stage of ambivalence toward professionals but did value professional contributions (Coplan & Strull, 1983).

A.A. differs from groups like those described above. A.A. does not depend on professionals for group formation or facilitation. A.A.'s rarely want to hear professional explanations of their malady, for they have lived it. A.A.'s written traditions advise against professionals giving help within the fellowship (Twelve Steps and Twelve Traditions, 1952, p. 170). In part, their

antiprofessionalism stems from A.A.'s history. An historical analysis of A.A.'s origins has suggested that the antiprofessionalism and anti-intellectualism of the fellowship originated from its roots in the pragmatic psychology of William James and the evangelical Oxford groups, a religious movement popular in the 1930s when A.A. began (Kurtz, 1979, pp.188-190).

The fellowship, nevertheless, does endeavour to cooperate with professionals who deliver help outside the group. A.A. literature reminds its readers that professionals provide much needed services that other alcoholics cannot give - psychotherapy, medical care, concrete resources - and recommends that A.A.s and professionals cooperate (If You Are a Professional, A.A. Wants to Work With You, 1972). A.A.'s Board of Trustees considered cooperation with the professional community important enough that in 1982 they published a workbook to promote interactions with professionals (CPC Workbook, 1982).

In spite of A.A.'s official stance, both professionals and A.A. members sometimes depreciate each other. A.A. members scorn professionals who prescribe tranquilizers as treatment for alcoholism. Professionals at times speak with disdain of A.A.'s simplistic and rigid doctrines as merely substituting a new dependency on the group for former dependency on chemicals (Bean, 1975; Chambers, 1953; Jones, 1970). "A.A.'s and professionals are like the Democrats and the Republicans," said one professional on his questionnaire, " both think they are right and both sides sneer when one fails and the other succeeds."

The author wondered how common these attitudes were and how treatment programs that worked harmoniously with local A.A. members succeeded in doing so. These questions prompted the study that this paper reports. It seemed unlikely that such directive activities as consultant, sponsor, or facilitator, suggested as appropriate professional practices with other groups, would find acceptance within A.A. The balancing roles proposed by Litwak and Meyer (1966) appeared more suitable for professional/A.A. interaction. The question, "How can professionals achieve the necessary distance from A.A. without losing the ability to link clients to it?" defines the purpose of this exploratory study.

METHOD

Surveys

All of the directors of 42 state-operated treatment centers received survey questionnaires that asked them to identify how the staff in their centers related to A.A., to recommend ways of linking to A.A., and to state how well they thought their center cooperated with A.A. members in the community. Because the directors answered on behalf of their entire center, they represented the population of public outpatient programs in one state. For purposes of generalizing the findings to other geographic areas, these respondents represent only a convenience sample, thus limiting generalizability.

The investigator obtained assistance from three individuals within A.A. who mailed questionnaires to 100 A.A. members around

the state. They sent two or three survey forms to members in each of the 42 communities in which there were treatment centers. The A.A. members answered the same questionnaire as did the treatment center directors.

Before the questionnaires went to the professionals, the researcher telephoned them to ask for their cooperation. The initial questionnaire produced a 76% response. Two follow-ups resulted in a 100% rate of return from the 42 program directors. Ethically, the names of A.A. members had to be kept anonymous, therefore, following up with nonrespondents could not be done. A.A. respondents produced a 31% return of completed forms with no prior phone call and no follow-up effort.

The questionnaire contained two questions asking how well the respondent thought A.A. members and the public substance abuse center cooperated in helping alcoholics. A Likert scale followed the questions, allowing for a rating from zero (no cooperation) to five (high cooperation). The form also contained checklists of linking methods used to coordinate and practices respondents would recommend for professionals who wanted to work with A.A. The form gave room for additional comments.

Interviews

After completion of the survey, the researcher interviewed the staff of three centers; each of which, according to survey responses, interacted differently with A.A. All of the three centers' staffs allowed themselves to be interviewed - a total of 18 people. In addition, the researcher interviewed a minimum of three A.A. members in each of the three communities - a total of 11 people. Intermediaries within A.A. selected members in the community for interviews by the researcher. The 11 people agreed to the interviews with enthusiasm.

The interviews followed a nonstructural format but each interviewee gave essential details about how he or she viewed the other group and how the two did or did not cooperate to achieve the common goal of helping alcoholics recover. Interviews with professionals took about one hour. Interviews with A.A. members lasted longer, about two hours. The researcher spent more time with A.A. members because most of them recounted the story of their personal recovery within A.A.

RESULTS

The survey showed that a majority of the respondents thought members of the two services in their communities cooperated. Professionals in 36 of the 42 centers told of cooperation. A.A. respondents, who represented 19 of the 42 communities, perceived cooperation with 12 of the centers. A.A.s in 23 of the communities did not respond to the survey. Thus respondents from both sides rated 12 of the centers as cooperative. They disagreed about the amount of cooperation between A.A.s and 7 of the centers. Professionals described 17 centers as cooperative for which no A.A. members reported. Professionals judged 6 of their centers as noncooperative; A.A.s did not respond from those communities.

Ways of Linking

Professionals reported ways of linking between centers and A.A. groups. Staff members attended meetings, and A.A. groups met in center offices in more than one-half of the communities. A.A. members worked as employees in 25 of the centers and as volunteers in 21 of them. A.A. members told of similar communication avenues. Instead of checking specific practices, some professionals chose a more indefinite response - informal visits.

A comparison of reports between communities from which all respondents thought cooperation existed and those from which only professionals reported cooperation, found one difference between them. Professionals and A.A.s in the more cooperative communities interacted more closely with each other. They chose specific linking practices, e.g., A.A.s met in the center. The professionals who perceived cooperation that A.A. members did not see, did not indicate these methods as often. Instead they more often designated that they worked together through informal visits.

The checklist for recommended professional roles contained several practices that had been suggested in the literature as well as activities commonly found in alcoholism settings. Table I shows the listed activities and the percentage of those who chose each of the activities.

Although bot A.A.s and professionals agreed on the most acceptable methods, professionals more often than A.A.s chose those methods that suggested exercise of influence inside of A.A. For example,43% of the professionals thought it acceptacle to be a consultant to A.A., whereas, only 16% of the A.A. members chose this as a recommended practice.

Table I

Rank Order Listing of Suggested Professional Linking Activities by A.A. and Professional Respondents

	Percentages	
Linking roles	A.A. N = 31	Professional N = 42
Attend open A. A. meetings	90	90
Invite A.A. groups to meet in the center	68	81
Go to Al-Anon meetings	68	62
Be a consultant to A.A.	16	43
Speak at A.A. meetings	16	38
Sponsor A.A. groups	16	33
Start new A.A. groups	6	19
Supervise A.A. members	6	7
Train A.A. members	3	9

Again, when affirmed cooperating communities (where both A.A.s and professionals saw cooperation) were compared with uncooperative or less cooperative places, the less cooperative professionals more often indicated the roles that A.A. members did not specify. For example, in the 13 communities where cooperation did not exist or was questionable, 6 professionals recommended consultation with A.A. and 6 suggested sponsoring A.A. groups. Among the 12 professionals from affirmed cooperating centers, 3 advised consultation and only 1 proposed sponsorship.

Relationships in Three Centers

The three centers chosen for further study each had reported different experiences with A.A. One center claimed good cooperation between it and local A.A. members. The A.A. members there agreed. Another center related that there existed no cooperation between them. Two A.A. members in that community sent the researcher's forms back in the mail without answering them (they were not counted among the 31 A.A. responses). The third center reported cooperation with A.A. through informal contacts only. A.A. members there had numerous complaints about the center and rated cooperation wit it as nonexistent.

Employees in the cooperative center worked closely with local A.A. groups. Three of them belonged either to A.A. or Al-Anon (the A.A. related group for families of alcoholics). The program's director required all staff to attend some open meetings. Although local A.A. groups did not have meetings in the center, they had a key to the building and used it on weekends for informal get-togethers. One A.A. member told of his volunteer work as a co-leader in a therapy group in the center. A.A. members in the community said that the local group had grown from lees than 10 to more than 100 in the past five years as a result of referrals from the center.

The center that had no relationship with A.A. described local members of the fellowship as antagonistic to professional treatment. An effort by the center's director, 10 years earlier, to attend A.A. meetings and to recruit volunteers from A.A. to help with the center's clients ended with mutual mistrust and misunderstanding. "They were suspicious of me," he said, "they seemed to be afraid I would ask them to do something they didn't want to do." An A.A. member in the community recalled the visits from the director. "They didn't want us in the center," she said, "they don't want the competition."

A.A. members in that community thought that the center's staff did not approve of the A.A. program. Although A.A.s referred newcomers who needed professional treatment to a nearby private center or to the state hospital they did not refer to the public outpatient program. The five staff members in the program did refer to A.A. but few followed through on the referrals. Those who did found themselves caught in the cross fire between the two and often dropped out of one or the other program. None of the staff ever attended A.A. meetings, nor did other encounters between them and members of the fellowship happen.

Treatment staff in the third center expressed high regard for

A.A., but A.A. members in the community related many complaints about the center. The A.A.s recalled times when alcoholics had been given tranquilizers in the center. They deemed the staff in the mental health center to be uneducated about alcoholism and characterized the substance abuse staff as young, naive and not professionally trained.

Two of the substance abuse staff had regularly attended Al-Anon or open A.A. meetings, but the other four people in the center had not. None of the employees were members of A.A. They linked clients to the fellowship by inviting A.A. members to address new client groups in the center on a weekly basis. Interested persons could leave the treatment group with the member and immediately attend a local A.A. meeting. Neither the treatment staff nor the A.A.s thought that this method of linking had worked very well.

Two attitudes expressed by all of the A.A.s interviewed in this community struck the researcher as significant. First, all indicated warmth and liking for the one person from the center who regularly attended A.A. meetings. Second, dislike for the center arose more from the A.A.'s judgment of professional inadequacy than from assessments of staff ignorance about A.A.

DISCUSSION

The study found that most state alcoholism program directors regarded linking with A.A. as important. Almost all of them saw themselves as successful in that effort. When the investigator defined good coordination as that which both professionals and A.A.'s rated as successful, the percentage of perceived cooperation dropped. Good relationships between A.A.s and professionals existed in communities where they interacted frequently. Further, the interactions followed certain patterns of routine activity - professionals went to meetings, A.A. groups met in the center, and members did volunteer work there.

Given an opportunity to recommend acceptable professional roles with A.A., most of the fellowship's members rejected those that had professionals giving advice to A.A.s taking responsibility for starting groups, or being a speaker at a meeting. Although most of the professionals had
had experience with A.A., some of them selected these directive roles as suitable activities for professionals working with the program. Moreover, the professionals whose centers cooperated less with A.A. more often chose the linking practices regarded as unacceptable by A.A. members.

The interviews clarified the survey data, underscoring that the cooperative centers maintained close contact with A.A. The two less cooperative centers had fewer contacts with local groups as well as several other problems, e.g., local A.A. members disagreed with professional treatments and thought professionals were not well enough educated for their jobs.

This article directs findings and recommendations to those most apt to read it - professionals. Difficulties do, of course, originate within A.A. A.A. members in the noncooperating community, for instance, had remained distant from the center, nursing resentments over events that had occurred long ago. The CPC

Workbook and other A.A. literature urges A.A. members to be tolerant of professionals and to find ways to encourage communication with them.

The findings supported the growing belief among professionals that coordination and involvement by them with mutual-aid groups should take place. This includes A.A. As practice wisdom and empirical efforts accumulate we find that professionals roles vary with diverse groups (Lurie & Shulman, 1983). But we have yet to find a group that wants professionals to leave them completely alone.

Litwak and Meyer's balance theory tells us that people do not help each other at a distance, but also that when they get too close they get in one another's way or try to control each other. This concept of coordination applies well to professional relationships with Alcoholics Anonymous. "We have to keep some separation," said one A.A. in our interview, "or the clinic would just gobble us up."

Social workers have always accorded primacy to connecting individuals with people and things that they need. This is a social work value. Social workers also possess skills that assist the solving of human problems. Knowing how to connect alcoholics to community supports puts skills and values into practice.

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