

# About AA

## A Health Care Professional Looks at A.A.

*When you once touch the life of an alcoholic and help him or her to recover, when you observe this incredible change from a suffering, helpless, sick . . . person to one who is alive, vital, functioning, and happy, you will be part of a rich, rewarding and profound experience.*

### "A.A. as a Resource to the Health Care Professional"

Health professionals have many misconceptions about Alcoholics Anonymous, even those who are enthusiastic about it and send patients to meetings. I know these misconceptions well; I had most of them myself at one time or another, and I deal with them on a daily basis. It is important that these misconceptions be discussed, as they often cause difficulties.

First, A.A. is not treatment. It is not a "medical or surgical application or service." A number of avoidable problems may arise when A.A. is thought of as treatment. The question of whether A.A. is effective is one example. If it is considered a treatment, in the medical sense, then its effectiveness should be tested against other treatments in a proper manner with random assignments of patients who should be studied for several years, by personal interviews, urine testing and family reports. This is not possible in principle because A.A. is a voluntary program whose members are anonymous. Medical treatment and A.A. are entirely different, and the question of whether A.A. is effective is meaningless in a scientific context.

An A.A. member reading this might become quite indignant: "Of course A.A. is effective, I am the proof and the thousands of others who flock to meetings throughout the world, we are the test." This points to the need to separate the A.A. group, where individuals and their stories are what is important, from the field of science, where statistics and replication are required. One is not better than the other, they are not comparable. Treatment programs run by professionals using A.A. principles or incorporating A.A. meetings into their format, however, can and should be tested against other treatments in a standard scientific manner. It must be understood that the results of these scientific enquiries when they are made have nothing whatsoever to do with the effectiveness of Alcoholics Anonymous.

Another example of problems arising from health professionals looking on A.A. as treatment in the medical sense is the impatience I often hear expressed with what is described as "the policy of A.A. against accepting addicts." This involves misconceptions on many levels. First, the evidence is, I think, overwhelming that drugs of abuse, including alcohol, act on

specific dopaminergic reward pathways in the brain—some drugs directly, some, like alcohol, indirectly. In reaching this pathway, the routes taken by addictive substances overlap and interact. This raises exciting possibilities for pharmacological treatments. It also suggests, from a neurophysiological point, that addiction is addiction and the drug of choice is largely irrelevant.

A neurophysiological point of view is restrictive, however. Different side effects are experienced with sedative drugs, like alcohol, than with stimulant drugs, like cocaine. Withdrawal is different for different drugs. Also, the social contexts in which drugs are used and the stimuli which give rise to cravings often are very different with, for example, heroin, cocaine and alcohol. The personal and interpersonal deterioration, the fear, shame, loss of control, manipulation of others and relentless narcissism of an addict's course are the same no matter what drug or drugs are involved. As a physician specializing in addiction medicine, I think it makes sense to address the aspects common to all addictions together while sorting out what kind of treatment or focus may be appropriate for a particular individual. A.A. doesn't work that way, though. The only requirement for A.A. membership is a desire to stop drinking.

There is no context in which A.A. should do anything other than be there for those who meet the only requirement. It really does not matter whether drugs act on a final common pathway any more than it matters whether the A.A. member has health insurance. A.A. is not a part of a provider network depending on our referrals for its survival. It doesn't operate in the mode health care professionals are accustomed to and it cannot respond to our demands. We need to use it wisely and to do so we need to know something about the organization. Unlike the hierarchies we are familiar with, A.A. is not built on a pyramidal system with decision-making power at the top. It consists of thousands of autonomous groups with a small central service organization, service not control. The officers of each group rotate usually every six months. The core concepts are outlined in the A.A. Preamble and in A.A.'s Twelve Steps and Twelve Traditions. There are standard formats for A.A. meetings, but groups differ widely in the composition of members and in the group's ambience. There are also differences in the ways groups address issues concerning drugs. Although 34 percent of A.A. members have been addicted to other drugs in addition to alcohol, these numbers are not distributed equally

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*This article was written by an A.A. member employed in the field of alcoholism treatment. Since its early days A.A. has maintained a good working relationship with health care professionals who work with the still-suffering alcoholic.*

among groups. There are some groups where the majority of members have had experience only with alcohol, and in such a group an alcoholic who has had extensive involvement with other drugs as well may feel less at home. In metropolitan areas most groups have a good proportion of younger alcoholics whose use of other drugs is an integral part of their stories and who struggle a day at a time to stay away from other drugs as well as alcohol. Addicts who have had no experience with alcohol can certainly attend open A.A. meetings. Others, however—considering themselves in essence alcoholics and wishing to stop drinking—do go to closed meetings and have told me they derive much help and can identify with what is being said.

I do not myself and would not advise others to suggest that addicts with no alcohol history go to closed meetings of Alcoholics Anonymous. There are Narcotics Anonymous (N.A.), Drugs Anonymous (D.A.) and Cocaine Anonymous (C.A.) meetings. Even though A.A. has a longer history and more members with stable sobriety, it is not a kindness to suggest that an addict go to a closed A.A. meeting where he or she may experience rejection, however gently that rejection be given. It is also not therapeutic to suggest to an addict that he or she go to a meeting and conceal the drug addiction. Professionals sending patients to A.A. need to know about different group ambiances and, ideally, should have an experienced A.A. member to consult or even to take a new patient to that first meeting.

Professionals sending patients to A.A. may have had difficulty with the notion of powerlessness. For some it implies helplessness, not accepting responsibility, developing a substitute dependency (on A.A.). Some feminist therapists contend that A.A. was designed for middle-class white male alcoholics. Women, minorities and poor folks have different problems. They need “empowerment” not to feel even more powerless. Unfortunately, words collect layers of meanings and in A.A. words are often used to refer to very specific A.A. concepts. Perhaps the best suggestion would be to go to a few meetings and become familiar with the concepts, because powerlessness doesn’t necessarily mean helplessness or irresponsibility, nor does humility mean grovelling. Perhaps the concept of powerlessness is best expressed in the Serenity Prayer. One is powerless over the things one cannot change—the disease of alcoholism, or other people’s behavior—but is willing to try what is necessary to change oneself. Changing oneself is extremely difficult. It requires help. The willingness to be open and accept that help is also part of the process. Willingness to accept help is not helplessness, just as acknowledging that there are matters over which one has no control is not powerlessness.

Finally, by accepting that having the disease of alcoholism is something for which one is personally not responsible does not imply that one is not responsible for taking every possible step to prevent a relapse. From my own perspective, patients who are working the Steps of A.A. gain in self-confidence, self-esteem, self-sufficiency and competence.

“Doing service” is another A.A. term which comes with a load of general meaning. In A.A. it implies gratitude, giving back what has been given, offering one’s own experience for others to use, not servility and not self-exploitation. To those

who are concerned about their patients developing a substitute dependence on A.A. I am tempted to say, so what? At its worst it has to be much better than being dependent on alcohol. Nobody gets pancreatitis from going to A.A. meetings. For some it may become a major part of their social life, for others, not. Given the numbers of people I see daily dying from alcoholism, substitute dependence on A.A. does not seem to me to be a major issue.

Last, there is tremendous confusion about A.A. and religion, particularly Christianity. This confusion is increased by the language of the Steps, by the frequent use of the Lord’s Prayer at meetings, by talk of getting down on one’s knees (very difficult for Jews for whom this is quintessentially Christian) and by the many members whose recovery in A.A. has led them to return to their religious roots. It is genuinely difficult for newcomers and visitors, when confronted by a language which is so evocative of religion, to accept the spiritual rather than religious nature of the A.A. program. I say “genuinely” because we often interpret objections of this sort as reluctance to accept one’s illness and get help. Sometimes it is. However, I have talked with class after class of medical students who have been sent to observe A.A. meetings, and with nonalcoholic trainees of all kinds, and this is a recurrent concern. Probably most people going to A.A. for the purpose of gaining information go to only one meeting. For many people it takes time and attendance at many meetings to be able to separate a personal concept of spirituality from the religious language in which it is embedded. Of course, the origins of that language are Christian. “*God as we understand Him*” too often evokes God as we *had* understood Him in Sunday school. It is difficult to bend the mind to the metaphor to focus on a higher power which can be anything outside oneself. Difficult, but essential if we are going to be able to help our patients and our students to understand the true nature of Alcoholics Anonymous. A.A. is full of agnostics and atheists who have developed a spiritual life which began with the acknowledgment that there is some power, force, source of good, that is outside themselves. It can be the power of the group. The name doesn’t matter, it is the outward focus that is important. For many in A.A. this spiritual life blossoms without any religious connection, nor is any necessary.

One might wonder why A.A. doesn’t modernize the language of the Steps or insist that the Serenity Prayer and not the Lord’s Prayer be used. But A.A. doesn’t work that way. The Traditions and organization have permitted great flexibility and changes of ambience in the groups while keeping stable the core principles and the language with which they are expressed. By its structure A.A. has avoided the perils of power and trendiness. Alcoholics Anonymous *is* its members. There is no separate decision-making body. Change happens slowly and not by decree, so the language will be with us for a long time. We must learn to work within its framework. If we as health care professionals can accept A.A. as it is and change ourselves, we will do our patients a great service.

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