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SOCIAL THOUGHT, SOCIAL MOVEMENTS AND ALCOHOLISM: SOME IMPLICATIONS OF AA's LINKAGE WITH OTHER ENTITIES

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Social thought on alcoholism can be classified into various traditions, all of which have ignored the literature on social movements. In the instance of what is known as the disease model, critics claim the approach blames the alcoholic. The argument is presented that the social movement perspective suggests that the victim of what passes as the politics of social policy formation will be the organization, Alcoholics Anonymous (A.A.). It is noted that some describe A.A. affiliations as resulting in social policy successes while others warn that professionals in the alcoholism field must rid themselves of AA's influence. The controversy surrounding the Rand Report (Armor et al., 1978) is examined in that context. The findings related to the differential treatment effectiveness of A.A. and professional treatment are re-examined, which indicated that the Rand study could have been interpreted as a document favourable to A.A. This discussion is concerned with why A.A. was denied what could have been a major victory.

Recently, Watts (1982) discussed three traditions in social thought on alcoholism. The first was defined as "the moral perspective and the Prohibition movement" which stressed the evil of alcohol and its destructive properties; the second was labelled the "modern alcoholism movement" (the "disease" model of alcoholism) which stressed the alcoholic as "sick"; and the third was the "new public health perspective" which stressed the need for societal controls over alcohol. Watts emphasized that the new public health movement represents an attempt to put alcohol back into alcoholism policies. This perspective includes the notion of shared responsibility for alcohol and the alcoholic among alcohol users, abusers and non-users.

In his discussion of the modern alcoholism movement, Watts (1982) indicated that the disease model ignores the role of alcohol and instead concentrates on alcoholism. He noted that the Alcoholics Anonymous (AA) program has grown in size and influence

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parallel with the disease concept of alcoholism and both (AA and the disease model movement) stress the unique susceptibility of alcoholics. According to Conrad and Schneider (1980:103-105), the factors which determine that vulnerability are as follows: 1) Alcoholics have predisposing characteristics that consistently differentiate them from nonalcoholics; 2) Alcoholism is a progressive, inexorable process, progressing through fairly identifiable stages; 3) Alcoholics suffer "loss of control" which implies that if an alcoholic begins drinking, then he or she will be unable to stop; 4) There is an absolute necessity of abstinence in the treatment of alcoholics. As a result, Watts suggested that the modern alcoholism movement has created two distinct groups, alcoholics and normal drinkers, treating alcoholics as unique, separate and particular. This process has been referred to as "blaming the alcoholic" (Beauchamp, 1980).

The purpose of this paper is to question the emphasis on the individual alcoholic as victim and to suggest that the alcoholism literature has treated AA as an organization central to social policy on alcoholism. It is the organization, not the individual alcoholic, that has been the hero or the villain in these critiques. The point is that this literature has totally neglected the body of social thought which deals with social movements, especially the implication that indigenous persons will ultimately be coopted when they engage in cooperative ventures with more powerful professional groups. This paper takes that perspective and utilizes the initial Rand Report (Armor et al., 1978) and the subsequent follow-up study (Polich et al., 1981) to indicate how AA has been damaged and has become the victim of its linkage with other organizations.

Social Thought on Social Movements: Who Is the Victim?

The most influential theoretical approaches to the study of social movements have been provided by Smelser (1963), Gurr (1970), and Turner and Killian (1972). While they differ, they share the notion that common grievances among a deprived population represents the potential genesis for all social movements. Each holds that discontent produced by some structural configuration is a necessary, if not sufficient, condition to account for the rise of any specific social movement. Further, before collective action is possible, a generalized belief is necessary concerning at least the causes of discontent, and under certain conditions, the modes of redress.

Recently, theorists have stressed the need to develop more general structural theories of social processes as the basis for the study of social movements (McCarthy and Zald, 1977; Wilson, 1973), stressing the linkages between social movements and other entities. This perspective has become known as the resource mobilization framework, which refers to societal support and constraint of social movement development. Studies cast in that perspective are concerned with identifying the variety of resources available from external sources that may be mobilized, the degree to which movements are dependent upon external support for their success, as well as the tactics used by authorities to control or incorporate movements.

Cloward and Piven (1974) have described in detail how authorities control and coopt disadvantaged groups. They have suggested that large scale public funding creates bureaucratic structures which become the domain of professionals and their special knowledge, a process they defined as the consolidation of expertise. The social service has provided numerous examples of how rewards have been used to coopt indigenous people, especially through their use as paraprofessionals (Reissman, 1965; Piven, 1974; Fry, 1976, 1977). Berman and Haug (1973) identified a major dilemma for paraprofessionals. Upward mobility within an agency may weaken the bonds between paraprofessionals and the groups from which they are drawn. Clients may resent the indigenous worker's advancement and upwardly mobile paraprofessionals can lose a sense of identification with clients; elsewhere, Bullington et al. (1969) have documented that phenomenon in a community-based drug abuse program, calling it the "purchase middle class conformity."

AA and Social Policy on Alcoholism

Blumberg (1977) has suggested that "it was not much of an exaggeration to observe that the development of a publicly funded alcoholism bureaucracy and of a community treatment personnel, with associated multidisciplinary researchers and centers for the study of 'alcohology' serves as a measure of the success of AA as a social movement" (1977:2122-2123). Schneider (1978) made a similar point when he attributed what he defined as the "success" of the spread and acceptance of the disease concept of alcoholism as a social product, resulting from the efforts of AA, the Yale Center on Alcohol Studies and the first director of the Yale Center, E.M. Jellinek. According to Schneider, the various parties cooperated to launch a national educational campaign designed to gain acceptance for the disease concept. Schneider suggested that the success of that effort was separate and apart from the validity of the disease concept and he stressed that acceptance represented a social accomplishment which owed its life to the efforts and vested interests of the cooperating parties.

Numerous individuals disagree with the position that AA's influence has resulted in a number of social policy successes. These critics tend to embrace two contradictory positions in that they either stress that AA has failed to accept its legitimate social responsibility because of the failure to support broad social change strategies or they argue that AA has exerted undue influence, often with harmful effects for the majority of alcoholics.

The first position is apparent in Gartner and Reissman's (1977) version of what they defined as the "self-help world view." They indicated that self-help groups do not look to structural-societal solutions to social problems. They stated that "AA is concerned about the treatment of the alcoholic, not about the removal of alcohol or the societal produced stress related to the stimulation of drinking...There is a basic tendency in the self-help world view to: 1) deal with the problem at the symptom level; 2) look for small scale solutions; 3) define marginal alternatives to the major institutional care giving system; and to be broadly

critical of institutions and the societal framework but not to organize a direct, rounded political attack"(1977:153).

An example of the second, contradictory position was provided by Tournier (1979) when he suggested that professionals in the alcoholism field must rid themselves of the political influence of AA and the National Council on Alcoholism. He argued that acceptance of AA's ideology represents a roadblock not only to the implementation of early intervention efforts, but to treatment innovation in general. His overview of AA and its role in policy influence regarding the treatment of alcoholism can be summarized as follows: 1) due to ideological stances which, in turn, create methodological problems, specifically the failure to cooperate with research, AA's effectiveness has not been demonstrated through proper scientific evaluation techniques; 2) despite the lack of proper evaluation, AAs suspected success with certain alcoholics has been generalized as a treatment method for the entire alcoholic population when it is most likely effective with only certain types of alcoholics; 3) the ready acceptance of AA and its ideology by one major segment of the alcoholism treatment establishment virtually precludes early intervention strategies; 4) AA and the National Council on Alcoholism have proselytized their beliefs with such vigour that the label "alcoholic" is being applied to different kinds of drinking problems that may require different kinds of interventions.

Tournier's (1979) article generated a major debate in the literature, one which rekindled interest in the previously published Rand Report (Armor et al., 1978). This occurred because Tournier has argued that AA's stress that alcoholics must accept their own loss of control over alcohol and AA's rejection of the notion that alcoholics may be able to return to normal drinking were primary examples of the negative results of AA's influence in the policy area.

While all of the contributions to the subsequent debate agree that AA was a major force in alcoholism treatment policy, whether they supported or disagreed with Tournier's (1979) position revolved around where they stood on the issue of whether alcoholics can successfully return to drinking. AA's negative stance on that point became the rallying point for both sides. Tournier had singled out Pattison et al. (1977) as the harbinger of what he defined as a revisionistic view of alcohol dependency (defined as a return of alcoholics to normal drinking), but it was the Rand report (Armor et al., 1978) which became the focal point regarding the scientific merit of the studies concerned with a return to normal drinking by alcoholics.

The issues related to the return to normal drinking question will not be addressed here;(*1) rather a comment in the debate provided by Moore (1979) recast the Rand Report (Armor et al., 1978) in a very different light and this reply is responsible for what follows in terms of the re-analysis of the Rand data. He stressed that both sides in the controversy surrounding the Rand Report had not made a very good impression, especially those aligned with AA. He saw their hysterical reaction as uncalled for, particularly because he reported that the Rand study had suggested that better results are obtained with a mixture of AA and

professional treatment than with either along, in which case they were about equal. As previously suggested, the debate in the literature had been interpreted as an attack on AA by Tournier's (1979) critics and supporters and Moore's comment suggested the need to re-examine the findings in that report related to treatment effectiveness.

The Rand Report

As Roizen (1978) has indicated, the public law that created the National Institute on Alcohol and Alcoholism (NIAAA) required the submission of an annual report which essentially amounted to an evaluation of the effectiveness of services and a justification for the expenditure of funds by the agency. Since a large proportion of NIAAA's resources were devoted to treatment delivered through a system of federally supported alcoholism treatment centers, effectiveness of these centers eventually became the evaluation focus. An outgoing monitoring system was established which at the time of the Rand Report (Armor et. al., 1978) contained demographic, treatment and outcome data on nearly 30,000 clients who had entered treatment at forty-four different centers throughout the country. The information collected by that monitoring system, along with a special eighteen month followup survey conducted in eight of the treatment centers, provided the data for the study. Some comparisons with the general population were provided through the use of several national surveys on drinking practices.

The summary of the report, first published in 1976, noted that as a group, the alcoholics who entered treatment in the various centers were severely impaired from excessive use of alcohol. They were found to drink nine times more alcohol than the average person, and to experience negative behavioral consequences at a rate nearly twelve times that for the nonalcoholic population. They were socially impaired, with more than half unemployed and more than half separated or divorced. They were engaged primarily in blue collar occupations and had lower incomes and less education than the average American (Armor et al., 1978:293).

To paraphrase the Report's summary, despite their impaired status, clients were found to show substantial improvement, both at six and eighteen months following intake. While the rate of improvement was reported to be about seventy percent for several different outcome indicators (alcohol related behaviors), social outcomes such as employment and marital status showed much less change. That finding was interpreted to reflect the greater emphasis by the centers on the immediate problem of alcoholic behavior (drinking). While the improvement rate was interpreted to be impressive, the report stressed that the improved clients included only a relatively small number who were long-term abstainers. About one-fourth of the clients interviewed at eighteen months had abstained for at least six months, and those who had both six months and eighteen months followups, only ten per cent reported six months of abstention at both interviews (Armor et al., 1978:294). Consequently, the majority of improved clients in the Rand Report were either drinking moderate amounts of alcohol at levels which were suggested to be far below what could be described

as alcoholic drinking or engaging in alternate periods of drinking and abstention.

Because of the fact that most of the clients listed as improved were not abstaining, the Rand Report (Armor et al., 1978:294) proposed a definition of remission that included both abstention and what they referred to as "normal drinking," defined as alcoholics who consumed only moderate quantities commonly found in the general nonalcoholic population, provided no serious signs of impairment were present. Specifically, to be classified as a "normal" drinker in the study, a person had to meet all the following criteria: 1) daily consumption of less than three ounces of alcohol; 2) typical quantities on drinking days less than five ounces; 3) no tremors reported; and 4) no serious symptoms. Serious symptoms were operationalized as frequent episodes of three or more of the following: blackouts, missing work, morning drinking, missing meals and being drunk. "Frequent" meant three or more episodes of the other symptoms (Armor et al., 1978:98-99). According to that definition, seventy percent of the client group was in remission after treatment.

The study (Armor et al., 1978:294-295) stressed that being in remission at one followup period was no guarantee that the client would be in remission at a later followup. However, as far as they were concerned, the crucial finding in the analysis was that relapse rates for those classified as "normal" drinkers were no higher than those for longer term abstainers, even when the analysis was confined to clients who were definitely alcoholic at intake. While the study noted that its sample was small and acknowledged that the followup periods were relatively short, the results were interpreted to suggest the possibility that for some alcoholics "moderate drinking" is not necessarily a prelude to full relapse, and that some alcoholics can return to moderate drinking with no greater chance of relapse than if they abstained. Finally, the report stressed that the finding had major implications for theories of alcoholism, particularly the notion that alcoholism is caused exclusively by a physiological predisposition to addiction. While the Rand Report went on to qualify the position outlined above, both in terms of the need to verify the findings with larger samples of alcoholics as well as with longer followup periods, the endorsement of normal drinking for alcoholics became the major source of controversy which surrounded the Rand Report.

The Rand Report did contain information on persons who had contact with the treatment system and yet received no formal treatment; they were either screened and never appeared for treatment or made a single appearance and never returned. This meant that the study was able to compare treated and untreated clients as well as to differentiate the effects of various levels of treatment. On that basis, the study compared the results for those who entered treatment as opposed to those who did not start treatment at all. Those who entered treatment had a slightly higher remission rate than those who either had no contact or the single contact with the centers. When the treated sample was divided according to the amount of treatment, the advantage was confined to those with higher amounts of treatment. Clients with lower amounts

of treatment had remission rates only slightly higher than those who received no treatment at all (Armor et al., 1978:295).

However, the study indicated that the untreated sample had remission rates on the order of fifty percent, which obviously tempered the importance of the overall seventy percent rate. As Moore (1979) suggested, the report then indicated that untreated clients regularly attending AA meetings also had remission rates near seventy percent. Armor's et al. (1978) overall interpretation was that formal treatment may play only an incremental role in the recovery from alcoholism. The study suggested that there is a natural remission from alcoholism and some alcoholics can do almost as well in AA settings as in formal inpatient and outpatient treatment settings.

The Differential Effects of AA and Professional Treatment

One of the problems which confronted the Rand Report's (Armor et al., 1978) analysis of the effects of treatment was the high percentage of clients who were also involved in other programs, with AA the most frequently cited other treatment source. The problem of attempting to differentiate between types of treatment was even more confounded because many of the centers included AA meetings as an adjunct to formal treatment. That institutional arrangement meant that the analysis had to consider whether some of the positive treatment effects identified could have been accrued from other than the treatment provided by the centers. When the differential effects of A.A. and other treatment were considered, the study interpreted the results to demonstrate that the highest remission rates were found among those who received treatment from the centers or from AA. If the client received some additional treatment (not from the centers or from AA), the chances of remission were much poorer and the prognosis did not improve even if the client received high amounts of treatment from the centers. In order to examine the effects of AA more closely, the report examined those outcomes according to the regularity of AA attendance, collapsed into "no attendance," "Irregular" and "regular" attendance categories and then cross-tabulated according to the amount of treatment received from the centers, dichotomized into either a "none or low" or "high" amount group. The original table is reproduced here and displayed as Table 1.

Table 1 includes three types of remissions: clients who abstained for six months, one month and the so-called normal drinking category. Non-remissions were also included in the table. Armor et. al. (1978:120-121) suggested that the crucial comparison in Table 1 is between regular AA participants and non-participants. They argue that when these two groups are compared, it is clear that the effects of AA depend on the level of treatment received from the centers. They noted that if the client received little or no formal treatment, AA made a substantial difference, raising the remission rate from fifty-five to seventy-one percent. However, they indicated that if the client received a substantial amount of treatment, AA made no difference. Table 1 would suggest that the percentage of remissions were almost constant, eighty-three percent with no AA attendance as compared to eighty-four percent with regular AA attendance. Their conclusion was that in the absence of

other treatment, AA achieves a substantial positive affect. Yet, if professional treatment is available, the impact of AA on remissions is minimal.

TABLE 1. Relationship Between Amount of Treatment and Indicators of Remission with Level of AA Attendance Controlled*

	Remission Rates (%)		
Amount of Treatment	No AA Attendance in Past Year	Irregular AA Attendance	Regular AA Attendance
None/Low Amount Remissions	55	55	71
Abstained 6 Months	16	12	36
Abstained One Month	8	15	35
Normal Drinking	31	28	0
Nonremissions	45	45	29
(N)	(268)	(82)	(28)
High Amount Remissions	83	62	84
Abstained 6 Months	28	20	48
Abstained One Month	14	24	26
Normal Drinking	41	18	10
Nonremissions	17	38	16
(N)	(112)	(66)	(50)

*Reprinted from Armor et al. (1978:120)

At that point, Armor et al. (1978: 120-121) indicated that AA's philosophy advocates total abstinence and suggested that when attention was directed to that outcome, only regular AA participation appeared to make a substantial and consistent difference. They concluded that the main impact of AA was not to increase remission rates, but rather to shift the pattern of remission in the direction of abstention. This, they stated, should not be allowed to obscure the greater effects of treatment by the treatment centers.(*2)

Look again at Table 1 and note that it reveals that almost half (Actually forty-one percent) of the remissions in the "high treatment" category with no AA participation fell into the so-called "normal drinking" category. As the discussion section will reveal, despite a lengthy debate, those who endorse the medical model did not raise questions regarding what light the data presented in Table 1 might shed on the abstinence question. With that in mind, the data in Table 1 were collapsed into abstinence and "non-remission and normal drinking" groups. The results are displayed in Table 2.

TABLE 2. Relationship Between Amount of Treatment and Remissions Defined in Terms of Abstinence with Level of AA Attendance Controlled

	Remissions Percentages		
Amount of Treatment	No AA Attendance in Past Year	Irregular AA Attendance	Regular AA Attendance
None/Low Amount			
Outcome			
Abstained	24	27	71
Drinking	76	73	29
(N)	(268)	(82)	(28)
High Amount			
Outcome			
Abstained	42	44	74
Drinking	58	56	26
(N)	(112)	(66)	(50)

When abstinence was used as the remission criteria, the data presented in Table 2 presented a very different picture regarding the differential effects of AA and professional treatment. When the comparison was made between the high treatment and the low-untreated groups without AA participation, the effect of treatment was to increase the abstinence percentage eighteen percent, from twenty-four percent for those in the none-low treatment category to forty-one percent for those who received high amounts of treatment. Receipt of treatment had a similar effect on the percentage of abstinence among those who were irregular AA participants, raising the abstinence rate from twenty-seven to forty-four percent. For those who regularly attended AA, the remission percentages were seventy-one and seventy-four percent. That is, seventy-one percent of those persons who were in the untreated low percentage category and who regularly attended AA were abstinent while seventy-four percent of those who received high amounts of treatment and regularly attended AA were abstinent.

When abstinence is used as the remission criteria, the data in Table 2 suggest that those who regularly attend AA had forty-seven and thirty-two percent increases in abstinence when compared to the no AA attendance group. Not only do those differences exceed the eighteen percent increase in abstinence which can be attributed to treatment, but the data in Table 2 implies that the effect of regular AA attendance is unaffected by the amount of professional treatment received. This interpretation is forthcoming because the difference between seventy-one and seventy-four percent is so small as to suggest no effect on abstinence.

Discussion

The re-analysis presented above suggested that the Rand Report (Armor et al., 1978) could have been interpreted as a document favourable to AA. If abstinence is the goal of treatment, then the data related to the differential effectiveness of AA and the treatment delivered by the centers leaves little doubt as to the more effective approach. As suggested above, Armor et al. (1978) clearly indicated AA participation was the major factor associated with abstinence. For those who were supposedly associated with or supporters of that organization, there was little need to re-assess the data as has been done here.

AA's supporters did assess and re-assess the data. The Rand Report (Armor et al., 1978:232-244) reprinted the transcript of a press conference held by the National Council on Alcoholism which brought together a number of nationally known experts on alcoholism. Collectively, those professionals characterized the study as an attack on alcoholics in general and universally raised issues regarding the scientific adequacy of the study, especially in terms of the sample size, length of the followup period and what was referred to as the "overly loose" criteria used to construct the normal drinking indicator. AA and its effectiveness in achieving abstinence was not mentioned.

None of the experts present at the press conference challenged the major recommendation forthcoming from the Rand Report (Armor et al., 1978), namely, that the treatment system be retained in its present form. The report had argued that the system be maintained because of its cost effectiveness. It seems that AA's supporters could easily have argued that the treatment system either be abandoned or at least stripped of its professional treatment staff. Since personnel, especially professionals, are the major contributors to costs in social service systems, the cost effectiveness emphasis should have focused attention on AA, which is, after all, a free service. Elsewhere, Moore (1979) argued that many experts press for more AA attendance because it is "so cheap."

Responses of critics to the Rand Report (Armor et al., 1978), and supporters as well, reflect their vested interests in the alcoholism treatment field. AA perse, had no voice in these proceedings and no one capitalized on what could have been a major victory for that organization. Referring to the fact that a number of AA members are now employed as paraprofessionals in the formal treatment system, Moore (1979) provided a comment which brings this discussion more into focus. He indicated that professionally staffed programs need the vocal support of AA and that a norm of reciprocity has developed between AA members employed as paraprofessionals and the programs which hire them. He now finds that those given employment no longer hold to the most dogmatic AA positions (like the fact that AA should not be associated with any outside enterprise like a professional treatment program)(*3) and instead, are receptive to psychiatric concepts.

Madsen (1979) responded in a similar vein to the Tournier (1979) article which suggested that AA influence was a roadblock to treatment innovation. To counter that claim, he cited his own study which indicated that AA cooperated with the National Council on Alcoholism and that both organizations were integrated into the

local treatment system, making referrals to facilities like hospitals, half-way houses and other professionally staffed treatment programs.

These comments are consistent with the description of how employment as paraprofessionals is used to coopt indigenous persons. Earlier, we suggested that it was the organization that will ultimately be the victim of this process. We have described how AA is portrayed in the literature as a major force in social policy related to alcoholism treatment. However, the organization, per se, has not been engaged in a single policy debate, and in the case of the Rand Report (Armor et al., 1978), it was theoretically represented by the National Council on Alcoholism.(*4) The critique of the Rand Report presented here suggests that AA's supposed ally did not attempt to push for an interpretation of that study which highlighted the effectiveness of AA in achieving abstinence.

The point to be made here is that AA has not had a role in social policy formation related to alcoholism treatment. If the Rand Report (Armor et al., 1978) serves as an example of the loyalty of those who supposedly speak for AA, these more powerful professional persons have done so to protect their own vested interests. We would argue that AA should not be involved in policy issues and find that the literature devoted to social movements indicates that cooperation with professionals will ultimately result in cooptation of the organization. AA and its members were denied the recognition that participation in their organization was the major factor in achieving abstinence in the Rand Report. As we have indicated elsewhere (Fry, 1977), that may be a minor loss when the long term implication of cooperation could be the disintegration of organizational integrity and finally, loss of control of the organization

In summary, this paper questioned the notion that certain traditions in social thought on alcoholism result in blaming the individual alcoholic. The argument was made that AA, the organization, has been both a hero and villain in the literature and ultimately may become the victim because of its members' relationships with more powerful professional groups. Studies which suggested how indigenous persons and groups are coopted through their employment as paraprofessionals were cited to bolster that point. A re-analysis of the Rand Report (Armor et al., 1978) data related to the differential effectiveness of AA and professional treatment was presented. The results were interpreted to suggest that AA and its members were denied a major victory concerning that organization's role in obtaining abstinence as a treatment outcome. The conclusion is that there is internal fragmentation in the various traditions (Watts, 1982) identified in social thought related to alcoholism. If self-help groups like AA are to continue to exist as autonomous entities, public policy must encompass the disease approach, one which allows alcoholics to assume responsibility for alcoholism without involvement in policy level decisions.

NOTES

1. The interested reader should see Freund, 1981; Madsen, 1979; Roizen, 1978; Sobell and Sobell, 1978.

2. In their four year followup of the original report, Polich et al. (1981:148-152) again reported that abstinence was associated with AA attendance. They presented a table (1981:151) which reflected drinking status at four years by AA attendance at the eighteen month followup. This table revealed that forty-two percent of those who were currently attending AA had abstained one year, as compared to sixteen percent who had never attended AA. In terms of those who had abstained from the time of the eighteen month check to the four year followup, twenty-two percent were currently attending AA regularly while eleven percent of those who never attended AA were abstinent over the same period. However, in their analysis of the factors related to abstinence, AA participation was left out because they stressed that there was a possibility that abstainers select themselves to be regular attendees of AA. It is of interest to note that they felt free to make comparisons between AA and professional treatment when they felt free to rely on their "normal drinking" indicator in the earlier report.

3. Gartner and Reissman (!977:27-28) note that AA is governed by a set of rules which guide the conduct of AA groups. The sixth tradition is as follows: An AA group ought never endorse, finance or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose. The preceding tradition, five, reads as follows: Each group has but one primary purpose - to carry the message to the alcoholic who still suffers.

4. Earlier, an article was cited by Schneider (1978) where he attributed the success of the campaign to gain acceptance of the disease concept to AA, the Yale Center on Alcohol Studies and the Jellinek model. However, Schneider's description of the events which launched the campaign indicated that AA was not formally represented. AA's involvement came from the efforts of a person Schneider defined as a one-time member of AA who was responsible for the founding of the National Council on Alcoholism, which Schneider indicated she saw as supplementing the work of AA in public education regarding alcoholism. This example provides support for the belief that AA has not officially or formally been engaged in policy formulations related to alcoholism treatment.

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