

Cooperation and Rivalry Between Professionals
and Members of A.A.

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Because Alcoholics Anonymous (AA) is an important resource for recovering alcoholics, most treatment centers want to work cooperatively with it. To identify factors that enhance this cooperation, the author surveyed AA members and professionals in the same communities and obtained a profile of their interactions, ideological similarities, and linking activities.

Except for anecdotal accounts, no empirical information describes relationships between helping professionals and members of Alcoholics Anonymous (AA) (1). The lack of research is surprising because AA is the oldest of the modern mutual-aid groups and, since its founding in 1935, has tried to cooperate with professionals (2). Moreover, many formal treatment programs for alcoholics rely on AA as a resource for clients and as the source of a philosophical foundation for treatment (3). In spite of close association between professionals and AA members, professional articles have identified ideological disagreement between them (4). The literature of various professions have reported mutual antagonism between professionals and members of other mutual-aid groups as well (5). Recently, however, articles in social work journals have encouraged social workers to take more interest in alcoholism and in AA (6).

Exploration of attitudes held by professionals and members of mutual-aid groups have not looked specifically at AA (7). Nor have they studied the mutual perceptions of professionals and group members. Instead, they have reported the thoughts of professionals only or of group members only. Further, such studies have not advanced theoretically based hypotheses. To address these deficiencies, the research reported in this article investigated the attitudes of both AA members and alcoholism treatment workers. The author surveyed and interviewed members of both sides whom she thought might interact with each other. Theories of interorganizational behavior provided a conceptual basis for the investigation.

Conceptual Foundation

Coordination between organizations may be viewed as a system of exchanges (8). Each organization uses resources of the other to achieve goals. Such resources may be information, funds, expertise, personnel, referrals, or public credibility. The exchange process may create dependence by one organization on another, which leads both to increased interaction and to a potential for conflict over

available goods (9). Thus, interaction could lead to harmonious interdependence or to conflictual dependence. In the case of AA's relationship with professionals, the resources exchanged would most likely be information, referrals, credibility, and personnel in the form of volunteers from AA who would help the professional program.

Domain consensus is another aspect of exchange. When two organizations share resources and goals, they usually share domains; they may serve the same population, treat the same disease, or render the same services (10). When organizations share domains, they exist in each others task environment and may form agreements about the shared resources, develop a division of labor that increases the power of both to achieve goals, or attempt to co-opt each other. Here again, there is potential for harmony and conflict when domains are shared. Because of AA's dominance in the alcoholism field, professional programs often incorporate aspects of AA's program into treatment approaches. AA and professionals thus frequently share the same domain in terms of population, disease, and services rendered.

Both the degree of interaction and domain consensus appear to be factors that may contribute to cooperation or conflict between AA members and professionals. To achieve productive interdependence, cooperating organizations must develop coordinating strategies that reduce conflict and promote the goals of both groups. Success in this endeavor may depend on the ability of the agents who serve as intermediaries (11).

The balance theory of coordination suggests that bureaucratic organizations and primary groups in the same community, such as AA, achieve a balance between independence and dependence by strategic linking activities that reduce the threat of co-operation (12). Litwak and Meyer, the authors of this theory, defined primary groups as those that resemble families, that is, the groups provide spontaneous, affective support and acceptance without the structure and complexity characteristic of bureaucracies. The bureaucracy's large size and numerous resources make the smaller primary group vulnerable to takeover or annihilation by the larger entity. To avoid this outcome, the formal organization must choose activities that allow the more vulnerable group freedom to maintain its different but complementary style. Litwak and Meyer outlined several practices that might achieve that purpose. The settlement house approach links the bureaucracy with the primary group by giving it a place to meet. Another nonthreatening linking practice is the use of a detached worker who is accepted by both parties and who acts as a message carrier between them.

Ideological differences may also account for conflict between organizations. The political economy framework for analysis of social networks includes the dimension of ideology (13). In the political economy model, ideology refers to members' beliefs about appropriate approaches to problem solving or treatment. Organizational values have also been suggested as factors in intergroup conflict (14). An example of how organizations with common domains adopt different ideologies can be found in a study of two psychiatric hospitals in Chicago (15). Most of one hospital's professionals thought in terms of physiological treatments, whereas the other institution's staff adhered to

psychotherapeutic approaches. The research did not focus on relationships between the two institutions, but one can imagine that the ideological dimension might have affected joint activity between the two hospitals.

Variables Studied

On the basis of the orientations described, the author chose four variables most likely to influence cooperation between AA members and professionals: frequency of interaction, domain consensus, types of linking activities perceived as effective, and ideological differences. Four hypotheses were advanced for exploration:

1. Professional and AA members who interact often will perceive cooperation. Cooperation is required for interdependence, and frequent interaction is necessary to achieve it. Conflict and lack of cooperation would probably result in reduced contact between parties.

2. Domain similarity in the form of rendering similar services will result in a perception of decreased cooperation. AA and alcoholism treatment centers obviously serve the same population and treat the same disease. Yet they base their methods on different kinds of helping. If the treatment center or the AA group offered similar services, the threat of co-optation might result in conflict and reduce the level of cooperation. This would most likely happen if the treatment center appropriated AA principles in the treatment framework, as many do.

3. Cooperative professionals will choose different linking roles for working with AA members than will noncooperative professionals. Based on the balance theory of coordination, the ability of the outreach worker may be a key to the success of efforts to cooperate.

4. When professional and AA members adhere to similar ideologies, they will perceive cooperation between each other. Lack of knowledge about the phenomenon of alcohol addiction and what methods should be used to treat the malady create an ideological climate in the field. That is, beliefs are adhered to that are not necessarily scientifically based. Typically, divergent views on the nature and definition of the problem and on appropriate interventions create anxiety and conflict.

In regard to the variables chosen for study, the author defined interaction loosely, as any activity that occurred between treatment staff and AA members in the community. The survey form used asked for a Likert-scale response to frequency of interaction, ranging from never (0) to daily (5).

Because domain consensus was the same regarding target population and disease, the likelihood of domain conflict in this study rested on the degree to which professionals and AA members perceived that they gave the same service. One would expect that treatment centers would provide detoxification, counseling, material resources, and education. Similarly, it would be anticipated that AA members would make what AA refers to as 12th Step calls, or calls reaching out to someone who asks for help, provide comradeship, and share stories of recovery (16). Domain similarity was defined as the degree to which respondents perceived

that one group rendered services that belonged to the other's typical activities.

Linking activities were defined as the way professionals chose to make and sustain contact with AA. Those practices might be professionals' efforts to share their expertise through consultation and advice. More egalitarian strategies would be inviting AA members to volunteer services to clients or asking professionals to attend AA and Al-Anon meetings.

The author defined ideology in two ways. One dimension related to the value of professionalism, such as objectivity and theoretical knowledge; the other related to various treatment approaches, including four professional models (medical, psychotherapeutic, behavioral, and social) and the mutual-aid approaches of AA (17).

Cooperation, the dependent variable, was defined as the perception by representatives of the professional agency and local AA members that the two organizations worked well together. Respondents were asked to indicate on two Likert-scale items whether they agreed that they cooperated with the other. Responses ranged from high agreement (5) to none (0).

Collection of Data

After a period of approximately one year, in which she observed one agency and its efforts to work with AA and attended open AA meetings, the author used two methods of data collection. A mail questionnaire went to directors of alcoholism treatment centers and the AA members in the communities where the treatment centers were located. Following the mail survey, the center personnel and AA members in three of the communities were interviewed. Each of the centers had reported different degrees of cooperation with AA: (1) Center A cooperated well with the local AA, (2) Center B tried to work with AA, but AA members reported poor cooperation, and (3) Center C had no interaction with AA. A detailed description of the methodology follows.

At the start of the study, the questionnaires were mailed to 42 directors of community-based alcoholism programs run by a southeastern state. The 42 constituted all the public, state-run programs located in communities. The author telephoned the directors prior to mailing the forms; afterwards nonrespondents received a follow-up postcard and, later, a repeat questionnaire. All 42 directors returned completed questionnaires. A snowball sampling method was used to contact AA members. Three members assisted by mailing the survey instruments to 100 other AA members in the 42 communities. No follow-up of AA non-respondents was made. Thirty-one of the AA members from 19 of the 42 communities completed and returned questionnaires. The overall response rate from this convenience sample was 51 percent.

The four-page questionnaire contained requests for identifying information and for perceptions of cooperation between the treatment center and local AA members. Respondents rated on a six-point Likert scale the frequency with which they interacted. To assess domain similarity, respondents were asked to check two identical lists of 19 activities and to indicate on one list which

activities they thought the other did. The number of overlapping choices would give a rough idea of how many services were being duplicated.

Two 10-item ideology scales required Likert-scaled choices in response to 10 statements reflecting professional versus mutual-help values and 10 items reflecting five different approaches to treating alcoholism. The professional (bureaucratic) values pertained to efficiency, expansion, objectivity, scientific knowledge, authority, education, and control. Mutual-help values found in AA reflected mutuality, traditional wisdom, subjectivity, anarchy, giving up control, and limitation (18). The treatment approach scale contained two statements for each of the five treatment paradigms, which were medical treatments using detoxification drugs and chemicals for depression, psychotherapeutic methods of expressive and insight therapy, behavioral operant and desensitization methods, social methods of vocational counseling and provision of shelter, and AA methods of accepting powerlessness and telling stories.

A checklist of coordination strategies allowed respondents to pick practices they recommended for coordination between centers and local AAs. Degree of cooperation was assessed according to Likert-scaled responses to a statement ("The center and AA members cooperate well") and to an item asking the respondents to rate the degree of cooperation from very cooperative (5) to totally uncooperative (0).

Following the survey, the researcher interviewed the entire staff of the three centers selected for follow-up study. AA members in each of the three communities were also interviewed. The centers were selected for follow-up because questionnaire responses indicated that each represented a different relationship with AA. According to its director and to two AA respondents in the community, Center A cooperated closely with AA. Center B's director reported cooperation, but two AA respondents gave opposite assessments, describing serious rifts between members of AA and the local mental health center in which the alcohol program operated. Center C's director claimed to have no relationship with local AA members; the lack of cooperation stemmed from relationship factors rather than to circumstances over which he had no control. The three centers were situated in geographically different areas: Center A was in the center of the state, Center B in the north, and Center C in the extreme south. AA members were chosen randomly for follow-up interviews by intermediaries who were AA members in the three communities. Altogether, 16 professionals (including paraprofessionals), 2 clerical workers, and 11 members of AA gave interviews.

The limited sample size, the sample's confinement to only one state, and the poor response rate from AA members posed significant problems for the research. Results cannot be generalized outside the state or to private treatment centers. The likelihood of bias in the responses cannot be overlooked, especially by AA members, among whom the more negative recipients of forms may have refused to cooperate with the research. The difficulty of contacting AA members by mail because of AA's proscription against the use of its directory for this purpose made the snowball technique the only

method available for contacting them and prevented follow-up with nonrespondents. Such problems are inherent in the study of AA and illustrate one reason why so few studies of AA exist. Further, the issue of cooperation between AA and professionals is a sensitive topic now because more professional treatment exists than ever before. The upsurge of professional attention to alcoholism has resulted in scrutiny and frequent criticism of AA by persons who are not part of it.

The study has merit, however, because it is the first and so far only one of its kind. The findings are tentative but should generate further exploration. The conceptual framework and methodology offer a base, as would a pilot study, for further examination of the topic. In addition, the use of follow-up field interviews helped to reevaluate and confirm the survey's findings.

Survey Results

Both AA members and professionals reported substantial experience in their respective groups; AA respondents averaged seven years in AA, and professionals averaged eight years of experience in the field of alcoholism treatment. The largest number (11) of professionals were social workers, 26 percent of the sample. Clinical chaplains made up the second largest group, 21 per cent. The remainder represented a variety of other disciplines, specifically, medicine, nursing, psychology, education, and addictionology. Eight of the professionals belonged either to AA or to Al-Anon. Of the AA respondents, 12 worked in nonprofessional occupations, 5 worked in fields other than mental health, such as law, veterinary medicine, and engineering, and 5 worked in the area of mental health treatment.

Overall, the findings of the survey reported three of the four hypotheses. Respondents who perceived frequent interaction between professionals and AA members also perceived cooperation. Domain similarity did not result in decreased perception of cooperation. Respondents who reported ideological similarity also reported cooperation. Cooperating professionals chose linking roles that were more acceptable to AA members than did noncooperating professionals.

Cooperation. The majority of respondents from both groups thought local AAs and treatment centers cooperated with each other. Of the professionals, 85 percent reported cooperation; of the AA respondents, 61 percent perceived cooperation. When responses by 19 professionals and 31 AA members from the 19 communities were paired, the results showed that in 12 communities both sides agreed on the degree of cooperation. In 7 communities the two disagreed. In the remaining 23 communities, 6 professionals reported that they did not perceive cooperation, and 17 reported that they did.

Frequency of Interaction. A comparison of the mean rating of the 12 cooperating professionals (according to both self-report and AA reports) and the 6 noncooperating professionals (according to self-reports) showed that the cooperation increases when there is more interaction: scores indicated $M = 3.70$ and 0.80 , $t(16) = 6.20$,

$p < .01$ on one item, and $M = 4.2$ and 1.6 , $t(16) = 4.2$, $p < .01$ on the other. The mean ratings of cooperating and noncooperating AA respondents also showed agreement between more frequent interaction and perception of cooperation: $M = 2.60$ and 0.60 , $t(29) = 5.80$, $p < .001$ on one item, and $M = 3.8$ and 1.1 , $t(29) = 4.6$, $p < .001$ on the other. The seven professionals for whom self-reports and AA reports differed were eliminated from these comparisons related to the dependent variable because the out-come was unclear.

Domain Consensus. Overlapping domain in the area of services rendered did not decrease the perception of cooperation. Generally, respondents perceived few overlapping activities. However, cooperating professionals and AA members perceived more overlap than noncooperators: an average of 4.4 overlapping activities were indicated by cooperating professionals and an average of 2.2 by noncooperators [$t(16) = 1.46$, not significant]; an average of 2.6 was indicated by cooperating AA respondents and an average of 1.2 by noncooperators [$t(29) = 1.80$, not significant].

Linking Activities. The findings supported the hypothesis that cooperating professionals would choose different linking activities from professionals who did not work as well with AA. Cooperating professionals and all the AA respondents selected the activities that most often are associated with professional-AA interaction: holding AA meetings in treatment centers, arranging visits by professionals to open AA groups, and having AA members work in treatment centers. All the professionals and 93 percent of the AA members recommended making referrals.

Ideological Differences. The findings support the hypothesis that ideological agreement corresponds with cooperation. When mean ratings by AA respondents and professionals were compared controlling for outcome, the cooperative respondents from both groups differed little in how they rated the statements on both ideology scales. They indicated statistically significant differences over only one item on each scale.

Noncooperators differed at statistically significant levels on six items on the values scale and over four items on the treatment approach scale. For example, on the values scale, center directors favored treatments based on scientific findings ($M = 3.7$); AA members did not [$M = 1.4$, $t(16) = 4.3$, $p < .001$]. On other items ("In order to help an alcoholic, the helper should also have the problem"), the professionals' mean rating was 3.6 and that of the AA respondents was 0.60 [$t(16) = 5.6$, $p < .001$].

Noncooperating professionals and AA members differed less in their attitudes toward treatment approaches. The widest difference occurred over opinions of the AA method - identifying with stories of recovering alcoholics. The professionals' mean rating was 2.8, that of AA respondents was 4.6 [$t(16) = 4.61$, $p < .001$]. Regarding professional treatments, noncooperating AA members rated antidepressant medication, operant conditioning, and vocational counseling less highly than did professionals.

Noncooperating professionals frequently picked activities that are not popular with AA and that would tend to put them in a "one

up" position, such as speaking to an AA group, consultation, supervision, and sponsorship. For example, 16 percent of the AA members and 43 percent of the professionals chose consultation, and most of the latter were noncooperating professionals or those whose cooperating status was unconfirmed.

Interview Findings

Interviews with all staff members of the centers and with a small sample of AA members in the three communities under-scored the conclusions based on the survey's findings. According to the survey questionnaires returned by Center A's director and two local AA members, that agency worked in harmony with AA. Three of the center's six workers belonged to either AA or Al-Anon. All staff members attended AA meetings, some as often as once a week or more, and AA members served as volunteer workers. For example, John W, a volunteer, told the interviewer about his coleadership role with a social worker in a treatment group. In another instance, a member of AA possessed a key to the center, which AA members used for social events on weekends. The treatment program incorporated the first five steps of the 12 Steps that are an integral part of AA. Although both AA members and professionals sometimes worried that the center duplicated AA's program, this concern did not create conflict between them. They valued the fact that alcoholics in the community made use of both forms of service. As evidence of this, the preponderance of AA members had once been patients in the center.

Center B's director had reported cooperation, but interviews indicated that this was a wish, not a reality. His staff was small and had no time to attend AA meetings or to interact with AA members in other ways. His program was collocated with a mental health center, and reception staff often referred problem drinkers to other mental health programs in the center. This gave outsiders, especially those in AA, the impression that alcoholics were improperly treated and given tranquilizing chemicals more appropriate to other disorders. AA members in the community confirmed the picture presented by the staff. Both alcoholism professionals and AA members hoped that increased staffing would help the program conquer these problems with treatment and with AA relationships.

Ten years prior to the investigation, Center C's director had attempted to form a relationship with local AA members and failed. Both sides recollected this and described his efforts to the interviewer. The director remembered trying to recruit volunteers; the AA members recalled being prohibited from talking with center clients. It seemed that the director, perhaps knowing little of AA's principles and program, had been presumptuous and authoritative in his request. He and his staff were still relatively unfamiliar with AA, and the center staff and local AA members harbored resentments toward each other. The AA members also complained that the center's physician used tranquilizers to treat alcoholics, a belief that the author learned was accurate. AA members never referred clients to the center, and clients who the center referred to AA rarely followed through on the recommendation.

Aspects of Cooperation

Overall, both follow-up interviews and the survey's findings indicated that cooperation between professionals and AA members involves frequent interaction, congruent ideas about treatment, and appropriate linking strategies. The most cooperative of the centers studied interacted often with AA because half its staff belonged to AA or Al-Anon. Staff members used AA approaches in their program and did not prescribe tranquilizers to clients. They were linked to AA by commonly accepted practices, such as employing volunteers from AA. Center B's staff did not have time for interaction with AA members, and its program did not have a distinct identity in the community. AA members did not differentiate the alcoholism program from other aspects of the mental health center. Although the alcoholism staff expressed attitudes about treatment that were congruent with those of AA members, other mental health staff did not. For example, a center physician told alcoholics that drinking was just a habit they could break if they really wanted to. Center C had similar problems, which were accentuated by a 10-year history of noncommunication and misunderstanding. Domain consensus, one of the variables studied, appeared to be achieved between professional programs and AA members. Professionals who borrowed AA approaches to use in treatment did not threaten AA members, who seemed to view this as validation of their success and as an indication of ideological congruence between AA methods and professional treatment.

Bridging professional treatment with continued recovery in AA deserves high priority as a clinical task. Research on treatment outcomes among alcoholics increasingly finds that participation in AA improves chances for successful rehabilitation (19). Observers in psychiatry and psychoanalysis have taken a new look at both the personality dynamics of chronic alcoholics and the processes in AA and found these processes to be an ingenious therapy for the ego disturbances that characterize the disorder (20). For example, AA's program directly alters the individual's narcissistic, grandiose perceptions of the self and assists in the development of a more mature, less egoistic self-concept (21).

Future study of relationships between helping professionals and AA should focus on private programs and on geographic areas other than that used in the author's investigation. Qualitative studies can identify additional factors that may influence cooperation. Follow-up with clients from cooperating and noncooperating professional programs should investigate the conclusion drawn by the author, that cooperation with AA makes a critical contribution to treatment outcomes. One might also ask how social workers, who have a traditional commitment to person-environment connections, compare with others in the ability to establish linkages between alcoholics and AA.

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