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Ideological Differences Between Professionals And A.A. Members

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ABSTRACT. A survey of A.A. members and professional alcoholism treatment center directors elicited responses to ideology scales developed for this research. Alcoholics Anonymous often has been called ideological, as though professionals did not adhere to ideologies. This report examines the ideologies of both A.A.'s and professionals and hypothesizes that ideological differences influence mutual cooperation between them. Both ideology scales elicited significantly different attitudes between A.A. and professional respondents on the majority of items. When comparisons were controlled for perceived degree of cooperation between them, the noncooperators on both sides differed with each other much more than did cooperating respondents.

Members of Alcoholics Anonymous (A.A.) embrace a twelve-step program and a way of thinking that differs from the thought of professionals. This paper reports a study of the ideological differences between A.A. members and professionals and evaluates the significance of those differences for cooperative relationships between members of both groups. An exploratory mail survey of A.A. members and professionals elicited their responses to scales containing contrasting positions on several dimensions. Follow-up interviews examined further the conceptual differences between A.A. members and professionals.

There is disagreement about the extent to which mutual helpers and professionals differ with each other. On the one hand, anecdotal reports have suggested conflict between the two (Chamberlin, 1978;Kleiman, Mantell & Alexander, 1975; Le Veck,1982; Lusky & Ingman, 1979; Mowrer, 1979). On the other hand, Borman reminded his readers that professionals have contributed to the founding of many, if not most, mutual-aid groups (including A.A.) and asserted that conflicts between the two have been inflated (1982).

Interorganizational theory and studies of organizational values have suggested that differing sets of values and beliefs may influence relationships between organizational entities, however, few empirical studies of this proposition exist (Benson, 1975: Rokeach, 1979). The study reported here began with the hypothesis that ideological differences between A.A. members and professionals would impair cooperative relationships.

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Many observers have described the A.A. program as ideological (Antze, 1979; Blumberg, 1977; Taylor, 1977; Tournier, 1979). In fact, the term ideology connotes secular beliefs and thus does not convey A.A.'s foundation in religious ideas and commitment to spiritual growth (Kurtz, 1979; Larrain, 1979). Criticism of A.A. often focuses on its ideological/religious overtones and implies that the pressure to accept A.A.'s belief system harms its members in some way. For instance, Jones (1970) referred to commitment to the A.A. program as "acceptance of a totalitarian ideology" (p.195). Further, Tournier argued that, although A.A.'s effectiveness as a treatment method has never been scientifically established, the fellowship's ideology dominates alcoholism treatment, a situation he thought limited new ideas in the field. (1979).

Despite claims of activity based on a scientific foundation, professionals also cling to ideologies (Strauss, Schatzman, Bucher, Ehlick & Sabshin, 1981; Baker, 1982, p.248; Rappoport, 1967,pp. 269-275; Frank & Davidson,(1983). The variety of treatment paradigms and theories of etiology give evidence of the ideological differences between professionals (Baker, 1982). For example, Strauss et al identified three therapeutic positions among mental health professionals: The psychotherapeutic, the somatotherapeutic, and the sociotherapeutic (1981). Notwithstanding these differences, commitment to a secular, scientifically-oriented and bureaucratic perspective is nearly universal in all professional disciplines (Larson, 1977; Lieberman, 1970; Bledstein, 1976). Thus one would expect all professionals to value aspects associated with enlightened, scientific thought and modern, large organization.

A.A., often described as nonbureaucratic, has no formal rules, no authority over members or groups, and no hierarchy. The fellowship limits its efforts to the mutual sharing of "experience, strength and hope" between members. A.A.'s literature on the steps and traditions, which members and groups voluntarily choose to follow, contain the fellowship's only form of structure (Taylor, 1977,p.6). Thus, the structure and the ideology in A.A. are one and the same.

The author constructed scales that would assess whether A.A. members and professionals' values differed. One scale assessed their responses to bureaucratic/professional dimensions such as scientific knowledge and rational-legal authority, which are characteristics of bureaucracy (Weber, 1978,pp. 956-1005). Scale items juxtaposed such values as the wisdom of personal experience and freedom from authority, which are characteristics of mutual aid. A second scale required responses to treatment approaches. Treatments for alcoholism generally fall into five categories: The mutual-help approach of A.A., medical treatment, social approaches, psychotherapy, and behavioral methods (Miller, 1980; Kissin, 1977; Royce, 1981).

In summary, the literature on mutual-aid groups (including A.A.) and professionals suggested that the two sometimes experience conflict when working together. It further indicated that the members of both groups hold ideologies that differ. The researcher hypothesized that the degree of ideological difference between them would influence whether and how well individual A.A. members and

professionals cooperated. Survey questionnaires sent to members of professional organizations and to A.A. members elicited responses to two ideology scales and questioned how well they worked together in their local communities. Responses showed, first, whether ideological differences existed between A.A.'s and professionals. Second, disparities between cooperative and noncooperative respondents gave clues as to whether values and beliefs influence cooperation.

METHOD

The investigator mailed questionnaires to 42 directors of alcoholism treatment programs operated by the state government in one Southern state. Three A.A. members assisted the author by mailing survey forms to 100 A.A. members in the same state. The forms went to approximately 2 or 3 A.A.'s in each of the 42 communities where there were treatment centers. Usable returns were received from 41 professionals (after two follow-up requests) and 31 A.A. members. This response represented 51% of the individuals sampled. It was impossible to follow up with nonrespondents in A.A., whose names were kept confidential by the members who distributed questionnaires.

The professional ideology scale consisted of 10 items that represented various aspects of professional versus mutual-aid philosophy (see Table 1). A six-point Likert scale after each statement allowed the respondent to indicate agreement with professional values (high score) or agreement with the mutual-aid perspective (low score). Respondents were to indicate their attitudes toward expansion as opposed to accepting limitation, control versus letting go, science as opposed to traditional wisdom, objectivity versus mutuality, the value of formal authority, of education and of efficiency.

The treatment approach scale contained 10 items designed to elicit attitudes toward the five therapeutic positions most often used in treating alcoholics (see Table 2). The items represented the psychotherapeutic, the medical, the social, the behavioral, and the A.A. approaches. The scale consisted of two items for each approach category. A six-point Likert scale followed each item so the respondent could rate it from essential at one extreme (high score) to harmful on the other (low score).

To assess degree of cooperation, the questionnaire contained the statement: "The mental health center and local A.A. group work well together in helping alcoholics in the community." A six-point Likert scale followed this statement. The form also asked for identifying information.

Although the data were primarily ordinal, a difference of means test (Student's) was used to provide comparisons between professionals and A.A. members. This allowed the investigator to gain some idea of the significance of differences and to assess whether the scales had validity. Spearman's rank order correlations between scale items provided evidence of the scales' validity and internal consistency. There were significant correlations between seven professional scale items (those items depicting expansion/limitation, science/wisdom[2], objectivity/mutuality[2],

authority and education). Only control and efficiency did not fit into the hypothetical construct of professional ideology. The treatment-approach scale produced significant correlations between responses to almost all of the professional treatments, whereas, responses to A.A. approaches did not correlate significantly with any of the professional approaches, but correlated highly with each other. Each item was compared independently and no effort was made to arrive at composite scale scores.

Table 1

List of Professional-Scale Items

1.	It is more important to try to help many people than to spend a lot of time with one person who may never benefit from your effort. (Efficiency)[a]
2.	If a program is successful in helping people solve one kind of problem, it should expand to treating other kinds of problems. (Expansion).
3.	Success is better achieved by striving directly for it rather than by taking it easy and letting go. (Control)
4.	The best way to solve a problem is to get control of the situation in which it arises. (Control)
5.	Treatment for alcoholism should be based primarily upon theories proven true by modern science. (Science)
6.	Old time-honored wisdom is usually not as valuable as the latest scientific findings and expertise. (Science)
7.	The most important thing in helping someone is having had the problem yourself. (Objectivity)
8.	A helping person should not become so involved with the other person that s/he shares his or her own experiences. (Objectivity)
9.	It is best for all groups to have people in formal positions of authority. (Authority)
10.	Groups attain their purpose best if the most highly educated have the most authority. (Education)

[a] The words in parentheses did not appear on the original questionnaire.

Table 2

List of Treatment-Approach Items

1.	Individual counseling with a professional therapist (Psychotherapy)[a]
2.	Professional help to find the cause of drinking (Psychotherapy)
3.	Medication for calming nervousness (Medical)
4.	Antidepressants for depression (Medical)
5.	Some tangible reward for nondrinking behavior (Behavioral)
6.	Relaxation training (Behavioral)
7.	Help getting a job (Social)
8.	Help finding a place to live (Social)
9.	Acceptance that he or she is powerless over the use of alcohol (A.A.)
10.	Identifying with stories of those who are recovering from alcoholism (A.A.)

[a] The words in parentheses did not appear on the original questionnaire.

Following the analysis of questionnaire data, the investigator interviewed A.A. members and professional personnel in 3 of the 42 communities chosen for study. Questionnaire responses indicated that the three centers differed in the degree to which they worked together. Fifteen professionals, 2 clerical workers and 11 A.A. members gave interviews. The interviews followed a nonstructured format during which the interviewees discussed, among other issues, their perceptions of ideological differences between A.A.'s and professionals.

RESULTS

A majority of A.A. and professional respondents perceived that the treatment centers and local A.A. groups cooperated with each other. Professionals (85%) saw more cooperation than did A.A. members (61%). Both scales produced differences between A.A.'s and professionals: mean ratings differed significantly on 5 of the professional scale items and on 8 of the treatment-approach items. Thus, there appeared to be support for the hypothesis that the two groups differ ideologically. The data also supported the hypothesis that ideology influences cooperation.

Characteristics of Respondents

Professionals in the sample reported having an average of 8 years experience in their occupation. A.A. respondents had averaged 7 years as members of the fellowship. Professionals represented a wide variety of disciplines - the largest number of them (11) being

social workers. Of the A.A. members, 21 were nonprofessional, 5 were professionals in fields other than mental health, and 5 worked in mental health professions. Four of the professionals also belonged to A.A. and 4 were Al-Anon members.

Differences Between Professionals and A.A.'s

On the professional scale, mean ratings of items differed significantly on attitudes toward organizational expansion, science, objectivity, and education (see Table 3). The largest difference between the two groups appeared in their responses to the objectivity/mutuality item: "The most important thing in helping someone is having had the problem yourself." Most of the professionals (83%) disagree with that statement, whereas, most of the A.A.s (94%) agreed with it. The items representing efficiency and control did not elicit significant differences between A.A.s and professionals.

The treatment-approach scale elicited mean responses that differed on all but two of the approaches (see Table 4). The two groups differed predictably. Professionals more valued their own approaches and A.A.s valued more the A.A. style of helping. The two groups did not differ as sharply on the treatment scale as on the professional scale. For instance, of all the methods, both professionals and A.A.s were most favourable toward the A.A. approaches, even though statistical differences in their attitudes toward the A.A. methods were more significant.

Differences Between Cooperators and Noncooperators

Respondents who reported cooperation between groups indicated more mutual agreement on scale items than did those who did not cooperate as well. The researcher compared responses between 4 groups: (1) cooperating A.A. members with noncooperating A.A. members;(2) cooperating professionals with noncooperating professionals; (3) cooperating professionals with cooperating A.A. members; (4) noncooperating professionals with noncooperating A.A. members.

The first comparison of cooperative and uncooperative A.A. members revealed no significant differences between mean ratings on both scales. The second comparison of cooperative and uncooperative professionals showed that they differed significantly over attitudes toward science on the professional scale and over the value of antidepressant medication on the treatment-approach scale. The cooperating professionals differed predictably in that they agreed more with the hypothesized A.A. position. The third comparison of cooperating professionals and A.A. members produced significant differences over the objectivity/mutuality item - "the helper should have the problem" - and the degree to which they valued "identifying with stories of recovering alcoholics" as a means of helping.

Table 3

Comparison of Mean Ratings by A.A.s and Professionals on Professional Ideology Scale

Statements	A.A.s N = 31		Professionals N = 41		
	M	SD	M	SD	t (two-tailed)
1. Efficiency	2.9	1.5	2.6	1.5	1.25
2. Expansion	1.4	1.5	2.3	1.2	3.0**
3. Control	3.5	1.2	3.2	1.4	1.0
4. Control	3.2	1.3	2.9	1.3	1.0
5. Science	1.2	1.2	1.9	0.8	2.3**
6. Science	1.0	1.3	1.4	1.3	1.6
7. Objectivity	0.5	0.9	3.4	1.2	15.2***
8. Objectivity	1.2	1.5	1.9	1.4	2.08*
9. Authority	1.2	1.4	1.5	1.2	0.9
10. Education	0.7	1.0	1.1	0.8	3.3**

df = 70 *p<.05 **p<.01 ***p<.001

The fourth comparison of noncooperating professionals and A.A. members showed they differed significantly on 6 of the 10 professional scale statements and 4 of the 10 treatment-approach statements - far more disparity than the other comparisons produced. They differed over attitudes toward organizational expansion, scientific knowledge, objectivity, formal authority, help to find the cause of drinking (psychotherapy), the value of antidepressants, help finding a job, and the value of identifying with stories of recovering alcoholics. This finding supports the idea that the ideological conflict inhibits intergroup cooperation.

Follow-up interviews with A.A. members and professionals in three communities supplemented the survey findings. Of the professionals interviewed, 9 of 15 thought members of the two groups had different perspectives, values and beliefs. Of the A.A. members, 10 of the 11 agreed that professionals and A.A.s possessed different ways of thinking. They characterized differences in various ways. One professional thought A.A. members were more spiritual. Another professional thought A.A.s believed less in a "medical model." A.A.s mentioned differences related to their histories of suffering, their preference for mutuality, and their rejection of hierarchical relationships.

The center that had established the most cooperative relationship with A.A. appeared to possess fewer ideological differences with the fellowship. Several of the personnel were recovering alcoholics who also belonged to A.A. The treatment program used A.A.'s Twelve Steps in its therapy and involved A.A.

volunteers as co-therapists. The other two programs did not work as well with local A.A. members and showed less knowledge of, agreement with, and use of A.A. philosophy in their treatment programs. For instance, one profession in the least cooperative center described A.A.'s program as a "rigid, one-track way of thinking." In both communities where the treatment centers cooperated less well with the fellowship, A.A.s objected to treatment approaches by the professionals. In both cases physicians associated with the treatment agencies were thought to be prescribing tranquilizers to alcoholics, a practice usually frowned on by A.A. members and by many professionals.

Table 4

Comparison of Mean Ratings by A.A. Members and Professionals to Treatment-Approach Scale

Approaches	A.A.s N = 30[a]		Professionals N = 40[b]		
	M	SD	M	SD	t (two-tailed)
1. Psychotherapy	2.4	1.3	3.0	1.2	2.1*
2. Psychotherapy	1.2	1.2	1.8	1.2	2.0*
3. Medical	1.1	1.2	1.3	1.3	0.66
4. Medical (Antidepressants)	0.6	1.0	1.1	1.1	2.08*
5. Behavioral (Rewards)	1.8	1.6	2.6	1.6	2.16*
6. Behavioral (Relaxation)	2.6	1.5	2.4	0.9	0.66
7. Social (Jobs)	2.0	1.2	2.6	1.2	2.14*
8. Social (Shelter)	1.8	1.2	2.6	1.1	2.75**
9. A.A.	4.9	0.2	4.4	0.9	3.57***
10. A.A.	4.4	0.8	3.6	0.9	4.0***

df = 68 *p<.05 **p<.01 ***p<.001

[a]one A.A. member did not answer on this scale

[b]one professional did not answer on this scale

DISCUSSION

The data indicate highly correlated values and beliefs that affect cooperation and communication. Comparison of the responses by A.A. members and professionals supported the hypothesis that ideological differences between them exist and that these differences influence the extent to which the two cooperate in assisting alcoholics who ask for help.

Earlier theory on organizational values suggest that they serve as important predictors of effective intergroup cooperation (Connor & Becker, 1979, p.78). The significance of ideological conflict, then, is that it interferes with the ability of professional care-givers and nonprofessional peer helpers to offer both treatment and continuing support in recovery.

Although the investigation uncovered ideological differences, it is also important to note that the differences were not as pervasive among the sample as conventional wisdom might indicate. Perhaps this lends credibility to Tournier's assertion that A.A. dominates contemporary alcohol treatments (1979, p.230). Almost all professional respondents (98% and 100%) agree that A.A. methods helped alcoholics. This represented more agreement by professionals for those two items on the treatment-approach scale than any other of the other methods received. A.A.s also indicated acceptance of many professional approaches. A large majority of the A.A. respondents thought 4 of the 8 professional approaches helped alcoholics. Only the two medical treatments, the operant-conditioning approach and the search for causation in psychotherapy received less than majority approval from them.

The study reported here had several limitations. Sampling bias constitutes an important methodological problem in studying members of mutual-aid groups (Knight, Wollert, Levy, Frame & Padgett, 1980). The sample of A.A. members who responded to this survey limits ability to generalize because of its questionable representativeness and small size. Moreover, the sample of professionals was drawn from a single state and only one kind of program. Nevertheless, the data do show that ideological differences can be operationalized and tested. Up to this time they have not been systematically studied in the literature on A.A. and professional therapy. Further study should evaluate the topic among larger and more representative samples. Such study might also examine the relationship of intergroup cooperation with treatment outcome.

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