THE QUEST FOR CONTENTED SOBRIETY: A DRAMATURGICAL ANALYSIS OF RECOVERY IN ALCOHOLICS ANONYMOUS

TERRY J. MURPHY

The Quest for Contented Sobriety: A Dramaturgical Analysis of Recovery in Alcoholics Anonymous

By:

Terry J. Murphy B.A. (Hon), M.A. (Soc)

Memorial University

2013

St. John's, Newfoundland and Labrador.

A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

Table of Contents

List of Tables & Figures

List of Appendices

ACKNOWLEDGEMENTS

I wish to express my sincere appreciation to my thesis supervisors, Dr. Robert Hill, Dr. Peter Sinclair and Dr. Scott Kenney under whose guidance this research was undertaken and to whom I owe a debt of gratitude for their well-informed advice, constructive criticism, diligence and patience.

I would also like to express my gratitude and appreciation to my children, Rachel and Joel, for their patience and understanding as I toted my various books and papers to parks, beaches and playgrounds in an effort to complete this work. To my mother, brother and sisters, thank you for your moral support and encouragement. Lastly, and most importantly, I would like to extend my special thanks to the men and women of Alcoholics Anonymous throughout the province of Newfoundland and Labrador who opened their hearts and shared their stories with me.

Abstract

This thesis examines the phenomenon of recovery as it is experienced and understood by members of Alcoholics Anonymous in Newfoundland and Labrador. Recovery involves more than just changes in the brains and bodies of the addicted person. It is more than changes in positive affect, mood or personality structure. Recovery is more than the gradual modifications of behaviour associated with learning models. In this dissertation, I present a new and alternative interpretation of recovery by applying insights from the fields of ritual theory and dramaturgy. A qualitative research design, using participant observation and in-depth interviews, were used to generate detailed descriptions of the social processes involved in recovery. Data generated from these methods have yielded new insights into the inner workings of AA not yet described in the existing sociological literature. Data from this study reveal recovery as a dynamic social process wherein the novice AA member, referred to in this study as the penitent, experiences dramatic personal change and transformation through the twelve step program. The experience of working the twelve steps is presented in this study as a personal rite of passage involving three phases of transformation: separation, liminality and incorporation or aggregation. At each stage of this transformational process the AA member must follow certain emotion display rules and learn how to work with others in the home group to become a contributing member of a performance team. The emotions and behaviours associated with recovery are thus strongly influenced by social factors which are unique to the subculture of AA. Findings from this study have the potential to flesh out and expand conceptual models of recovery and to better inform social policy on addictions.

Chapter 1: Introduction

1.0 Notes from the Field, March 27, 2009

Tonight was a special night for Tony, a man in his forties who grew up in rural Newfoundland. The occasion was Tony's 'birthday' marking his first year of continuous sobriety as a member of Alcoholics Anonymous. He brought his wife and two children, boys around the ages of 10 and 6, and his two older brothers who sat quietly in the corner of the room. The chairs in the small church basement were arranged theatre style to provide enough space for the larger than average crowd on this Friday night. I estimated the crowd at about 50 people, perhaps 35 men and 15 women. I recognized the faces of the regulars but there were a dozen or so people who I hadn't met before, including Tony's family. Family and friends of AA members will sometimes participate in the meetings on Friday nights, especially for a birthday celebration, since Friday meetings are open, not like the closed meetings on Mondays and Wednesdays which are reserved only for those who profess to have a drinking problem.

The meeting opened in the usual manner with the chair requesting a moment of silence. With heads bowed, the Serenity Prayer was recited in unison: "God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." This was followed by the reading of the Twelve Steps and Twelve Traditions, the devotional reading 'Thought for the Day' and the standard reading from the AA Big Book 'How it Works.' Joe, a man in his sixties, called the meeting to order by telling the story of how he became an alcoholic and how he recovered with the help of AA. It is a requirement in AA for the person chairing a

meeting to first qualify as an alcoholic; to prove he has a drinking problem. It becomes obvious to everyone in the room that Joe is indeed an alcoholic after he describes multiple drinking and driving offenses, time spent in jail, and being fired from jobs because of alcohol. "But AA changed all of that. I've learned how to live my life and how to find some peace and contentment here in these rooms. If it can work for me, it can work for anyone," Joe stated with confidence. After a brief rendition of his recovery story, Joe asked Tony's sponsor, a middle-aged man named Dave, to come forward. Dave stood before the crowd and paid tribute to Tony's hard work and his commitment to AA. "Tony has come a long way since he came to us a year ago. I remember when he came here he would hardly say a word. But that's changed. Tony has contributed a lot to our group. He chairs meetings, he visits the boys and girls at the detention center to spread the AA message, and he's always willing to help out. Tony is faithful to our motto that in order to keep sobriety, you have to give it away." Dave called Tony forward to hand him a bronze plated medallion about the size of a loony, adorned with a triangle with the number 1 etched inside and a personalized inscription bearing Tony's name and the words "To Thine Own Self Be True." Tony thanked Dave, and told the audience that without his sponsor's help, he wouldn't have made it. He turned to his wife and children and thanked them for their support. "I didn't think I would make it. But I had a lot of reasons to get sober." Pointing at them, he said tearfully "they are my reason for being here. AA saved my family." Several old-timers in the group commented how inspiring it was to see how AA can still change lives and heal families. The meeting formally closed with everyone in attendance joining hands and forming a large circle to say the 'Lord's

Prayer.' At the end of the meeting, everyone gathered to shake Tony's hand and to share in the birthday cake purchased for this special occasion.

1.1 Introduction

These field notes are part of an ethnography of men and women who belong to AA in Newfoundland. The human drama found in "the rooms," as members of AA often refer to their meeting spaces, is played out in scenes like the one described above on a daily basis around the world. About six months after this event I would witness another drama, this time involving Tony's relapse. At the end of a meeting one night in August, I would hear news from several members of the group that Tony had gone out drinking over the past week and was now back on the bottle. I had noticed that Tony's attendance at AA meetings had become sporadic over the past couple of months. When he did show up, he had little to say, muttering the words "I think I'll pass tonight thanks..." whenever the chair asked him if he wanted to share his experiences with the group. Instead of hanging around after the meeting to share a cigarette or two with the guys on the front step, I noticed that the normally affable Tony would leave immediately after the 'Our Father' prayer had been said and walk briskly to his car in the parking lot. It was hard to piece together the reasons for Tony's departure from AA, why after a full year of sobriety, he had decided to quit the group and resume his destructive drinking habits. There is a maxim in AA that when an alcoholic resumes drinking, his or her alcoholism becomes worse than before, and this appeared to be the case for Tony. According to one member of the group, Tony was facing another drinking and driving offense and his wife had left him.

AA etiquette suggested that members not openly discuss Tony's relapse. This would be 'doing an inventory' of another person's program. It is encouraged, even expected, for members to conduct their own self-examination, to measure their own progress by doing what is called a moral inventory, but to measure Tony's or another member's progress (or lack thereof) in recovery is frowned upon. However, over the next several weeks, Tony's relapse would be discussed discreetly outside of the meeting hall as members of the home group struggled with collective feelings of worry, guilt and resentment over their friend who had become such a valued member of the AA fellowship. "Maybe we let him down by not properly preparing him for the program," shared Mike, a 20 year veteran of AA. Joan, one of the few women in the group, offered her opinion: "I never sensed he was working his program like he should have. Maybe he thought that coming to meetings was all that was necessary. But the real work takes place outside of the meetings when you work the twelve steps." "I saw it coming," shared another, "Tony would always say he was coming to AA for his family. That's the wrong motivation. You have to do it for yourself." Another offered the opinion that Tony was not vigilant enough about fighting his disease. "Alcohol is cunning, baffling and powerful," said Bob, quoting from the AA Big Book, "but it's also patient. Our disease will wait a long time to try to trip you up, to try to get you back on the bottle," he shared. The way Bob described the 'disease' - it was as if alcoholism was an internal enemy of Tony's soul, patiently working a strategy to trip him up, to prevent him from becoming a better man.

This ethnography will attempt to make sense of scenes like the ones I have just described and to make sense of the drama surrounding recovery within the fellowship of AA. Readers will acquire an insider's view of how the men and women of AA socially construct their disease and how they experience recovery, a complex personal transformation that continues until the day the recover*ing* alcoholic dies. In conducting my research, I set out to answer the following questions: How are men and women in Newfoundland and Labrador socialized into the role of recovering alcoholic within the fellowship of AA? How do AA members conceive of, and make sense of, their disease? How do members of AA display or 'act out' their recovery and what signs and indicators do they look for as proof that an alcoholic is recovering? What are the implications of these social constructions of disease and recovery for social theory and social policy as it relates to the field of addictions – to alcoholism in particular?

I begin this chapter by introducing the reader to the debate over whether alcoholism is a disease, and what recovery, remission or cure might mean for alcoholics. Following this discussion, I will examine an alternative paradigm for the examination of alcoholism and recovery. This paradigm views disease and recovery as dramatic productions involving AA members as actors learning their roles as recovering alcoholics. Much of this role preparation takes place back stage where AA members learn emotional management strategies worked out with significant others within the fellowship. After engaging in this emotion work, alcoholics then perform their recovery on the front stages of the rooms of AA, subjecting themselves to the careful scrutiny of fellow members who are looking for signs to validate the actor's truth claims that they have found sobriety, or

better yet, 'contented sobriety.' In the final part of this chapter, I will lay out the organization of the study so that the reader can better understand the phenomenon of recovery from the perspective of members of AA.

1.2 The Debate over Alcoholism and Recovery

> "Addiction is a disease of the brain, and the associated abnormal behavior is the result of the dysfunction of brain tissue, just as cardiac insufficiency is a disease of the heart" (Dr. Nora Volkow, Director of the U.S. National Institute on Drug Abuse quoted in *Time*, March 17, 2005).
>
> "Addiction: New Research Suggests It's Not An Illness. It's a Choice." (*Maclean's*, June 1, 2009). Feature article with Harvard psychologist & addictions researcher Dr. Gene Heyman.

Attempts to describe alcoholism remind me of the story of the three blind men trying to describe an elephant. One man, holding the tail, says "an elephant is long and narrow." Another, feeling a tusk, describes the elephant as sharp and pointy. The third, holding a foot, declares that an elephant is round and flat. Because of their limited powers of observation, none of the men has it quite right. I believe it is the same way with alcoholism. The voices most likely to be heard in the discourse over alcoholism are those who work within the medical establishment - the medical researchers, psychiatrists and physicians, clinical psychologists and the various helping professionals who try to help the 'sick' alcoholic recover from his or her disease.

Medicine focuses primarily on the bodies and brains of alcoholics. According to genetic researchers, alcoholism is a genetic disorder that plagues those unfortunates who happen to be born with the A1 or alcoholic gene (Cloninger et al., 1981; Babor et al., 2005). The etiology of the sick brains possessed by these unfortunates is traced back to

early childhood trauma involving deprivation or abuse - stressors which activate pre-existing genetic codes for alcoholic drinking patterns. Researchers point to the flawed brain chemistry of addicts as major contributors to this phenomenon, specifically to elevated levels of the stress hormone cortisol or the impeded production of the feel-good chemicals of dopamine and serotonin (Nixon, 1994; Spear, 2000).

For researchers who focus on the physiological dimension of this disease, the cure for alcoholism rests on the ability to heal a sick brain, to re-balance the hormonal and chemical systems of the body's most vital organ (West et al., 1999; Mate, 2008). This paradigm has spawned billions of dollars in pharmaceutical research to create new medications for the alcoholic and the drug addict. For example, the drug antabuse (Disulfiram), created by Dutch researchers, was designed to induce acute sensitivity to alcohol by preventing the breakdown of the neurotransmitter dopamine (Ulrichsen et al., 2010). Unfortunately, antabuse has enjoyed limited success in the treatment of alcoholism. Its principal benefit is that it buys some time for recovering alcoholics by reducing their craving for alcohol; however, it does little to address any of the underlying physiological or psychological causes of the illness. The medical establishment, aided by the pharmaceutical industry, has yet to find a pill that can cure alcoholism.

Psychologists, social workers, therapists and counselors tend to focus on the maladaptive thinking and behaviour of the alcoholic. Those working within this paradigm focus upon the cluster of behavioural and cognitive traits associated with the *alcoholic personality* like his or her tendencies toward impulsiveness, gregariousness, self-destructiveness and self-loathing (Barnes, 1979; MacAndrew, 1986). Or they point to the

presence of obsessions and compulsions as the hallmarks of this disease. Obsessions are the pervasive, persistent thoughts about drinking that preoccupy the minds of alcoholics and which seem to block out almost all other concerns. Compulsions are the actual behaviours that drive the alcoholic to drink at unhealthy, destructive levels despite the fact that the drinker wants to stop and recognizes the fact that if s/he doesn't stop drinking, s/he may die. The key for those working out of this paradigm is to identify the roots of these destructive tendencies, to understand the social dynamics that spawned them, and to replace these destructive behaviours and cognitive processes with more socially acceptable, adaptive behaviours (Scott, 2005).

According to the medico-scientific paradigm, alcoholism, as one form of addiction, can be objectively measured, assessed, diagnosed and classified according to clinical criteria based on empirical observations - and those responsible for the diagnosis and prognosis of this disease are considered experts by virtue of their medical training and credentials. Nowhere is this paradigm better reflected than within the pages of the Diagnostic Statistical Manual of Mental Illness (DSM IV, 1994), the so-called 'bible' for medical professionals who seek to diagnose and treat patients afflicted with alcoholism and other addictions. The Substance-Related Disorders in the DSM are divided into two categories: Substance Use (Dependence and Abuse) and Substance-Induced (intoxication, withdrawal, delirium, dementia, amnesic, psychotic, mood disorder, anxiety, sexual dysfunction, and sleep disorder). To meet the criteria for dependence, the client must have a maladaptive use pattern causing some type of impairment with at least three of the following occurring in one year: tolerance: withdrawal: more or longer use than planned: desire without ability to cut down or control usage, time spent on obtaining, using or

recovering from the substance: impact on activities that are social, occupational, or recreational (do less or not at all): and continued use in spite of physical or psychological problems related to use.

Perhaps the reason why such experts seem to dominate the public discourse surrounding alcoholism and recovery stems from the relative power of the medical establishment. As the eminent philosopher Michel Foucault points out, medical knowledge in Western societies is highly valued (Foucault, 1963). Knowledge is power and the burgeoning addictions-recovery industry and the specialized field of addictions medicine attests to the stronghold the medical establishment has over this disease known as alcoholism. Healthcare economist Christopher Roebuck has estimated that the weekly cost of treatment per patient in the U.S.A. runs between $91 (for outpatient care) to $700 (for extended stay residential treatment). The treatment industry is thus a substantial economic sector, with vested political interests and considerable lobbying power (Roebuck et al., 2010).

Despite the enormous expenditures on addiction treatment, the disease concept of alcoholism has come under a great deal of scrutiny in the social sciences. In their book *Deviance and Medicalization: From Badness to Sickness* (1985) Peter Conrad and Joseph Schneider discuss the reasons for the medicalization of alcoholism despite the inherent weaknesses of medical and scientific explanations of the disease. One reason for the promotion of alcoholism as a disease in the 19th century involved the politicization of the drinking issue by the temperance movement. The National Commission on Alcoholism and the Yale School of Alcoholic Studies, institutions staffed by medical doctors, social workers and social scientists, were successful in challenging ideas promoted by

temperance supporters who suggested that alcoholics needed to repent and abstain from alcohol for the rest of their lives. Instead, the proponents of the new science of alcoholism presented evidence that alcoholism was an illness and that it should no longer be addressed as a moral issue to be handled by the church. As Gusfield (1967) and Rosenham (2002) point out, the statement that alcoholism is a disease was not so much a declaration of scientific discovery as a shift in public policy redefining the alcoholic as sick and thus bringing him into the domain of medical clinics, university research institutions and welfare agencies of the state.

Other critics suggest that addiction and perhaps mental illness in general, is a myth concocted by the medical establishment to maintain their power and prestige (Scheff, 1999; Szasz, 1961). Thomas Szasz, the distinguished 'anti-psychiatrist' argues that it makes no sense to call alcoholism a disease when there is no identifiable difference in the morphological structure of the brain, or any conventional indicators of pathology when alcoholics are compared to normal drinkers. Furthermore, professionals working within the medical paradigm often disagree on the diagnosis of addiction using the criteria established in the DSM IV (1994). Szasz points out that there is still a subjective element to making the diagnosis of a "maladaptive" use pattern and that two physicians treating the same patient will often come to different conclusions (Schaler, 2004:196-199).

Stanton Peele, the author of *Diseasing of America (1995)*, suggests that medicine still offers the best hope for the suffering alcoholic, despite the fact that researchers may not agree on the etiology, the diagnosis and the prognosis of the disease. He sees the

position advocated by Szasz and his followers as an abdication of medicine's responsibility to care for the ailing patient:

> Like many who deny the existence of something called addiction (and also mental illness), Szasz can be clueless when confronted with real human compulsion and emotional despair. People kill themselves with drugs and alcohol, believing until their last breath that they cannot escape their substance abuse. People roam the streets babbling to themselves, commit suicide, and are lost in delusion and despair (Schaler, 2004: 180).

If the disease concept is a matter of confusion and contention, so too are the ideas surrounding recovery. What exactly is meant by recovery, remission or cure from this disease? Does proof of a cure lie in the fact that the alcoholic no longer drinks to the point of intoxication or even drinks at all? Is the state of abstinence, being clean and sober the only marker or proof of recovery? Is it the fact that the alcoholic can resume normal social functioning becoming productive once again in the social domains of work, family and community? Or, does recovery have more to do with a general increase in positive affect and emotional well-being so that the alcoholic can become a happier, more contented person? In a recent article titled "What is Recovery? A Working Definition from the Betty Ford Institute" a blue ribbon panel on addiction and recovery sponsored by the prestigious Betty Ford Clinic concluded that "no one has yet defined or operationalized an acceptable definition of recovery from addictions..." Researchers suggested that although the term recovery is widely used, the lack of a standard definition for it has hindered research on recovery-oriented interventions (Journal of Substance Abuse Treatment (33) 2007: 221-228).

What is curious about the debate over whether alcoholism is a disease, what constitutes recovery, and whether the medical model provides the best hope for those suffering from addiction, is the fact that a group who identify themselves as recovering alcoholics have been largely excluded. Members of AA have a distinct perspective on alcoholism and recovery: yet their perspectives have been largely ignored, undervalued or unappreciated. The public may have heard about the twelve steps and about the AA organization but there is relatively little research to reveal the intricate workings of this fellowship and the distinctive social processes involved in recovery.

If we study the experiences of those who belong to AA, we will discover a significantly different perspective on the disease of alcoholism. Let me direct the reader's attention back to my field notes describing Tony's one-year birthday celebration. If we look more closely at the interactions among the actors, the symbols employed by the group, and the various rituals performed in the meeting, we will uncover a much more nuanced, richly textured presentation of alcoholism and recovery.

1.3 Interaction Rituals, Emotional Energy and the Front Stage of Recovery

Drama is an important term used in my analysis of the AA experience. The sociologist Erving Goffman suggested that social interactions of the type described at the beginning of this chapter have much in common with dramatic productions (Goffman, 1959, 1963). What members of AA describe as the disease of alcoholism and their attempts to arrest it, to put it into remission, or to achieve what is commonly called recovery, can be conceived in terms of a theatrical presentation. There is a front-stage performance, as described in my field notes where Tony accepts his one-year medallion before an

audience of fellow AA members. The event was carefully planned beforehand, in the back-stages, where Tony's sponsor, along with other old-timers, carefully orchestrated the presentation of the medallion with the intention of selling the AA solution to others in the audience that night. The cakes, the medallion, the readings – all were essential props in the theatrical presentation of Tony's one year celebration. Even the decision to remove the tables in the cafeteria and to arrange the seats row by row in theatre-style was made at a business meeting prior to the Friday night celebration as a way to improve the visibility of all attendees and to bring greater focus on Tony's accomplishment. The entire event was staged so that everyone in attendance would get the message that if they have a drinking problem, AA can help.

When we examine the back stage scene which takes place outside of the meeting room, as AA members grapple with Tony's departure and relapse, we will also find an underlying social script, a subtext in the conversations and interactions between members of AA, which speaks to the complexity of their social order and their unique perspective on the phenomenon of recovery. Hidden tensions emerge around the problem of who is 'getting' the program and who isn't, who is experiencing authentic recovery and who isn't, and how the progress of each and every member affects the group as a whole.

In AA a good deal of the front stage work involves the enactment of rituals as members meet in the public domains of the rooms. These rituals direct the dynamic social processes involved in the enactment of recovery. Rituals are not necessarily religious in nature: the term is used in sociological literature to describe the etiquette followed by members, the largely unconscious, routine observance of interpersonal or common

courtesies demonstrating members' commitment to a vast array of shared rules of interpersonal conduct. As Goffman (1959, 1963, 1974) points out, what we commonly call etiquette is, in fact, a complex code of ceremonial or ritual prescriptions and proscriptions governing our interactions with one another. The social world of AA relies heavily on ritual. These have never been explicitly coded into the AA Twelve Steps or the AA body of literature, but nonetheless rituals guide the interactions of members as they individually and collectively experience recovery. When multiple rituals are employed in succession, with one ritual flowing into another, as a way of orchestrating a ceremony or shared experience, they comprise what Randall Collins (2005) calls *interactional ritual chains*.

Interactional rituals and interactional ritual chains are designed to heighten and enhance what Collins (2005) calls "emotional energy" which is a vital ingredient for the creation, maintenance and sustenance of a social group. Emotional energy is communicated both verbally and non-verbally through interaction rituals, giving it an almost contagious quality. For example, interaction ritual chains are at work when a group of sports fans communicate excitement and enthusiasm as they raise their hands in the ritualized wave formation now so commonly seen in North American stadiums. The wave builds up, first from one or a few enthusiastic fans who are the first to raise their arms in the air, followed by those seated next to the originators of the wave, until finally, thousands of fans catch the initial enthusiasm as the wave motion repeats itself around the stadium. Emotional energy of a more negative quality can also be experienced when a church is filled with mourners who experience an apparent build-up of sadness and

appear to cry in unison, almost on cue, to express collective feelings of loss and sadness at a particular moment in a funeral ritual.

In meetings of AA, one can witness the same build up and release of emotional energy through the enactment of interactional rituals. Interaction ritual chains create positive, invigorating emotional energy that is necessary for both novices and old-timers to want to return and participate in AA events and gatherings. In my fieldwork notes, I refer the reader to several rituals which were designed to build up positive emotional energy (feelings of camaraderie, togetherness, calm, serenity) among adherents of AA:

> (1) the collective recitation of the Serenity Prayer - "Lord, Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference," and the reading of authoritative 'sacred texts' from the AA Big Book to open the meeting;
>
> (2) the chair qualifying as an alcoholic by describing his/her story; similar to the ritual of testifying of how one is saved in evangelical Christian churches;
>
> (3) the sharing of the birthday cake to mark ceremonial milestones, in this case, the one year birthday (read 'rebirth'). In fact, the whole cake-sharing ritual is a type of communion involving the partaking of sacred foods among the faithful;
>
> (4) the ritualized form of communication whereby each AA member begins a public utterance with the words "Hi, my name is __ and I am an alcoholic." Goffman (1974) would describe this as an inclusion ritual. In an AA context it is also a type of social leveling device to reflect the organizational value that all members are ostensibly the same, regardless of age, gender, profession or experience in the group;
>
> (5) the holding of hands and the communal recitation of the Lord's Prayer.

These are just a few of the ritualized forms of behavior one will find in AA. If these rituals are performed as intended, those in attendance at an AA meeting will report that they enjoyed the feelings of togetherness and camaraderie, that they felt better (calm,

at peace, energized) as a result of participating and that they feel motivated to return. The participants in an AA ritual are also left with the hopeful feeling that it is possible to overcome the despair of their addiction, that they are part of something bigger, (the international body of AA), and that they carry a special message of hope for anyone who still suffers from alcoholism.

Props and symbols like the one year medallion, with the AA symbol of the triangle and the words unity, service and recovery etched on each side, play an important part in the enactment of rituals. There are also the sacred texts displayed around the room including the book "Alcoholics Anonymous" commonly known as the "Big Book" among those in the fellowship, along with various posters displaying popular mottos and aphorisms - "One Day at a Time," "To Thine Own Self Be True," "Let Go and Let God." These props provide a sense of historicity among adherents, conveying the idea that AA traditions go back in time and are rooted in much older legitimized forms. The triangle, for example, is an important symbol used in many secret societies, but in the case of AA there may be a connection to fraternal organizations, such as the Sons of Temperance, which probably served as an organizational forerunner for the fellowship (Kurtz, 1991). The historical connections between AA and other organizations will be explored later but we can see how symbols, in the enactment of rituals, contribute to the overall production value of disease and recovery among members of this subculture.

1.4 Emotion Work and the Back Stage of Recovery

In AA much of the work of recovery takes place outside of the public domain of the rooms. As novices enter the program they are encouraged to work the twelve steps of recovery, a systematic program of personal transformation which involves a great deal of private, very intimate emotional interactions between a novice and his/her mentor or sponsor. In these interactions, AA members engage in a type of emotion work wherein highly negative emotional states involving guilt, shame, fear and anger are processed through a complex series of emotion management strategies as formulated in the twelve steps. In my analysis of this emotional work (which AA members are more likely to describe as spiritual work), I employ certain concepts and theories from the field of the sociology of emotion, an emerging field within sociology, which helps us to understand how human emotions are managed, manipulated and expressed in social contexts such as are found within the fellowship of AA.

The emotion work that is performed in AA most often takes place between a more seasoned, experienced AA member who acts as a sponsor to the less experienced sponsee. The experience of becoming a sponsor, and learning what the job of sponsee entails, is an area that has received little attention in the research literature. Yet, sponsoring is critical to the mission of AA and like any specialized role, it has its rewards as well as its hardships and challenges. I will examine this important social role with the aim of trying to understand how sponsoring contributes to the recovery of the alcoholic.

I will also attempt to explain how emotion work is carried out through activities like prayer and meditation. These terms are loaded with religious connotations but very little is known about how members of AA actually conceive of prayer, meditation and other spiritual techniques and practices that they consider to be vital to their recovery. I will examine how AA members incorporate these practices into their recovery programs and how they utilize written texts like the AA Big Book and the Twelve and Twelve, along with other resources offered through the AA organization.

1.5 Organization of the Study

This study considers recovery from alcoholism as a lived experience. This experience is reflected in each AA member's recovery story, a narrative account of how each person comes to the realization that they have a drinking problem and how they use the AA program to achieve recovery from alcoholism. The recovery stories examined in this ethnography all share a common narrative structure or social script around which this study is organized.

In the next chapter, I will examine the history and structure of Alcoholics Anonymous. The international fellowship of AA provides the social context for the recovery stories of alcoholics in Newfoundland and Labrador. If we examine the history of this organization more closely, we will discover that the AA program of recovery is based upon a unique blend of ideas from science and religion: ideas emanating from such diverse figures as Carl Jung, Sigmund Freud and William James and from organizations like the Washingtonian Movement of the 19th Century and the Christian Oxford groups of

the early 20th Century. The ideas derived from these sources inform the twelve steps as well as the organizational principles directing each local group as embodied in the twelve traditions of Alcoholics Anonymous. An examination of the history of the twelve steps, the twelve traditions and how AA was established provides a necessary social and historical context for the recovery stories examined in this ethnography.

In chapter three, I will consider how sociological theories, particularly those within the interactionist tradition, can provide conceptual tools to make sense of the recovery experience. I will also consider how the theoretical approach used in this research can complement the existing medical and social scientific literature dealing with alcoholism and addictions.

In chapter four I will examine the research methodology employed to understand the AA experience. With an emphasis on social interaction, symbols, rituals and performance, research methods are required that will best reveal these dimensions of recovery. In chapter four I will outline the different methods employed in my research which include participant observation, in-depth interviews, textual analysis and secondary analysis. I will further explain some of the challenges I encountered in carrying out my research with a group of subjects who belong to a deviant subculture.

In chapter five, I will describe how individuals become affiliated with Alcoholics Anonymous and the social processes involved as they come to the conclusion that they are alcoholics. The social context for becoming an alcoholic occurs within the local AA group known as the home group. Each home group in AA is autonomous and it is within

the context of the home group that each member experiences the program of recovery. These early socialization experiences with the home group are critical as novice members learn how to play the role of recovering alcoholic.

In chapter six I will study how members experience the twelve steps as a systematic program to achieve personal transformation. I will consider how individuals make sense of concepts like surrendering to their disease and reaching out to a 'higher power' as well as their experiences with performing each of the twelve steps. As we shall see, AA members describe alcohol as a powerful enemy and it is the experience of being defeated by this powerful enemy that provides the pivotal experience of being drawn into the fellowship and establishing a common bond and sense of camaraderie.

In chapter seven I will explore the various social roles which exist within the home group and AA as a whole. These social roles provide opportunities for AA members to work as a unit or performance team in the enactment of recovery. I will also examine the important relationships established within the group among significant others, particularly between sponsor and sponsee, a type of mentoring that is vital to the recovery experience of each member.

Finally, in chapter eight, I will conclude by looking at implications for social theorizing about the complex public health problem of addiction. I will also consider the practical social policy implications of the research findings presented in this study.

1.6 Conclusion

Several decades of scientific research have provided great insights into the psycho-social-biological nature of alcohol dependency. Much of this research has been highly critical of the disease model of alcoholism promoted by AA, particularly the view of alcoholism as a chronic condition wherein the individual suffers from an 'allergy' to alcohol and, instead of becoming cured, finds him or herself in a perpetual state of remission. This model has been criticized as scientifically outdated and highly disempowering to people who struggle with addiction (Thatcher, 2004; Mate, 2008). Indeed, the term 'alcoholism,' commonly used in the fellowship of AA, has been rejected by many addictions professionals today. In its written materials, the World Health Organization (WHO) has formally replaced the term alcoholism with the term "alcohol dependence syndrome." As noted earlier, the Diagnostic Statistical Manual (DSM IV, 1994), currently classifies alcohol dependence as a mental illness. This new scientific language represents a deliberate distancing from the allergy metaphor and the disease model championed by AA.

Although AA has done a great deal to popularize and solidify the disease concept of alcoholism, my research will demonstrate that the conception of alcoholism from an AA perspective sharply diverges from the rational, positivist understanding of disease promoted by the medical model. While recognizing the important criticisms of the disease model of alcoholism as reflected in more recent scientific studies, I deliberately adopt the non-scientific term 'alcoholism' and refer to it as a 'disease' to expose the unique and distinct understandings and perspectives of those who belong to AA. Thus, for

the purposes of this study, an alcoholic is a person who defines him or herself as an alcoholic and who claims to have the 'disease' of alcoholism.

As my research will reveal, there are no expert diagnosticians standing at the entrances of church basements to determine whether an individual is an alcoholic. Instead of consulting the DSM, the so-called bible of the psychiatric profession, AA members apply the knowledge contained within their own authoritative texts like the *Big Book* and the *Twelve and Twelve*. AA members ultimately determine for themselves whether they are alcoholics, making sense of their disease as they interact with others in the fellowship. Terms like disease, along with other ostensible medical terminology like obsession and compulsion, are used within the fellowship but they are used metaphorically, to represent a particular world view and to legitimate shared life experiences. When AA members allude to their disease they convey the message that "I am a sick person, not a bad person." This message allows members to approach the problems of alcoholic drinking with a greater measure of compassion, gentleness and empathy as they work their cure which involves the twelve steps of recovery.

My research will demonstrate that the AA program of recovery is strange medicine indeed as it contains a curious mixture of liturgical readings, prayers and auricular confessions of past misdeeds from one drunk to another. These practices, which are far-removed from the world of conventional medicine, are used to achieve the "total psychic change" that is necessary to achieve sobriety, as stated in the principal text of AA (AA World Services Inc., 2001: xxix). I will explain that in their attempts to achieve this total psychic change, some members fall short and experience simple sobriety or

abstinence. They manage to 'put the plug in the jug' as AA's would say but they never learn to experience contented sobriety, an elusive state of recovery closer to what the eminent psychologist Abram Maslow described as self-actualization (Maslow, 1954). A person who claims to have contented sobriety has fully fathomed the AA program and reports that s/he has learned the art of joyful living. Such claims attest to the status hierarchies found within AA, an organization that is no different from any church, religious body or secular institution wherein members construct their own criterion for success and failure. If you stick with AA long enough you will hear that some members get the program while others don't. By examining the recovery stories of the men and women who participated in my study, I will expose these hidden status hierarchies and explain the rules of recovery as they exist within the unique social world of AA.

Chapter Two: The History and Structure of Alcoholics Anonymous

2. 0 Profile of a Key Informant

Bob is a key informant for this study. He has been a member of AA for nearly twenty five years. He is well-known and well-regarded within the provincial fellowship and even enjoys a high level of notoriety across Canada and parts of the United States. Bob's recovery story is colourful and fascinating. He grew up in rural Newfoundland where he experienced horrific levels of physical violence, psychological abuse and neglect as a child and eventually turned into a career criminal. Bob's is the classic AA redemption story and he captivates his audiences wherever he shares his story– to inmates at Her Majesty's Penitentiary, to young offenders at the provincial correctional facility or to the Innu and Inuit of Labrador when he travels the Labrador coast on AA outreach missions.

Studying the history of AA in this province remains a passion for Bob. For many years, he collected artifacts like old photographs or pamphlets from the first known AA group in Newfoundland and Labrador which was located in Corner Brook, on the province's west coast. Bob's favorite archival piece is an old photo of Jerry M., credited with founding the Corner Brook fellowship.

Bob explained how Jerry's sponsor was himself a sponsee of AA's founding father, Bill W. "Imagine," said Bob, "Newfoundland's founder has a direct connection to the great man himself." Despite Bob's enthusiasm for the historical connection between the founder of AA and the founder of the first AA group in Newfoundland, further research reveals a somewhat more convoluted path from Bill W. to the shores of Canada's newest province.

Little research exists on the history of AA in Newfoundland other than what is described on the website silkworth.net. According to this source, AA began in Canada in 1940 in the province of Ontario. The Reverend George Little of Toronto was apparently so impressed with the Big Book, with its Christian-oriented solutions for alcoholism, that he initiated the country's first AA meeting with the help of a fellow clergyman, the Rev. Percy G. Price of the Metropolitan United Church. The first AA group in Canada consisted of six alcoholics, along with the two clergymen, who met weekly in a private dining room at a Toronto restaurant. When the good news was reported to the New York office, Bill W. was apparently delighted that AA "is now established in Canada." From there, the Toronto group expanded to Windsor, on to London and Sault St. Marie, drawing more and more members into the AA fold.

Rev. George Little's interest in AA continued undiminished and in 1947 he arranged for a weekly AA meeting to be held in the Mimico Reformatory. This was the forerunner of extensive and effective AA work in correctional institutions from coast to coast in Canada. The same year, a committee of three Toronto AA members presented a brief to the Ontario Minister of Health, urging that a long-term program to deal with alcoholism be considered. This resulted in the setting up of the well-known Addiction Research Foundation, first with offices and detox facilities located in Toronto. AA also began to flourish among military personnel and veterans of World War II, with AA meetings beginning to appear on military bases and in veterans' hospitals—at Sunnybrook Hospital in '48 and at Camp Borden soon afterward.

AA continued its expansion into Quebec, then westward to the Pacific and later, into the Atlantic provinces. The account of AA in Newfoundland and Labrador is somewhat scanty, due to a lack of historical research, but it appears that the province acquired its first AA group through the efforts of an alcoholic named "Jerry M." The description of Jerry M. offers very little about his own personal struggles with alcohol or of the conditions surrounding the establishment of the province's first AA group. The brief caption from silkworth.net simply reads:

> Jerry M. had left home and become a drunk in Montreal. He reached New York, where he joined AA before returning to form a group in his own town. Shortly afterward, a group began in St. John's, the capital city.

"Knowing our history as a fellowship is important," shares Bob, "because if we don't know where we come from, we will never be able to reach our full potential as an organization. I know that my experience as a member of this fellowship is connected through a long line of other recovering alcoholics in Newfoundland and Labrador and even to the founders of Alcoholics Anonymous in New York."

2.1 Introduction

The official beginning of AA is listed as June 10, 1935 in *Alcoholics Anonymous Comes of Age* (1957). This organization flourished in a specific social climate that existed in middle-class America in the early 20th century. The U.S.A. had struggled with the problems of drinking for centuries prior to the formation of AA and a number of preceding social movements, fraternal organizations and religious groups had tried to offer solutions to the perplexing problems surrounding alcohol. As Sagarin points out

"...the meeting between Bill W. and Dr. Bob would not have led so easily to AA's formation had there not already existed in America both the necessary social climate and a history of somewhat similar rehabilitative efforts" (1969: 32).

In this chapter I will discuss the social and historical processes at work in defining alcoholism as a disease. The *medicalization* of drinking occurred at a time when the medical establishment was becoming one of the most powerful social institutions in the United States. Following this discussion, I will examine AA as a fellowship that originated with an enigmatic stock broker named William Griffith Wilson (Bill W.) and a down and out physician, Robert Holbrook Smith (Dr. Bob). I will identify the major organizational forerunners and trace the intellectual and philosophical roots of AA. Finally, I will examine some of the more important legacies for those who continue to follow the AA path today.

2.2 Medicalization and the American Drinking Culture

The U.S.A. has had a tumultuous relationship with alcohol throughout its history. As early as 1657 the General Court of Massachusetts made illegal the sale of strong liquor "whether known by the name of rumme, strong water, brandy or wine" (Moore and Gerstein 1981:16). This legal intervention was unusual because informal social controls (like gossip or ostracizing drinkers) had normally been sufficient to curb the abuse of alcohol among the colonists. Indeed, by today's standards, the early American colonists were prodigious drinkers. Alcohol was viewed as a gift from God and in the State of Massachusetts the population enjoyed this gift, consuming on average three and a half gallons (about 13 liters) of absolute alcohol per year per person. That rate was

dramatically higher than the present rate of consumption, estimated at 4.2 liters per adult worldwide and 8.6 liters per adult in the United States (Blue 2004: 73).

Alcohol had always been an important social lubricant in the civic life of America but it was a decidedly male prerogative in the 19th Century. DeTocqueville, the famous French philosopher who traveled through America in the 1800s included a depiction of a Michigan tavern in his journal:

> We had ourselves taken to the finest inn of Pontiac (for there are two), and we were introduced, as usual, into what is called the bar-room; it's a room where you are given to drink and where the simplest as well as the richest men of the place come to smoke, drink, and talk politics together, on the footing of the most perfect exterior equality (Blue 2004: 246).

As evident from DeTocqueville's writing, much of male socializing took place in these gathering spots where all classes came together to drink heavily, swap stories, gamble and fight. A number of fraternal organizations like the Masons, for example, favoured the tavern as a meeting place before the establishment of the lodge. Yet even outside of the taverns, drinking was a pervasive part of life and an important part of the customs and rituals that bonded men together in fraternal relationships. Drinking customs formed part of the initiation rites associated with the admission of apprentices into their crafts; similarly the practice of "footing" - the payment of whisky to the shop by every newly hired journeyman on his first day of work - established a ritualized means for new workers to be incorporated into the workplace. W.J. Rorabaugh (1979: 10) estimates that only about twenty percent of alcohol consumption in the 19th century took place at taverns, that is, at places specifically intended for drinking; the remaining eighty percent occurred in the course of commercial transactions, manufacture, elections, and other communal gatherings. Men commonly drank while working, as did ministers

while preaching, for liquor was, in Paul Johnson's words, "an absolutely normal accompaniment to whatever men did in groups" (1978: 56).

Concerns about excessive drinking became increasingly politicized by the late 18th century and various social elites were sounding the alarms that drinking constituted a serious social problem (Gusfield, 1996). During this period, alcoholism was viewed as a vice, a moral problem, even a spiritual condition (O'Dwyer, 1993). Moral models labeled alcoholics as "bad," "weak-willed" or "degenerate" individuals who needed to repent or change their wicked ways (Keller, 1976). Punishment in the form of incarceration, banishments, even public flogging was preferred to treatment because a cure was not envisioned (McHugh et al., 1979).

A challenge to the moral model first appeared with the work of a Swedish physician, Magnus Huss (1807-1890). The importance of his work lay in the fact that he was the first to systematically classify damage that was attributable to alcohol, describing in detail the various gastric problems and mental disorders associated with excessive drinking. He wrote his work *Alcoholismus Chronicus, or Chronic Alcohol Illness. A Contribution to the Study of Dyscrasias Based on my Personal Experience and the Experience of Others* in Swedish first, to reach Swedish-speaking readers. It was later translated into German and English (Wilkerson, 1996). Huss was certainly not the first to conceive of excessive drinking in disease terms. The notion that excessive consumption of liquor could be described as an illness was articulated much earlier by Benjamin Rush, the Surgeon General of George Washington's revolutionary army, in a pamphlet called *An Inquiry into the Effects of Ardent Spirits on the Human Mind and Body* in 1784. "'Drunkenness is the result of a loss of willpower. Initially drinking is purely a matter of choice. It becomes a habit and then a necessity." This notion, which sees the drinker as

dependent upon his poison, is well-founded, but the treatment Rush considered necessary to effect a cure—cold baths, total abstinence and blood-letting—was ill conceived and gave only disappointing results. Since it proved almost impossible for Rush to impose his radical therapy in everyday surroundings, he proposed the construction of detoxification establishments, asylums and 'sober houses', where regular offenders would be shut up until cured (Bennett and Ames, 1985).

Rush sparked a rancorous debate within the medical establishment about the most effective way to treat the alcoholic. Jean-Charles Sournia, in *A History of Alcoholism* (1990) suggests that institutional and professional conflicts began to emerge in the 18th century. According to Sournia, heads of the insane asylums did not want to have inebriates there, because it would damage the reputation of their facilities. Heads of inebriate treatment facilities equally did not want to send inebriates to the early insane asylums, where free whisky, opium and other drugs, between both patients and staff, were more the rule than the exception. Despite the apparent differences between the insane asylums and the inebriate facilities, many of the same treatment approaches were adopted including various nutritional regimes, exercise, leisure, work, sun baths, a great variety of water cures, electrical and chemical convulsion therapy, and even infecting alcoholics with gonorrhea because this allegedly reduced their craving to drink (Sournia, 1990: 110-119).

Inside these institutions many of the debates focused on how to rehabilitate the drunkard, debates which continue to resonate today. One debate, for example, centered on whether former addicts should be allowed to work within inebriate treatment facilities or whether non-addicted professional staff were more appropriate. The etiology of alcoholism was also hotly debated.

Sournia quotes one prominent theorist of the mid 1800s who defined "drunkenness" as a moral vice of the lower classes requiring punishment, whereas "inebriety" was a disease of the higher classes, meriting rest and renewal. Among the occupational groups represented for treatment of inebriety were physicians, lawyers, engineers, druggists, reporters, clergymen and actors - in that order (Sournia, 1990: 150-160).

In the early history of alcoholism treatment, entrepreneurs quickly realized that recovery meant big business. The Keeley Institutes were a hugely successful chain of privately owned miracle cure centers peddling injections of a secret formula which supposedly took away all desire to drink or use drugs or tobacco. The formula was later shown to be a placebo. The Keeley Institutes helped many thousands of alcoholics to achieve long-term abstinence in the 1890s and later. The secret formula, allegedly based on chlorides of gold, was a catchy gimmick that captured the imaginations of alcoholics hoping for a quick cure. Historians suggest that the real curative power lay in the spirit of mutual support and self-respect engendered by the Institutes' treatment and post-treatment approaches (Lemanski, 2001).

By 1900 there were more than fifty such special recovery institutions in the United States (Wilkerson, 1996: 142-151). Many of these facilities resembled prisons with their barred windows, locked doors, room inspections and personal searches of patients. As such, they were highly effective agents of social control. By 1925 most of these treatment centers had collapsed as the temperance movement and prohibition advocates were able to focus attention on legal controls as the only solution to the alcohol problem. With the passage of the Prohibition Amendment in 1919, the medical model lost much of its appeal and the recovery business dwindled.

In retrospect, the early treatment centers and asylums represented the first cohesive institutional attempts to treat alcoholism as a medical problem. They pioneered physiological explanations of inebriety and physical methods of treatment. They managed to reconstruct public dialogue in such a way that the inebriate was seen less as a moral and religious failure and more as a vulnerable sick person. Yet, they failed to demonstrate any cohesive and convincing methodology of treatment that could seduce the American public away from the conviction that drunkards should be thrown in jail and alcohol should be outlawed. While Prohibition proved to be a setback for the medical model and its disease proponents, the process of medicalization would soon be aided by other emerging social forms, namely the mutual aid and self-help movements.

2.3 Organizational Forerunners of Alcoholics Anonymous

Prohibition proved to be an interesting social experiment but it ultimately did not solve the "alcohol problem," which weighed heavily on the American consciousness. Americans recognized that alcohol could pose a serious problem for men, for their families and for the nation at large, but there seemed to be little appetite for the kinds of solutions proposed by the Prohibitionists. Yet, where the state had failed, a number of civic organizations and groups did boldly come forward with their own unique solutions for rehabilitating the problem drinker and addressing the larger social problems surrounding alcohol. Of these organizations, three in particular stand out as early forerunners of Alcoholics Anonymous: the Washingtonian movement of the 1840s, the fraternal temperance organizations of the late 19th century and an evangelical Protestant movement known as the Oxford Group movement, which was active in the early 1900s.

The Washingtonian Movement

The Washingtonian Movement provides an interesting historical parallel to AA. The movement can be traced back to the 1840s at a time when the temperance movement was gaining momentum across large urban centers of the United States. The basic idea of the Washingtonians was for reformed drunkards to tell their stories of how they were disgraced by the evils of alcohol and how they managed to redeem themselves with the help of God. McCarthy, commenting on this movement, reports that "everywhere the pattern was the same. A former inebriate, telling his story in dramatic fashion, was able to persuade hundreds in the audience to take the pledge and in turn become missionaries in the cause" (1958:17).

The movement lacked endurance, however, as there appeared to be little follow-up and support for the converts who pledged to abstain from alcohol after hearing a stirring lecture. It is estimated that the Washingtonian movement lost its appeal after little more than a decade of staging speeches and lecture events. An important reason for its decline in popularity is attributed to its involvement in Prohibition politics, which moved the organization away from its central task of preaching the message and winning new pledges for the temperance cause.

It is unlikely that the founders of AA considered the Washingtonian Movement as a model for its organizational structure. However, the demise of the movement as a result of its political action was duly noted by the founders of AA and became an important guiding principle for the way it related to outside agencies. In *Alcoholics Anonymous Comes of Age* (1986: 124-125), the political conflicts within the Washingtonian movement and its rapid decay were explicitly used to support the principle that AA should take no stands on outside issues

(Tradition Ten in the Twelve Traditions of AA). This principle of non-alignment remains an important feature of AA groups today.

The Washingtonian movement was significant in the formation of AA for another reason: it focused exclusively on a specific actor who was thought to be at the center of the alcohol problem: the drunkard. This was a radical departure from the message of the temperance movement: that *any alcohol* consumption could be potentially dangerous and that drinking in any form was a matter of concern. The habitual drunkard was considered merely one form of victim in the scourge of alcohol consumption. As Gusfield (1996: 192) points out in his study of alcoholism and its emergence as a social problem:

> The idea that there exists a specific segment of the population of drinkers who suffer from the use of alcohol, that they cannot be helped without special procedures of intervention, and that a specialized referral structure of organizations and professionals is needed to help them is not an old one... while excessive use of alcohol was often observed as a matter of concern before the nineteenth century, it was not organized as a problem - as a demand that public organizations attempt resolutions to alleviate the problems of troubled people. When alcohol did emerge as a public issue, the concern of the temperance movement was with drinking, and not only with a special segment of drinkers. 'Habitual drunkards' were, of course, recognized, but only as a part of a problem of drinking. The general incapacities of alcohol were given dominance in thought and policies of the movement. The alcohol problem was not encapsulated, nor was the remedying of the 'habitual drunkard' a primary, or even major, aim. Only in the Washingtonian movement of the 1840s and 1850s was there an attempt to direct attention specifically toward the drunkard as the target of an anti-alcohol movement.

Gusfield and others (Levine, 1978; Schneider 1978; Conrad and Schneider 1980) point out that the Washingtonian movement succeeded in shifting public attention away from the general problems of alcohol to the more specific pathologies of the drunkard. This shift in public attention also provided support to the disease conception of alcoholism that was beginning to emerge by the late 1800s. By this time, a group of physicians working in mental institutions

became aware of alcohol patients as presenting a unique kind of mental illness. In the 1870s these doctors established the *Quarterly Journal of Inebriety* and also championed the creation of special clinics, hospitals, and other facilities specifically for the inebriate (Wilkerson 1996). As we will see, AA adopted, intact, the argument of doctors in the temperance era that alcoholism was a type of medical problem and that the only cure for the disease was to stop drinking forever.

Fraternal Temperance Orders

In terms of its organizational structure and ideology AA bears some resemblance to the groups of craftsmen and professionals in the early temperance movement who met to support each other in their pledge to abstain from spirits. Fraternal organizations such as the Masons and the Oddfellows share a polycephalous group structure, a strong emphasis on regular meetings and fellowship, and in many cases, secretiveness with respect to the outside world.

There is no direct evidence from the AA literature that the founders looked specifically to these organizations but it is plausible that the founders and early members of AA drew together practices and principles from fraternal orders and adapted them for AA purposes. In testimony before the Special Subcommittee on Alcoholism and Narcotics of the U.S. Senate Committee on Labor and Public Welfare, on July 24, 1969 Bill alluded to AA as a "secret society" as he recounted the early history of the fellowship:

> The first AA group came into existence in June 1935 in Akron, Ohio. Then there was a return to New York, and a group started there. A few people in from Cleveland began to come to the group meetings in Akron. We grew very, very slowly, trial and error all along the way...Up to this time (1939), we have been virtually a secret society (Bill W, 1969: 59).

One fraternal order with close philosophical ties to AA was the Sons of Temperance. This brotherhood of men originated in 1842 at the same birthplace as AA, New York. The organization had a highly restricted membership and developed its own system of secret rituals, signs, passwords, hand grips and regalia. In order to become a member (called a "brother"), a man had to be nominated by an existing brother. Three other brothers would then investigate his life to determine if he was worthy of membership. A bylaw required fellow brothers to visit any sick brother at least once a day, and one of the orders of business at each meeting was to identify any brothers who were ill. The Sons of Temperance was somewhat unique among fraternal organizations as it later admitted women into the organization (see www.masonicmuseum.com).

Although noble in their ambitions, fraternal organizations met with some opposition in the growing temperance movement. Many people felt that a secret society, with its elaborate rituals, might not be in the best interests of the movement, particularly in the aftermath of the Anti-Mason Movement which depicted fraternal organizations as unfriendly, even heretical, to the Christian tradition. Another criticism arose out of the recognition that, while Temperance Fraternities like the Sons did admit women, they did not offer a hospitable, welcoming and supportive environment for them (Clawson, 1990). Interestingly, the same criticism has been leveled against AA from its early history and the organization still struggles with the recruitment and retention of female members who often report that AA meetings are chauvinistic and insensitive to women's problems (Beckman, 1993; Aaltonen & Makela, 1994). Yet, fraternal organizations grew at an impressive pace throughout the 19th Century and helped plant the seeds of mutual help movements that stressed regular fellowship and the pursuit of self-improvement or self-transformation within a small group context. And, as we shall see, the importance of

maintaining a written tradition through certain revered texts has also helped AA maintain at least a modest degree of uniformity between AA groups.

Oxford Group Movement

The Oxford Group Movement is specifically cited as a key agent in the establishment of AA (AA World Services Inc., 2001). The Oxford Group itself was an offshoot of the Young Men's Christian Association, which sought religious conversions with methods developed in missionary work in China (Kurtz, 1991; Peterson, 1992). Founded by a Lutheran minister from central Pennsylvania, Frank Buckman, the Oxford Group stressed that people could solve their own problems by confessing their sins and dedicating their lives to God (Cantril, 1963). Buchman insisted that members of the Oxford Group should be guided by the "four absolutes" - absolute honesty, purity, unselfishness, and love. Somewhat similar to the Washingtonians, Oxford Group members would spread their message through aggressive evangelical campaigns featuring prominent members who would publically confess their sins and their experience of redemption.

One Buckman protégé was instrumental in establishing AA at its birthplace in New York City. Sam Shoemaker, who had received an elite education at St. George's School, Newport, Rhode Island and at Princeton University, first met Buckman in Peking in 1918 while he was on an overseas missionary trip. Inspired by Buckman's missionary work in exotic places and by his personal charisma, Shoemaker became an Episcopalian Minister at Calvary Church in New York in 1931. When he was established there as the Rector, Shoemaker invited Buckman to make Calvary Church the headquarters for the burgeoning Oxford Group movement.

Woolverton (1983), in his historical analysis of the Oxford Group Movement offers a description of Buckman's skills as a spiritual empire builder:

> Like Shoemaker, Buchman relied on the wealthy as well as on the famous for both conversions and contributions. A dexterous spiritual director, he encouraged the confession of sins (often of a sexual nature) in small groups or house parties. Buchman was consistently reductionistic, jingoistic, and generally a stranger to subtlety. One of his favorite personal mottos was "Sorry is a magic little word." A showman himself, he made extremely able use first of radio and film, then television; he showed extraordinary administrative ability and dominated his movement autocratically (Woolverton, 1983:8).

By 1937 the Oxford Group movement had become increasingly politicized and its leader, Frank Buckman, expressed some fascist sympathies, which created tensions with his friend and colleague, Sam Shoemaker. When Buchman repudiated the specifically Christian character of the Oxford Group and renamed his now anti-communist movement Moral Re-Armament, Shoemaker got out and turned to pick up the pieces of his spiritually devastated parish. "I got completely out of the old group in 1941," he wrote to a friend, "and have seen nothing of any of them since." No doubt it was Buchman's support of Adolph Hitler that prompted Shoemaker to declare that Buchmanism was "a religious counterpart of the totalitarian movements" (Woolverton, 1983:23).

In spite of his split with Buckman and the controversies surrounding Moral Re-Armament, Reverend Shoemaker and his Episcopolian Calvary Church are still credited with providing a spiritual home to AA since Bill W. was a member of the Oxford Group under Shoemaker's spiritual leadership. The AA Big Book lists the key tenets borrowed from Oxford Group practices: the need for moral inventory, confession of personality defects, restitution to those harmed, helpfulness to others, and the necessity of belief in and dependence upon God. These goals would necessarily be achieved through fellowship in a small cell group which would meet regularly. Indeed, Reverend Shoemaker was emphatic that a program of spiritual recovery could only be achieved within the "the crucible of laymen working it out among themselves.

sharing experiences with one another" (Woolverton, 1983: 49). That was the key to success, according to Shoemaker, to maintain the group guidance that the founders of AA learned from the church.

2.4 The Emergence of Alcoholics Anonymous

It was the failure of the temperance movement and the Prohibition experiment that set the stage for AA in the 1930s. Early AA members made a point of stressing that alcohol as such is not bad, that there are simply individuals who cannot drink moderately (Room, 1989). Prior rehabilitative efforts, like the Washingtonian Movement and the Oxford Group Movement, were able to tap into America's rich spiritual resources but these groups became highly politicized and used aggressive proselytization techniques, thus alienating the very constituency they tried to help: the drunkards and alcoholics. At the same time, America's history with alcohol revealed that older, more established fraternal and religious organizations contained ideas and formulas which could be put to use in the battle against inebriety and alcoholism. All of these lessons of history were taken to heart by two people with severe drinking problems - William Griffith Wilson (Bill W.) and Robert Holbrook Smith (Dr. Bob) and used in a creative way to establish Alcoholics Anonymous.

AA managed to revive the disease model after a period of latency brought on by the Prohibition era. AA suggested that alcoholism was a type of allergy that caused individuals to experience an insatiable craving and a loss of control (AA, 1935). The *Big Book* describes alcoholics thus:

> We alcoholics are men and women who have lost the ability to control our drinking. We know that no real alcoholic ever recovers control. All of us felt at times that we were regaining control, but such intervals, usually brief, were inevitably followed by still less control, which led in time to pitiful and incomprehensible demoralization (2001: 30).

Dr. Bob, a physician and cofounder of the organization describes the life of the alcoholic:

> After they have succumbed to the desire (i.e. the 'lust for alcohol') again, as so many do, and the phenomenon of craving develops, they pass through the well-known stages of a spree, emerging remorseful, with a firm resolution not to drink again. This is repeated over and over (2001: XXIX).

There is some debate among historians about whether the modern disease model of alcoholism was invented by AA. William Miller (1989) and Ernest Kurtz (1991), both renowned AA historians, categorically reject any claim that the origin of the disease concept is to be found in AA. According to Kurtz, the original AA conceptualization of alcoholism is "emotional and spiritual maladjustment" (1979:5). When AA did use medical terminology, it was primarily for metaphoric value as when Dr. Bob suggested that alcoholics are allergic to the substance of alcohol. As Miller suggests, the allergy metaphor was more for sense-making than for science (Miller, 1989).

That having been said, however, there is no doubt that AA later became, and is today, inextricably interwoven with the disease concept. Dr. Bob and Bill W. were instrumental in mobilizing the American medical community and solidifying the disease concept of alcoholism by helping to establish the Yale University Institute of Alcohol Studies and its empirically based *Quarterly Journal of Studies on Alcohol* (both founded in 1940). A key proponent of the disease model was the charismatic Marty Mann, the first woman to attribute her recovery to AA. Sponsored by the Yale Institute of Alcohol Studies and promoted by AA, she crisscrossed the U.S.A. making thousands of speeches popularizing the disease concept. She portrayed the alcoholic not as a bad person who should be punished but as a good person who was sick and could be helped. What Kurtz adds to this story is strong evidence that Mann's presentation ran far

ahead of anything that scientific research at that time could support. Indeed, Dr. Tiebout, one of the seminal thinkers of AA, reflected in 1955 that he trembled to think "how little we have to back up our claims. We are all skating on pretty thin ice" (quoted in Kurtz, 1991: 65).

Key Figures in the Establishment of AA

"Bill W.'s Story" is featured in chapter one of the Big Book, giving him preeminence as the Founding Father of AA (AA World Services Inc. 2001). Wilson was a veteran of World War I and was already a rambunctious drinker by the time he became a stock company investigator in New York City in the early 1920s. The volatile stock market of the early twenties was good to Bill in the early part of his career and allowed him to enjoy a life filled with drinking and partying. However, Bill's economic prospects abruptly changed with the stock market collapse of October, 1929 and the ensuing Great Depression. Bill turned even more to the bottle to ease his fears about supporting himself and his young wife. In his own words "Liquor ceased to be a luxury; it became a necessity. Bathtub gin, two bottles a day and often three, got to be routine" (AA World Services Inc., 2001:5). Bill continued his heavy drinking to the consternation of family and friends for the next several years. As a result of his drinking, he lost his house, his livelihood and nearly his marriage. He struggled with delirium tremens, thoughts of suicide and worried that he was going insane as a result of his drinking. Bill's brother-in-law, a physician, recommended the bella-donna regime as a medical intervention of last resort consisting of a combination of rest, hydrotherapy, mild exercise and vitamin supplementation in a hospital setting. Unfortunately, Bill did not respond favourably to the treatment.

While Bill was in hospital, he received care from a psychiatrist named Dr. William Silkworth. Silkworth shared his own clinical impressions concerning the etiology of alcoholism.

suggesting that drinkers like Bill shared a built-in predisposition or allergy to alcohol, which was incurable and which required a life-time of abstention from drinking. As Silkworth would explain in a letter of endorsement for AA:

> We believe...that the action of alcohol on these chronic alcoholics is a manifestation of an allergy; that the phenomenon of craving is limited to this class and never occurs in the average temperate drinker. These allergic types can never safely use alcohol in any form at all; and once having formed the habit and found they cannot break it, once having lost their self-confidence, their reliance upon things human, their problems pile up on them and become astonishingly difficult to solve...men and women drink essentially because they like the effect produced by alcohol. The sensation is so elusive that, while they admit it is injurious, they cannot after a time differentiate the true from the false. To them, their alcoholic life seems the only normal one. They are restless, irritable and discontented, unless they can again experience the sense of ease and comfort which comes at once by taking a few drinks - drinks which they see others taking with impunity. After they have succumbed to the desire again, as so many do, and the phenomenon of craving develops, they pass through the well-known stages of a spree, emerging remorseful, with a firm resolution not to drink again. This is repeated over and over, and unless this person can experience an entire psychic change there is very little hope of his recovery (AA World Services Inc., 2001: XXVIII).

This notion, that alcoholism was the result of an allergic response and constituted a life-long ailment would later inform a core AA belief that alcoholism is a disease (Judge, 1994).

Bill seemed to take little comfort from this notion that he suffered from a fatal allergy to alcohol. His situation was desperate and he had given up all hope that he could ever be rehabilitated. His outlook changed, however, when a childhood acquaintance, a self-described alcoholic named Ebby T., paid him a visit at the hospital and reported that he had become sober by finding God through the Oxford Group. At first, Bill was suspicious of his friend's conversion and questioned the need to turn over his drinking to some invisible deity. Ebby T., sensing Bill's reluctance to accept religious dogma, suggested a formula for conceptualizing God that would become a fundamental tenet of AA theology. As Bill recounts in his own words:

> Despite the living example of my friend, there remained in me the vestiges of my old prejudice. The word God still aroused a certain antipathy. When the thought was expressed that there might be a God personal to me this feeling was intensified. I didn't like the idea. I could go for such conceptions as Creative Intelligence, Universal Mind or Spirit of Nature but I resisted the thought of the Czar of the Heavens, however loving His sway might be....My friend suggested what then seemed a novel idea. He said, 'Why don't you choose your own conception of God?' (AA World Services Inc., 2001: 12).

Ebby T's suggestion to reach out to a 'higher power' of one's own making should be seen in historical context. In the 1930s the relationship between spirituality, psychiatry and higher states of consciousness were popular themes explored by such writers as William James, Carl Jung and to an extent, Sigmund Freud. We can see the influence of these figures in Bill W's own testimony of the origins of Alcoholics Anonymous:

> Alcoholics Anonymous had its start in the offices of one of the founders of modern psychiatry. I refer to Carl Jung, who in the early 1930s received a patient from America, a well-known businessman (Rowland H.). He had run the gamut of cures of the time and desperately wanted to stop drinking, and could get no help at all. He came to Dr. Jung and stayed with him about a year. He came to love the great man. During this period the hidden springs of his motivation were revealed. He felt that now, with this new understanding, plus communication with this new and wonderful friend, he had really shed this strange illness of mind, body and spirit.
>
> Leaving there, he was taken drunk, as we AA's say, in a matter of a month, perhaps, and coming back, he said, "Dr. Jung, what does all this mean?" Then Jung made the statement that I think led to the formation of AA. It took a great man to make it. He said, "Rowland, up until recently I thought you might be one of those rare cases who could be aided and made to recover by the practice of my art. But like most who will pass through here, I confess that my art can do nothing for you."
>
> "What," said the patient, "Doctor, you are my port of last resort. Where shall I turn now? Is there no other recourse?"
>
> The Doctor said, "Yes, there may be. There is the off chance. I am speaking to you of the possibility of a spiritual awakening - if you like, a conversion."
>
> "Oh," said the patient, "but I am a religious man. I used to be a vestryman in the Episcopal Church. I still have faith in God, but he has little in me, I should think."
>
> Dr. Jung said, "I mean something that goes deeper than that, Rowland - not just a question of faith. I am talking about a transformation of spirit that can motivate you and set you free from this. Time after time, alcoholics have recovered by these means. The lightning strikes here and there, and no one can say why or how. All I suggest is that you expose yourself to some religious environment of your own choice.

> The patient went to England. He became associated with the group of that day in later years called Moral Re-Armament, and to his great surprise he began to feel released from this hideous compulsion. He returned to America. He had a place in Vermont. There he ran into a friend of mine, a friend about to be committed, a friend we AA's lovingly call Ebby. Ebby, at the time a wealthy man, had just run his car through the house of a farmer, into the kitchen, pushing in the wall, and when he stopped, out stepped a horrified lady from inside, and Ebby said, "how about a cup of coffee?" This was the extent of his illness...Rowland got hold of him, took him to New York, and exposed him to the Oxford Groups, whose emphasis was upon hopelessness - in the sense that on one's unaided resources one could not go far. Another was on self-survey. Another was on a species of confession, and then there was restitution and belief in a Higher Power. That movement was rather evangelical, but AA owes it a great debt, in what to do and also in what not to do (Bill W. 1969: 80).

Bill W. corresponded with Carl Jung as he continued to work out the formula for the twelve steps and the AA program of recovery. Jung, in turn, encouraged Bill W. to pursue his interest in psychiatry and religion, as reflected in a letter addressed to Bill W. in 1961. In this letter Jung offers some explanation as to why he would encourage Roland H. to explore spirituality as a potential cure for his alcoholism:

> Our conversation had an aspect of which he did not know. The reason that I could not tell him everything was that in those days I had to be exceedingly careful of what I said...His craving for alcohol was the equivalent, on a low level, of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God. How could one formulate such an insight in a language that is not misunderstood in our days. The only right and legitimate way to such an experience is, that it happens to you in reality, and that it can only happen to you when you walk on a path which leads you to higher understanding. You might be led to that goal by an act of grace, or through personal and honest contact with friends, or through a higher education of the mind beyond the confines of mere rationalism...I am risking giving you a full explanation because I conclude from your very decent and honest letter that you have acquired a point of view above the misleading platitudes one usually hears about alcoholism. Alcohol in Latin is "spiritus" and you use the same word for the highest religious experience as well as for the most depraving poison. The helpful formula therefore is: spiritus contra spiritum (quoted in Lead and Norris 1997:455).

In another letter to Jung, Bill W. goes on to describe the importance of religious conversion in the transformation of the alcoholic, recognizing that there might be different varieties of conversion experiences as detailed in the writing of the psychologist William James:

> I find myself terribly depressed...caused by my inability to find the slightest faith. Ebby again visited me and repeated the simple Oxford Groups' formulas. Soon after he left me I became even more depressed. In utter despair, I cried out, 'if there is a God, will He show himself?' There immediately came to me an illumination of enormous impact and dimension, something which I have tried to describe in the book Alcoholics Anonymous, and also in AA Comes of Age...My release from the alcohol obsession was immediate. At once I knew that I was a free man. Shortly after my experience, my friend Edwin came to the hospital, bringing me a copy of William James's The Varieties of Religious Experience. This book gave me the realization that most conversion experiences, whatever their variety, do have a common denominator of ego collapse at depth (quoted in Leach and Norris, 1997:454).

Finally, we have the intellectual contributions of Freudian psychoanalytic theory. Freud's contributions to the AA program are perhaps more subtle and understated than the formally acknowledged contributions of Jung and James. Certainly, there is no evidence that Bill W. ever personally corresponded with Freud as he did with Jung. Still, Bill W. borrowed from Freud the idea that the neurotic personality was arrested or delayed in an early stage of personality development and subject to narcissistic pathology. Freud referred to such an individual as "His Majesty, the baby," as described in his 1914 essay *On Narcissism: An Introduction*. In the earliest AA literature, including the AA Big Book, one will find a number of references to the phrase "His Majesty, the baby," to describe the selfishness, immaturity, haughty arrogance and low self-esteem of the alcoholic. In the Big Book, Bill W. offers this description of the alcoholic:

> Selfishness - self-centeredness! That, we think, is the root of our troubles. Driven by a hundred forms of fear, self-delusion, self-seeking, and self-pity, we step on the toes of our fellows and they retaliate. Sometimes they hurt us, seemingly without provocation, but we invariably find that at some time in the past we have made decisions based on self which later placed us in a position to be hurt...So our troubles, we think, are basically of our own making. They arise out of ourselves, and the alcoholic is an extreme example of

> self-will run riot, though he usually doesn't think so. Above everything, we alcoholics must be rid of this selfishness. We must, or it kills us! God makes that possible. And there often seems no way of entirely getting rid of self without His aid. Many of us had moral and philosophical convictions galore, but we could not live up to them even though we would have liked to. Neither could we reduce our self-centeredness much by wishing or trying on our own power (AA World Services Inc., 2001: 62).

In Bill W's formulation, the alcoholic drinks excessively because of unresolved issues from the past that generate guilt, shame, anger and an overall negative emotional state which dominates the present. The alcoholic is not mature enough, not grown up enough to handle life on life's terms and to deal with the wreckage of the past. In Freudian language, the alcoholic has little conscious awareness of the motivations and emotional states driving the present; instead s/he is controlled by the unconscious mind, which is rooted in the past. This unconscious mind, according to Freud, is the repository of primitive instinctual motives, and also memories and emotions that are so threatening to the conscious mind that they have been unconsciously pushed down through the process of repression (Storr,1989: 20-30).

Bill W. adapted these ideas and suggested that the alcoholic, "his Majesty, the baby," could only recover from the disease of alcoholism by dealing with the past and becoming more aware of the underlying causes of excessive drinking. As we shall see later in this study, this objective, of dealing with the past, of 'expanding the personal consciousness' in Freudian language, is achieved largely through steps four and five of the AA program of recovery. Sounding like a Freudian acolyte, Bill W. describes excessive drinking as but a symptom of these deeper, underlying conditions affecting the psyche:

> We (alcoholics) needed a personal housecleaning, which many of us had never attempted. Though our decision was a vital and crucial step (Bill is referring to the decision to accept God's help through steps 1,2 & 3), it could have little permanent effect unless at once followed by a strenuous effort to face, and to be rid of, the things in ourselves which had been blocking us. Our liquor was but a symptom. So we had to get down to causes and

> conditions...therefore, we started upon a personal inventory. This was step four. A business which takes no regular inventory usually goes broke. Taking a commercial inventory is a fact-finding and fact-facing process. It is an effort to discover the truth about the stock-in-trade. One object is to disclose damaged and unsalable goods, to get rid of them promptly and without regret. If the owner of the business is to be successful, he cannot fool himself about values. We did exactly the same thing with our lives. We took stock honestly. First, we searched out the flaws in our make-up which caused our failure. Being convinced that self, manifested in various ways, was what had defeated us, we considered its common manifestations (AA World Services, 2001: 64).

I will examine how these steps are interpreted and experienced later on in this study but we can see how Bill W. was able to apply some of these ideas from the prevailing philosophies and intellectual currents of his day and how he managed to incorporate them into the AA program of recovery.

Another key element in the program revolved around the notion of mutual-help and the provision of service to other suffering alcoholics. When Ebby T. first visited Bill in hospital, he encouraged his friend to reach out to other alcoholics as a way of maintaining his own sobriety. This would become another cornerstone of the AA approach summed up in their motto that "in order to keep it (sobriety) you've got to give it away."

Bill's first attempt to give it away occurred when he met his AA co-founder on a business trip in Akron, Ohio. After a business deal fell through, Bill was tempted to get drunk. Convinced that he had to talk to another alcoholic or relapse, Bill W. sought out the company of Dr. Bob after contacting a local Oxford Group minister who was listed in a church directory. By contacting the minister and eventually a woman named Mrs. Henriette Sierberling, Bill obtained the name of another alcoholic in the area, Dr. Bob, whom he met at Mrs. Sierberling's house (Leder and Martin, 1982). Some weeks after their encounter, on June 10, 1935 Dr. Bob took his last drink, a date that is commemorated as the birth of AA.

There is some debate about the exact roles and contributions made by Dr. Bob and Bill W. as co-founders of AA. By many accounts, Bill W. is seen as the principal organizational pioneer of AA - drafting The Twelve Steps and Twelve Traditions of the program and doing much of the work in setting up the organization. Dr. Bob, on the other hand, is often depicted as the Spiritual Progenitor of the movement and his experience of finding his 'higher power' certainly influenced the traditions evolving out of the Akron and Mid-West AA movement. As Kurtz (1991) reports, Dr. Bob maintained closer ties with the Oxford Group as he worked with AA groups in Akron in the early years of the organization. Dick B., a member and historian of AA, recounts in his elaborate on-line website (www.dickb.com), that Dr. Bob was much more comfortable with the evangelical tenor of the Oxford Group and its conservative, Christ-centered theology. In Akron, for instance, joining AA usually meant first being hospitalized, then kneeling and praying in the presence of the group for help with one's problem and one's life. Dr. Bob would reportedly visit alcoholics in hospital daily and invite them to "surrender their lives to Jesus Christ" as a precondition to joining AA. In Akron meetings, members were also encouraged to publically confess their sins before their group.

In New York, a more secularized and cosmopolitan urban center, members were not expected to kneel and there was a strong emphasis on not preaching when talking to another alcoholic. Furthermore, Catholics in the New York groups reported that they felt uncomfortable confessing before a group and were apparently influential in convincing Bill W. to formulate the movement's fifth step, which encourages more private disclosure (Johnson, 1987). Another key difference lay in Bill W.'s apparent fondness for the writings of William James who adopted a pragmatic approach to religion heavily infused with concepts from popular psychology. James

emphasized the role of beliefs and thoughts in a conversion experience and prompted Bill W. to emphasize the importance of correcting the "stinking thinking" that permeated the cognitive style of alcoholics (Kurtz, 1991; Pittman, 1988; Rehm, 1993). Critics of the New York legacy like Dick B. lament the fact that AA has strayed from its pure, biblical, Christian heritage and has been saddled with 'psychobabble' (www.dickb.com).

The Growth of AA

Despite these initial growing pains and adjustments, AA attracted 100 members between 1935 and 1939, and in 1939, it received its name "Alcoholics Anonymous" from its book that discussed a theory of alcoholism, the 12 steps, and stories of alcoholics (AA World Services, 2001). The book is better known in recovering communities as the Big Book.

The creation of an organizational structure for AA began in 1938 with the formation of the Alcoholic Foundation, tasked with the responsibility of raising funds for the movement, and with the setting up of a company to publish the Big Book. A headquarters for AA, later called the General Service Office, was set up in New York, in connection with the publication of AA literature, videos and meeting directories.

Since AA had no real models to follow, it struggled in its early years to define positions on issues like leadership, professional staffing of offices, ownership of property including profits accrued from Big Book sales and public relations. Bill W. became the key person in managing the day to day operations of the General Service Office, including overseeing the publication of the AA periodical Grapevine and formally conveying important organizational principles

through what is now known as the AA Preamble.[2] In 1946 Bill published his views on the successful methods AA groups had used to deal with organizational problems. These were called the Twelve Traditions.

The basic program of AA is outlined in the Twelve Steps. published in the Big Book. There is some debate about the authorship of The Steps but they were widely debated among members during 1938 and 1939 and the wording reflects these collective discussions and the consensus that emerged. According to Dick B., the most controversial debates occurred over references to the notion of a higher power with Dr. Bob favoring references to Jesus Christ in place of references to a "Power" or "God...as we understood him." The 12 Steps serve as the backbone of AA for the individual member:

The Twelve Steps

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed. and became willing to make amends to them all.
9. We made direct amends to such people wherever possible. except when to do so would injure them or others.

[2]AA Preamble: Alcoholics Anonymous is a fellowship of men and women who share their experience. strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership: we are self-supporting through our own contributions. AA is not allied with any sect. denomination. politics. organization or institution: does not wish to engage in any controversy: neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

The 12 Traditions, published in 1946 and confirmed in 1950 at the First International Conference of AA (AA World Services, 1953), are guidelines for the development of AA.

Twelve Traditions

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose, there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.
6. 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.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

Written Traditions in AA

The written word has always been important in transmitting ideas from one generation of AA members to the next. By far, the best-known AA book is the Big Book. It was an attempt to

describe the experiences of the early founders of the movement as well as to present the success stories of those who participated in AA's 12 step recovery program. The stories comprise more than half of the text. The Big Book is now into its fourth edition (Alcoholics Anonymous World Services Inc., 2001) and only the story section has received any substantial editing. The most recent edition includes more personal stories from women and ethnic minorities.

The first issue of AA Grapevine was published in 1944, originally for members in the New York area. Since then, Grapevine has become an international periodical, with many of its articles expanded into books or edited down in pamphlet form. A collection of Bill W.'s Grapevine writings was later published as The Language of the Heart (1989). Another collection of Bill W.'s texts had been published earlier in As Bill Sees It (1967).

Other texts produced by AA's own publishing company, called AA World Services, Inc., are called "conference-approved literature" and include:

- Twelve Steps and Twelve Traditions (1986, originally published in 1953) - consists of Bill W's essays on the content and meaning of these two sets of principles
- Alcoholics Anonymous Comes of Age (1957) - describes the events of the 1955 convention, from which it took its name. It also includes the speech given by Bill W. on the history of AA.
- The AA Service Manual and Twelve Concepts for World Service (1962)- lays out a detailed description of the organizational structure of AA but focuses more on the structure of AA in the U.S. and Canada.
- Dr. Bob and the Good Oldtimers (1980), Pass it On (1984), Came to Believe (1973), Living Sober (1975) - shorter monographs of the experiences of the early members and co-founders along with some practical advice for maintaining sobriety.

2.5 Conclusion

Alcoholics Anonymous remains one of the most resilient and influential civic organizations of the 20th Century. In the United States, AA reports a membership of 1,190,637. Canadian membership is listed at 95,984 and members in other countries number 729,097 (www.aa.org).

The growth of AA is all the more impressive because many of the organizations from which Bill W. borrowed ideas have suffered from steady declines in membership including fraternal organizations, political parties, churches and many civic organizations - a pattern noted in Putnam's famous study *Bowling Alone* (2000).

AA is also responsible for the twelve step movement and the generation of a host of mutual-help groups built around its organizational principles. These include Narcotics Anonymous, Gamblers Anonymous, Co-Dependents Anonymous, Al-Anon, Al-Ateen, Overeaters Anonymous, Incest Survivors Anonymous to the more esoteric Sex and Love Addicts and Women Who Love Too Much. The AA motto that "all you need to form a new group is a resentment and a coffee pot" has indeed proven to be a successful formula for growth all over the world.

When we look more closely at the history of AA, we can identify important legacies, which provide a blueprint for the AA experience today. First, AA can be considered as an organizational and intellectual *bricolage*. This French term is used to describe how something is made or put together using whatever materials happen to be available. The founder of AA, Bill W. was, in a sense, the ultimate bricoleur, borrowing judiciously from the fields of psychology, religion, medicine and history. In crafting his own recovery, and in constructing a systematic program of change for other alcoholics - Bill W. adopted ideas from such diverse figures as Carl Jung, Mary Baker Eddy, the founder of Christian Science, and William James, considered by many as the father of modern popular psychology. Bill W. dabbled in various therapies and treatments involving Christian Science, ESP, and according to one biographer even

experimented with LSD in the 1960s in an effort to raise his personal consciousness (Cheever, 2004).

In creating an organizational structure for AA, Bill W. learned from the successes and failures of fraternal organizations, Christian sects as well as political and religious movements like the Washingtonians, fraternal orders and the Oxford Movement. His organizational genius lay in his ability to recognize the failings and shortcomings of much older organizations and his adaptation of institutional features that seemed to fit into his unique vision for AA. In testimony before the Special Subcommittee on Alcoholism and Narcotics of the U.S. Senate Committee on Labor and Public Welfare, on July 24, 1969, Bill explained his approach to organizational engineering: "If it seemed to work, get with it! If it failed, discard it. That was our practice until about four years later, when after hundreds of failures, we found that we had a hundred people sober" (Bill W, 1969: 91). Ultimately, the creation of AA catapulted William Wilson from defeated, alcoholic stock broker to be declared by Time Magazine in 1999 among the top 20 of the *Time 100: Heroes and Icons* who exemplified "courage, selflessness, exuberance, superhuman ability and amazing grace" in the 20th century.

Perhaps Bill's wisest move as bricoleur was to deliberately align his fledgling organization with the medical, scientific establishment by crafting alcoholism as a disease. For AA, the marriage to the medical establishment represented a coup of sorts for its founder. In an address to the New York Medical Society Section on Neurology and Psychiatry in 1944, Bill suggested that AA:

> ...is a synthetic concept - a synthetic gadget, as it were, drawing upon the resources of medicine, psychiatry, religion, and our own experience of drinking and recovery. You will search in vain for a single new fundamental. We have merely streamlined old and proven principles of psychiatry and religion into such forms that the alcoholic will accept them. And

> then we have created a society of his own kind where he can enthusiastically put these very principles to work on himself and other sufferers (Bill W., 1954: 25).

He went on to say:

> We have torn still other pages from the Book of Medicine, putting them to practical use. It is from you gentlemen we learn that alcoholism is a complex malady; that abnormal drinking is but a symptom of personal maladjustment to life; that...our obsession guarantees that we shall go on drinking, but our increasing physical sensitivity guarantees that we shall go insane or die if we do. When these facts, coming from the mouths of you gentlemen of science, are poured by an AA member into the person of another alcoholic, they strike deep - the effect is shattering...the alcoholic is reduced to a state of complete dependence on whatever or whoever can stop his drinking. He is in exactly the same mental fix as the cancer patient who becomes dependent, abjectly dependent if you will, on what you men of science do for cancer. Better still, he becomes 'sweetly reasonable,' truly open-minded as only the dying can be (Bill W., 1954: 31).

The relationship Bill W. forged between AA and the medical establishment can be best described as symbiotic or win-win. For the medical establishment AA provided a pool of subjects from which to test its theories and carry out its medical research. This was certainly the case for E.M. Jellinek who is credited with establishing the modern disease concept of alcoholism but it continues with more contemporary medical researchers particularly in the field of genetic and heredity studies of alcoholism. Even the powerful pharmaceutical-medical alliance has benefitted from its association with AA as it was able to find willing participants in its drug trial research for the drug Antabuse, which was designed to eliminate or reduce the physical cravings of alcoholics. The provision of willing subjects for medical research and experimentation was certainly a benefit for the medical establishment but even more importantly, medicine could claim a measure of success for the rehabilitation of alcoholics who managed to find remission from their disease - even if the physicians making referrals knew little of what actually occurred inside the rooms. In a sense, the medical establishment has managed to piggyback on the work of AA, and in doing so, it has

extended its hegemony over this disease and managed to create an impressive addictions-recovery industry in the process.

For members of AA the alliance with medicine allowed them to legitimize their approach as medically approved and provided them with a more humanistic approach to dealing with their disease. Framing alcoholism as a disease allowed Bill W. and his fellowship to escape the moral judgment of drunkards as bad in favour of a view of the alcoholic as sick. The language of medicine and disease also established a sense of community, a shared vocabulary among AA members. To say, "I am sick but I am in recovery" is a code for modern members of AA and other twelve step groups to signify inclusion into a community built around shared life experiences.

Like their founders, modern members of AA are also bricoleurs, borrowing concepts, ideas and principles from the AA program, applying these to their own lives in the hope of recovery. Even the famous 12 steps are presented as suggestions to be used in an individualized program of recovery. On an individual basis, AA members cobble together parts of the AA program that seem to work for them, adopting ideas, concepts and theories which are personally meaningful, in an effort to make sense of this phenomenon they call a disease; while discarding elements of the AA program that don't seem to fit their particular stories. As I hope to demonstrate through this research, the work of recovery from this disease of alcoholism is very much a type of bricolage where AA members make use of a diverse range of ideas, conceptual tools and materials available through the AA program to construct a new sense of self through the identity of recovering alcoholic.

The Twelve Steps and Twelve Traditions, as well as the advice and guidelines detailed in the body of AA literature, offer a type of conceptual model or map for AA members to follow. Still, the heart of the program is based on the concept of one alcoholic helping another, especially during

periods of stress (Kurtz, 1991). This helping is carried out during AA meetings as members talk about their own experiences and listen to others in what is supposed to be a supportive, non-judgmental atmosphere. It is in the meetings that members are exposed to the AA model and its precepts in a formalized, ritualistic sense. These principles and precepts are then reinforced and given new meaning through the unique helping relationship that evolves between an individual and his/her sponsor.

Those who enter any of the rooms in the province of Newfoundland and Labrador inherit a script of recovery built around the twelve steps and the twelve traditions. Like Bill W. and Jerry M., the founder of AA in this province, each new member of AA is challenged to examine themselves with rigorous honesty and to overcome significant obstacles on their journeys of recovery.

As I have demonstrated in this chapter, the tools of recovery in AA are drawn from diverse traditions and intellectual backgrounds. AA is indebted to fraternal temperance organizations, the Oxford Group and the Washingtonian Movement for inspiring the design of localized, autonomous home groups that are linked together into an impressive organizational structure of international scope. The guiding principles for each home group are reflected in the twelve traditions of AA, which offers a sense of uniformity and consistency for any AA member who might take in a meeting anywhere in the world. Spiritually, the twelve steps are grounded in Christian principles which involve confession, taking stock of one's faults or flaws, making amends and committing to personal change with the help of a higher power. Intellectually, much of the work that is involved in doing the steps, particularly the fourth and fifth steps as I will demonstrate, involve bringing to the awareness of the AA member motivations and urges which are buried deep in the unconscious. Thus, when AA members speak of becoming more aware of their defects of character and learning how to correct

them, they owe a debt of gratitude to Freud, Jung and William James, who inspired Bill W.'s ideas about the twelve steps. Ultimately, the promise of the steps is that the AA member can transform him or herself from a self-centered, immature and irresponsible "his Majesty, the Baby" into a mature, selfless, responsible and functional member of society.

In the next chapter, I will review the sociological literature as it pertains to the AA experience and highlight some theories and concepts that will help us to better understand the personal transformation of men and women who share this challenging journey.

Chapter Three: Theoretical Framework and Literature Review

3.0 Introduction

There are more than two million members of AA worldwide. In Newfoundland and Labrador, AA reports over 82 active groups (those which meet at least once per week) with approximately 700 members - men and women like Tony, introduced at the beginning of this study, whose lives have been torn apart by alcohol. The growth of AA from a union of two solitary drinkers, Bill W. and Dr. Bob in 1930s America, to a fellowship which extends to remote communities throughout Newfoundland and Labrador, is indeed a significant social phenomenon. Yet, despite the popularity and influence of this social movement, a review of the research literature reveals that little is known about how members subjectively experience the social world of AA.

In this chapter, I will examine a sociological perspective which can inform the study of recovery from the disease of alcoholism as it is experienced by members of AA. This perspective is known in sociology as interactionism, a broad theoretical field, from which I have mined several concepts and principles which are relevant to the phenomenon of recovery. I will highlight four approaches in particular from this theoretical field: dramaturgical analysis, the sociology of emotion, symbolic interactionism and the study of interaction rituals. Following the discussion of theories I will present an analysis of the body of sociological literature on the subjective experience of recovery as well as the medical and social scientific literature on the nature of this 'disease.'

3.1 Dramaturgical Analysis

Erving Goffman (1922-1982) was, perhaps, the most creative and influential theorist of interactionist processes since George Herbert Mead. In both his first and last major works - *The Presentation of Self in Everyday Life* (1959) and *Frame Analysis: An Essay on the Organization of Experience (1974)*, respectively - Goffman suggested that day-to-day interactions have much in common with being on stage or in a dramatic production. He begins with a rather simple observation:

> When an individual enters the presence of others they commonly seek to acquire information about him or to bring into play information about him already possessed. They will be interested in his general socio-economic status, the conception of self, his trustworthiness, etc. Although some of this information seems to be sought as an end in itself, there are usually quite practical reasons for acquiring it. Information about the individual helps to define the situation, enabling others to know in advance what he will expect of them and what they may expect of him (Goffman,1959:1).

Goffman viewed social life as something like a staged drama where members of the audience judge our performances and are aware that we may slip and reveal our true character. Consequently, most of us attempt to present ourselves in ways that are most favorable to our own interests or image. This is part of the overall strategy of "impression management" (Goffman,1959; 1963). For example, a waiter may dress neatly, be polite and try to demonstrate a mastery of the menu when s/he interacts with diners. By maintaining this "personal front" (Goffman, 1959:24), the waiter tries to manage the diner's impression of him, influence their definitions of the situations and affect their conduct. This is part of what Goffman called a front stage performance designed in this particular example to please the diner and hopefully to maximize the tip. Goffman also

points out that in this simple interaction, the waiter may engage in back stage behaviour where s/he is not required to perform a specific role and can relax since s/he is now out of the view of the audience. When s/he enters back stage in the kitchen, for example, the waiter can poke fun of the diners and mock their behaviour.

In Goffman's dramaturgical analysis, face-saving behaviour refers to the strategies that we use to rescue our performance when we experience a loss of face. One such face-saving technique is studied nonobservance, where one role player ignores the flaws in another's performance to avoid embarrassment for everyone involved. For example, waiters will often overlook the fact that a diner mispronounces the name of a dish or s/he will gently assist someone who is completely inept at using a cork screw on a bottle of wine. Of course, actors may experience slips in their performance at times, in which case members of the audience will look for evidence of deception. Parents often do this with their children when they evaluate their verbal responses along with their nonverbal behaviours. (Can they look you in the eye, for example? Do they appear nervous etc.?).

Although Goffman approaches the front stage and other aspects of his system as a symbolic interactionist, he also discusses their structural character. For example, he suggests that actors attempt to manage others' impressions of the groups, establishments, and organizations that they represent. The members and personnel of such social units often constitute what Goffman calls "performance teams" that cooperate in "staging a single routine" (Goffman, 1959: 79). For example, members of a church may cooperate in staging shows of harmony, celebration and respectability. Similarly, doctors and nurses sometimes cooperate in staging shows of calm confidence and competence under life-

threatening circumstances, particularly when family members of the patient are involved. As I shall demonstrate, members of an AA home group will stage birthday celebrations and speaker meetings as a way of selling the AA solution to newcomers. In such cases, team members may provide directions through such subtle cues as raised eyebrows or strained facial expressions to support one another's performances.

The concept of role figures prominently in Goffman's analysis of performance teams. He was particularly interested in the degree to which an individual embraces a given role. Role distance deals with the degree to which individuals separate themselves from the roles they are in. Sometimes, actors exhibit role distance as a method to manage stress or alleviate tension among team members as, for example, when a teacher shares a story of how he failed a particular subject when he was a student - just as he is about to deliver failing grades to his class.

It is interesting to note that Goffman himself was uncomfortable being labeled as a symbolic interactionist (Goffman, 1988). Goffman seemed to draw as much inspiration from Emile Durkheim and the British anthropologist A.R. Radcliffe-Brown as he did from Blumer, Cooley and Mead, particularly in his analysis of rituals of interaction. Ritual, in a Goffmanian sense, refers to the countless routine observances of common courtesies and interpersonal etiquette. Borrowing a distinction from Durkheim, Goffman (1971: 62-65) classifies interpersonal rituals as either positive or negative. Negative interpersonal rituals are those behaviours through which we avoid intruding upon one another's personal boundaries or territories. We would not sit in a chair in a movie theater, for example, if there was already a jacket placed over the seat, thus respecting the

jacket as an important boundary marker. However, our ritual treatment of those we do know is almost opposite. Friends will go out of their way to cross a street, wave, verbally greet and touch each other. This is a positive interpersonal ritual to affirm and signal to themselves and others the exact nature of their very personal relationship. Here is the way Philip Manning (1992:133) describes the role of ritual in everyday life:

> For Goffman, ritual is essential because it maintains our confidence in basic social relationships. It provides others with opportunities to affirm the legitimacy of our position in the social structure while obliging us to do the same. Ritual is a placement mechanism in which, for the most part, social inferiors affirm the higher positions of their superiors. The degree of ritual in a society reflects the legitimacy of its social structure, because the ritual respect paid to individuals is also a sign of respect for the roles they occupy.

Goffman also adopts a more structuralist position on understanding behaviour when he focuses on "...the basic frameworks of understanding available in our society for making sense out of the events and to analyze the special vulnerabilities to which these frames of reference are subject" (1974:10). According to Snow (2007), Goffman's frame analysis performs three important functions in interpretive work. First, frames focus attention on our surroundings by highlighting what is relevant or irrelevant, what is in-frame and what is out of frame. Second, they act as articulation mechanisms by linking the various highlighted elements, so that a story is told about them, so that one set of meanings rather than another is conveyed. Third, they serve a transformative function through the reconstitution of the way some things are seen in relation to other things or to the actor. In this sense, no human utterance or behaviour can be properly understood apart from the way it is framed. An executive who uses the corporate jet for a holiday in

Jamaica may perceive this act as a justifiable bonus, but for the shareholder the same act can be framed as an abuse of power.

Throughout his writings, Goffman shows us the fragility of society, interaction and self. As he examines the condition of the mental patient in *Asylums* (1959) or the impact of a facial deformity in *Stigma (1963)*, he demonstrates that we all employ various theatrical and ritual devices to conceal displeasing elements of our personality and to find our place in the interaction order. Goffman once suggested that the purpose of studying social life is to "cause others to see what they hadn't seen or connect what they hadn't put together" (1981:4). Goffman's work has been very influential in developing some of the conceptual tools employed in the exciting new field of the sociology of emotions.

3.2 The Sociology of Emotions

In the late 1970s, theories of interaction processes began to shift direction, focusing on how emotions are involved in interpersonal relations and the structuring of social encounters. These emerging theories, arguably on the cutting edge of interactionism, remain a diverse and eclectic field.

Sociologist Arlie Hochschild (1983), recognized as a pioneer in the sociology of emotion, argued that emotions are affected by more than just biological or psychological conditions. We are socialized to feel certain emotions, and we learn how and when to express (or not express) those emotions. The social regulation of emotions is largely achieved through what Hochschild termed feeling rules, which shape how, where, when and with whom an emotion should be expressed. For example, in her study of airline stewards, Hochschild noted that the airline industry as a whole encourages stewardesses

to suppress feelings of anger, disgust and displeasure even when airline passengers engage in obnoxious and rude behaviour. Instead, as part of their professional training, stewards are taught to engage in more appropriate emotional labour by greeting rude passengers with a smile, practicing body work like deep breathing to calm their anger, or learning to re-frame adult passengers as anxious children who are in need of comfort and emotional support. Hochschild uses the following case to demonstrate the potential negative effects of emotional labour:

> A businessman asked a flight attendant, "Why aren't you smiling?" She looked at him in the eye. "I'll tell you what. You smile first, and then I'll smile." The businessman smiled at her. "Good," she replied. "Now freeze and hold that for fifteen hours." Then she walked away (1983:192).

Hochschild's work is one of several efforts in the late 1970s to examine emotions sociologically. Her analysis of the mechanisms of emotion work added a dramaturgical emphasis to emotional dynamics.

Other social researchers have built upon Hochschild's ideas by emphasizing how emotions can become social objects that we think should not be expressed. Gary Alan Fine (1987: 87), for example, in his study of Little League baseball teams, points out the central importance of emotional control for the boys, parents, and coaches. It is important to learn how to play baseball but also to repress inappropriate feelings (i.e. laughing at another's pain or getting angry at other teams winning), to control aggression, to hide fears, and to keep from crying. In their study of medical doctors, Robert Coombs and Pauline Powers (1975) found repression of feeling. The doctor:

> ...cannot take death and dying personally and is expected to retain composure, no matter how dramatic or tragic the death scene must be. Rationality and clear judgment in moments of grave peril must characterize his or her every action.

> The physician who loses coolness and presence of mind also loses confidence of patients and staff. Clearly, a doctor sobbing over a favorite patient is no doctor at all (Coombs and Powers, 1975:251).

Yet, for those doctors who were interviewed, emotion was felt internally but not expressed. One interviewer in the study reported: "Everybody I've talked to so far is having a horrible time dealing with death and dying; and it isn't just on a professional level, but personally too" (Coombs and Powers, 1975: 264).

The sociology of emotion is becoming more and more diverse as interactionists working within this field endeavor to integrate insights from feminism, exchange theory, ethnomethodology and phenomenology. In one approach to studying emotional exchanges, based more on conflict models, Halberstadt and Saitta (1987) demonstrated how smiles reflect the gender-based patterns of dominance and subordination in society. Women have been socialized to smile and frequently do so even when they are not actually happy. Women were also more likely to sustain eye contact during conversations as a means of showing their interest in and involvement with others. By contrast, Wood (1999) shows that men tend to display less emotion through smiles or other facial expressions and instead seek to show that they are reserved and in control. Men may also use eye contact as a sign of domination and are more likely to stare at other people (especially men) in order to challenge them and assert their own status.

3.3 Interaction Rituals and Emotional Energy

The sociological and anthropological literature on rituals offers a rich perspective for the study of addiction and recovery. One of the earliest works on ritual theory was *The Rites of Passage*, first published by Arnold van Gennep in 1909, which examined the rituals

involved in transitions from one stage of human life to another. Regardless of the content of specific rituals accompanying a particular rite of passage in a particular culture, Van Gennep noted that the process of transition remains essentially the same.

According to Van Gennep (1960 [1909]), a rite of passage is a universal phenomenon involving three phases: separation, in which participants are removed from the structure of everyday life in the social order; transition (or margin, or limen signifying "threshold" in Latin), in which participants undergo an intense experience with different norms and characteristics from those accompanying the regular patterns of social organization; and aggregation (or (re)incorporation), through which participants re-enter the social order in a different place, status, or state of being. This model remains flexible, as Van Gennep notes that while every rite of passage includes "preliminal," "liminal," and "postliminal" phases, "these three types are not always equally important or equally elaborated" (1960: 11). Thus, as a descriptive framework, the rite of passage engenders a broad application and has become, as Terence Turner puts it, "an anthropological commonplace" (1977:53).

The widespread recognition and use of Van Gennep's model in both anthropology and society is largely due to Victor Turner, who has reflected:

> Liminality is a concept, borrowed from the French folklorist Arnold Van Gennep, which, like a pebble, I tossed speculatively into the pool of my anthropological data about a dozen years ago.... Since then it has been spreading rings in my work and thought over wider ranges of data drawn not only from preindustrial societies, but also from complex, large-scale civilizations (1992:48; 1977: 361).

For Turner, the rites of passage model provides a framework not only for examining community rituals ascribing new status, but more importantly, for understanding liminal experiences that transform people and, in turn, plays a role in the transformation of society. Because Van Gennep was most interested in the structure of rituals accompanying publicly recognized changes in social identity, for instance the transition from boy to man, single to married, all three phases of a rite of passage bore a great deal of significance. For Turner, the "first and last speak for themselves" (1992: 48). Turner is far more interested in the transitional (or liminal) phase, stating that the other two merely "detach ritual subjects from their old places in society and return them, inwardly transformed and outwardly changed, to new places" (Turner, 1992: 48-49).

This focus on the middle phase of Van Gennep's framework is due largely to Turner's interest in the anthropology of experience. As Turner states:

> In my professional life as an anthropologist, the terms "function" and "structure" have had almost talismanic value. Both are borrowings from other disciplines: function from biology and mathematics, structure from architecture, engineering, and linguistics. I am not going to linger on plains of contention littered with so many broken spears. Too much time is wasted on negative polemics. I would like to revive our abiding anthropological concern with "experience." We have not borrowed this term from other human studies; it is peculiarly our own (1985: 205).

Turner's anthropology of experience resonates with sociologists who would emphasize microsocial processes and subjective experience as the key to understanding human behaviour. In his work, Turner notes the existence of rites of passage in complex industrial civilizations through such religious and/or secular examples as a confirmation/bar mitzvah, high school graduation, fraternity hazing, or wedding ceremony. These phenomena involve some of the same structures and functions as their

counterparts in nonindustrial societies, that is, participation in ritualized behaviour that results in a socially recognized shift in status. However, within industrial societies, such rituals rarely involve that which Turner most associates with rites of passage - the intense transitional/liminal experience through which one is revitalized or "inwardly transformed and outwardly changed" (1992: 48-49, 129). Thus, for Turner, a rite of passage is less about shifting social status and more about personal transformation - a process of transition from which one returns to society empowered by renewed creative energy, an expanded world view, and a greater sense of hope.

Randall Collins (2005) offers an interesting example of a micro-level theory of emotions that draws on Erving Goffman's and Emile Durkheim's insights about the emotion-generating effects of rituals. Indeed, Collins' work builds upon Durkheim's notion of "collective effervescence" – the intense feelings that arise among participants in religious ceremonies and rituals (Durkheim, 1912). "My analytical strategy," Collins says, "is to start with the dynamics of situations; from this we can derive almost everything that we want to know about individuals, as a moving precipitate across situations" (Collins, 2005: 4). Local situational encounters have explanatory priority because they are the foundation of social life and human experience. Everything depends on them (Collins, 2005: 259).

According to Collins, the basic unit of sociological analysis is the encounter of at least two people who interact. What transpires in such encounters is mediated by the exchange of rituals, which according to Collins, contain the following elements: (1) a physical assembly of co-present individuals; (2) mutual awareness of each other; (3) a

common focus of attention; (4) a common emotional mood among co-present individuals; (5) a rhythmic coordination and synchronization of conversation and nonverbal gestures; (6) a symbolic representation of this group focus and mood with objects, persons, gestures, words and ideas among interacting individuals; and (7) a sense of moral righteousness about these symbols marking group membership.

In Collins's view, interaction rituals are performed in a type of emotion market: individuals consider whether they can afford to invest the time, energy, cultural capital, and other resources to participate in the various rituals available to them. In his model, actors exercise rational choice to select those interaction rituals that provide them with maximum emotional energy, that is, feelings of pleasure, contentment, excitement and other positive emotions. In Collins' worldview, human beings are all "emotional junkies," seeking to avoid those rituals which lead to a drain of emotional energy (Collins, 2005: 21). This leads us to avoid certain types of parties, religious ceremonies, family activities or work meetings which we are likely to experience as boring, depressing or emotionally unsatisfying. What kinds of rituals provide the most positive emotional energy for the costs involved? For Collins, those encounters where individuals can have power (the capacity to tell others what to do) and status (the capacity to receive deference and honour) are the most likely to generate high emotional payoffs. Thus, for the head of a department, a meeting (as a ritual event) might be experienced as emotionally satisfying but for someone with little cultural capital to command respect, the same meeting might produce low or negative emotional energy. In an AA context, the member who is awarded a 20 year sobriety medal experiences positive emotional energy in the form of deference

and honour and might also possess power through institutional roles like sponsor, circuit speaker or meeting chair.

The outcomes of interaction rituals are summarized by Collins (2005) as follows:

> 1) Individuals feel solidarity with one another; they imagine themselves to be members of a common undertaking.
> 2) They are infused with emotional energy (EE), a feeling of exhilaration, achievement and enthusiasm which induces initiative.
> 3) IR membership generates collective symbols. The "lenses through which we see," the "very structure of consciousness" (374), symbols are the moral repository of the group and, hence, are assigned sacred qualities that must be defended and reinforced.
> 4) Violations of these symbols provoke righteous indignation towards, and sanctions against, those guilty of transgression.

Interaction rituals, in short, provide the basic ingredients that hold society together in "pockets of solidarity" (Collins 2005: 15, 235). Interaction rituals also provide the individual with an identity and a purpose. And it is the stuff too that explains alienation and social conflict. The energized individual, in this case the AA member who claims contented sobriety, is someone who is sufficiently integrated into a social network. And without interaction rituals (i.e. the reading of sacred texts, the qualifying of the chair as an alcoholic, the turn-taking rules of speaking in an AA meeting) people could not be readied for performance, individuals could not find a place in the social order and conflict could not be managed.

In the field of addictions research, interactionist theories emphasizing dramatic production, emotions and interaction rituals offer an exciting set of conceptual tools with which to examine the reality of recovery from the so-called 'disease' of alcoholism. Other theories, broadly defined as symbolic interactionism, can also be applied to the study of recovery.

3.4 Symbolic Interactionism

Symbolic interactionism represents an alternative to macro-oriented social theories which point to large-scale external forces as important determinants of human behaviour. Theories like functionalism and conflict theories emphasize the influence of structures such as class, the state, religion, or bureaucracy on human behaviour. Interactionist approaches, on the other hand, emphasize individual agency and subjective experience in human interaction. Interactionists acknowledge that macro structures and cultural and economic forces affect the day to day experiences and perceptions of individual actors but they also point out that actors endow these forces with meanings. It is this dual nature of human experience - that individuals experience culture and macro structure as a force which acts upon them from the outside but that they also possess the unique human capacity to act back, interpret, manipulate and make sense of their situations from the inside that distinguishes interactionist approaches from other theoretical approaches in sociology.

Ethnomethodology is one of the approaches within symbolic interactionism that offers important conceptual and methodological tools for studying individual agency and subjective experience. This approach seeks to understand how people construct a sense of ongoing reality. That is, what rules do individuals follow as they learn to fit into a particular situation? How do we know that we actually belong to a group? Sociologist Harold Garfinkel (1967) initiated this approach and coined the term ethnomethodology as the study of ("ology") the interpersonal "methods" that people ("ethno") use.

Garfinkel was critical of mainstream sociology for not focusing on the methods that people employ to make sense of their world. He placed considerable emphasis on language as the vehicle by which this reality construction is done. Indeed, for Garfinkel, our effort to verbally represent our actions to others is the primary method by which a sense of the world is constructed. This verbal representation relies on indexicality - that is, our own accounts of how our behaviour is tied to particular contexts and situations. An utterance, Garfinkel noted, indexes much more than it actually says; it also evokes connotations that can be understood only in the context of a situation (Garfinkel, 1967).

To uncover the indexical nature of ordinary interactions, Garfinkel and his associates conducted a series of "breaching experiments" (Garfinkel, 1967:5). For example, in one such experiment, Garfinkel advised his students to return home on the weekend but to act as if they were boarders in their own homes, rather than as members of the family. Students reported that their parents and siblings suggested that they were crazy or making no sense when they asked their parents how much it would cost to eat a sandwich from the fridge or if it was okay to sleep in their own bedrooms. In another breaching experiment, students were advised to challenge every statement during the course of a conversation. The end result was a series of conversations revealing the following pattern (Garfinkel, 1967: 42):

> Subject: I had a flat tire.
> Experimenter: What do you mean, you had a flat tire?
> Subject (appears surprised and then replies in a more hostile manner): What do you mean, "What do you mean?" A flat tire is a flat tire. That is what I meant. Nothing special. What a crazy question!

Garfinkel's research strategy focused on the process or methods for constructing a reality rather than on the substance or content of the reality itself. By analyzing the dynamics revolving around conversations as they unfold, Garfinkel also helped to develop an approach known as conversational analysis, which sought to get a more fine-grained view of action.

By analyzing talk and conversation among people in situations, conversation analysis hopes to discover the elementary and more fundamental processes by which society is held together. This approach is now a highly technical way of analyzing strips of conversations typically recorded and then converted into a transcript. There is a system of notation for indicating pauses, points of emphasis, overlaps, and other features of conversations. Harvey Sacks' analysis of conversational turn taking further broadened the appeal of this ethnomethodological approach into formal linguistics and it is becoming increasingly popular in the study of human emotion. Ethnomethodological approaches such as these revealed emotional commitments to everyday norms through purposeful breaching of the norms. For example, students acting as boarders in their own homes reported others' astonishment, bewilderment, shock, anxiety, embarrassment, and anger. Family members accused the students of being mean, inconsiderate, selfish, nasty, or impolite. Actors who breached a norm themselves reported feeling waves of emotion, including apprehension, panic, and despair.

Interpretive interactionism lays out a different viewpoint from ethnomethodology, which some symbolic interactionists criticize for taking too many aspects of a person's life for granted (Charon, 2007; Denzin, 1990). Norman Denzin, one of the chief

proponents of this approach, was interviewed at a national conference honouring his work on symbolic interactionism (Ellis, Bochner and Denzin, 2002). During the interview, Denzin explained his fascination with a recurrent theme – the idea of the epiphany. His interest in epiphanies began when he was writing *On Understanding Emotion* (1984). Denzin explained that he had been reading Jean-Paul Sartre and Jacques Lacan on language and the self, and Sartre's ideas on human emotion. "It was in Sartre's biography of Flaubert that Sartre asked himself: where do you start with a man who wrote over the course of his whole life? To which Sartre responded: you start with a moment that left a mark on his life" (Ellis, Bochner and Denzin, 2002: 188). This idea of moments that leave a mark on people's lives captured Denzin's sociological imagination.

Denzin's brand of interpretive interactionism has many applications for the study of transformative experiences as it relates to the recovering alcoholic. His description of epiphanies as interactional moments that leave a mark on people's lives and that have the potential to create transformational experiences for the person has particular relevance (1989: 70-71; 1990: 15-18). Epiphanies involve existential crises that alter how people define themselves, and their relations to others. Through epiphanies, personal character is revealed and fundamental meaning structures are altered. Such experiences, Denzin notes, involve painful shattering emotions and their meaning is given retrospectively. "Epiphanies are relived and re-experienced in the stories persons tell about what has happened to them" (Denzin, 1989: 71).

Denzin describes four types of epiphanies: the major, the cumulation, the minor or illuminative, and the relived:

> In the major epiphany, an experience shatters a person's life, and makes it never the same again...The cumulative epiphany occurs as the result of a series of events that have built up in the person's life...In the minor or illuminative epiphany, underlying tensions and problems in a situation or relationship are revealed...In the relived epiphany, a person relives, or goes through again, a major turning point moment in his or her life (Denzin,1990:17).

With its emphasis on symbols, self, significant others and the definitions of situations, symbolic interactionism is uniquely positioned to study the experiences of recovering alcoholics. While several studies of AA have employed interactionist theories, concepts and principles, there are still significant gaps in our knowledge about how individuals come to define themselves as alcoholic and how they interpret the AA program in such a way that facilitates sometimes dramatic personal transformations. A summary of the research on AA will reveal these weaknesses.

3.5 Research on Alcoholics Anonymous

Most studies of AA have focused on its history (Pittman, 1988; Kurtz, 1991) or of the efficacy of AA as a treatment modality (Thatcher and Clark, 2004; Galanter, 1990; Pattison, 1982; Ogborne, 1989). Other studies have been conducted on the process of becoming affiliated with AA but these tend to focus more on the psychological and/or social characteristics of prospective members. Psychological characteristics that have been attributed to AA members by various researchers include authoritarianism, extroversion and affiliative needs (Bradley, 1988; Donovan, 1986; McClelland, 1972). In one study of affiliation with AA, Trice and Roman (1970) explain affiliation by means of a combination of social traits, physical characteristics, and psychological predispositions. According to Trice and Roman, "the successful AA affiliate is characterized by affiliative and group dependency needs, a proneness to guilt, considerable experience with social

processes which have labeled him as deviant, and relative physical stability at the time of entrance into treatment" (1970: 58). A comprehensive meta-analysis (Emrick et al., 1993) point out that nearly eighty percent of studies on affiliation are based on inpatient or outpatient treatment samples, and most of these were retrospective. As Emrick et al. argue, because of selection-bias, retrospective studies of clinical populations are particularly ill-suited for an analysis of factors affecting the likelihood of affiliation with AA. Clinical populations consist of people with current drinking problems, and patients who have had previous contacts with AA are a selection of members who have failed in their attempts to use the AA program to achieve sobriety (Emrick et al., 1993).

Only a few studies have focused on the experiential aspects of AA membership and these have been based on an anthropological approach focusing on how AA is adapted to specific cultures (Maxwell, 1984; Rudy, 1986; Sutro, 1989; Peterson, 1992). Rudy's ethnography of AA members in the American Midwest provides a good description of the social processes involved in the initial stages of affiliation with AA but much of his work is dedicated to describing a typology of members as they come to realize they are alcoholics. Furthermore, there are methodological problems with Rudy's work since he bases his data on observations at meetings (and it is not clear whether these are open meetings accessible to the general public or closed meetings accessible only to self-professed alcoholics). Rudy uses other data from a small sample of six life-history interviews of AA old timers within the group selected for the study. With such a small sample, it is impossible to get a sense about the experiences of newcomers and people who leave the organization (AA drop-outs) or about the different levels of attachment

within the organization (i.e. hard core members versus those loosely affiliated with the organization).

George H. Jensen's *Storytelling in Alcoholics Anonymous: A Rhetorical Analysis* (2000) is based on an ethnographic study spanning four years. Jensen introduces his study with an analysis of Bill W.'s Story as it appears in the first chapter of AA's central text, Alcoholics Anonymous. Jensen argues that Bill W.'s Story as it appears in print cannot fully capture the oral tradition of storytelling as it occurs in AA meetings. He discusses storytelling as practiced by the Washingtonians, a temperance organization much like AA. He also discusses the influence of the spiritual program of the Oxford Group on the development of AA's Twelve Steps. Storytelling in AA, Jensen argues, encourages the member to cast him or herself as a hero who overcomes great odds to achieve sobriety. The best stories employ humor, irony, and parody in the oral traditions of the Washingtonians.

Similar to Jensen's focus on oral traditions and the central role of storytelling in AA, O'Halleran (2003; 2009) identifies key features of AA discourse based on his analysis of speaker meetings and convention meetings. Categories of AA discourse include witnessing, confessing, identifying and qualifying. Witnessing is about illustrating the power of AA to transform one's life (similar, he points out, to Protestantism's claims about the power of Christ). Confessing involves presentation of self as a sinful alcoholic and in need of a higher power. Identifying as alcoholic breaks the cycle of secrecy, isolation and shame by allowing AA members to display empathic identification and the commonalities of experience. Qualifying involves the assertions of

one's identity as an alcoholic and the displays of one's alcoholism through narrative accounts of personal experiences – facilitating the 'we' of recovery as opposed to the 'I' of recovery.

In another study, *The Alcoholic Society*, Norman Denzin (1993) develops a theory of the alcoholic self that explains how two myths of American drinking culture contribute to the social construction of alcoholism. First, there is the myth of wine and roses which asserts that the intimate, loving and sexual self can only come into existence in a setting that joins wine (or any alcoholic beverage) and roses. This myth argues that members of the opposite sex have the greatest chance of finding love, romance and intimacy in those settings where alcoholic beverages are served. Second, the alcoholism alibi argues that in any culture, only a small number of drinkers have, or will have, a problem with alcohol. This myth allows a culture to have its drunks, alcoholics and problem drinkers concurrently with social drinking. Denzin argues that such cultures practice a form of bad faith which shifts responsibility away from the culture and its institutions and onto the shoulders of the individual drinker. While an undeniably important contribution, Denzin's ethnography of American AA members reveals little about how members actually utilize the Twelve Steps and employ AA's body of knowledge as expressed through its literature and oral traditions. Again, there appear to be methodological problems in Denzin's approach since his data are limited to observations at AA meetings. As I will argue in my study, much of what occurs in meetings is what Goffman would describe as front stage performances. The sharing at meetings, particularly open meetings where non-alcoholics may be present, are carefully edited speech events describing what an AA member may

be experiencing in his battle against the disease of alcoholism and in his own recovery. What happens backstage as the AA member works his program by interpreting the 12 steps, applying lessons gleaned from AA literature and sharing with a sponsor - are all important social processes not addressed through Denzin's study.

There is an emerging literature on AA from a feminist perspective. One feminist pioneer of alcohol studies is Jean Kirkpatrick who initiated her own program of recovery in 1975 called Women For Sobriety (WFS). Kirkpatrick, who identified herself as an alcoholic in *Turnabout: New Help For the Woman Alcoholic* (1977), wrote about the social stigma attached to alcoholic women and the shame and guilt women feel about their addiction. Kirkpatrick argues that these negative feelings deter women from seeking treatment and make it harder for women to recover once in treatment. Because alcoholic women suffer from low self-esteem compounded by social stigma, she advocated a unique program outside of AA to address women's needs specifically (Kirkpatrick, 1986).

Kirkpatrick highlighted important differences between male and female alcoholics that later research confirmed. For example, women suffering from alcoholism have also been found to have higher rates of depression (Hezler, Burham and Keener 1991) as well as suicidal thoughts (Hill 1984) when compared to male alcoholics.

Feminist studies of AA tend to be highly critical of the spiritual beliefs and practices imposed on women in recovery. According to several authors, women have been passive recipients of the AA philosophy and are not aware of the patriarchal influences prevailing in AA or how these influences affect them (Faludi,1991: Bebko and

Krestan,1991; Rapping,1996; Tallen,1995). In fact, these feminist authors suggest that the twelve steps are potentially dangerous to women, since they are perceived to be similar to the larger religious practices which oppress women. Another feminist scholar, Elaine Rapping, in *The Culture of Recovery* (1996) argues that the twelve-step model of AA has created a generation of women who have become self-absorbed and interested only in personal development rather than in structural change. As such, women are encouraged to view themselves as the problem rather than organizing to change the political, sociological and external environment.

In contrast, other feminist writers describe women as active participants in developing a feminist culture within AA and the twelve-step movement (Davis,1997; Levi,1996; Van Den Bergh, 1991; Schaef,1987). These feminist scholars view AA as successful in helping women psychologically in terms of emotional and behavioural health. Therapists, psychologists, and educators integrate feminist principles into their work with women who attend twelve-step recovery programs and recommend that women modify the program to fit their own feminist interpretations. For example, Melody Beattie in *The Codependents Guide to the Twelve Steps* (1990) suggests that women completing the fourth step not only take an inventory of their character defects as instructed by the step, but also include a list of character assets at the same time. Such modifications allow women to put a gendered lens on the interpretation and practice of the twelve steps.

3.6 Conclusion

A summary of the literature on alcoholism and recovery reveals a number of gaps and weaknesses. The positivist approach of the medical literature emphasizes the role of genetics, biological predispositions and impaired neurochemical processes and states of the brain. The preponderance of studies from a medical perspective, while important for producing knowledge about the possible role of genetics and heredity in alcoholism, reveals little about the actual meanings attached to becoming a recovering alcoholic.

The sociological literature does not go far enough in clarifying and elucidating the recovery experience and what it means to alcoholics to be suffering from the disease of alcoholism. The limitations of the existing sociological and anthropological literature are partly attributable to problems of methodology. This is seen most notably in the ethnographies of Norman Denzin (1988; 1992), Rudy (1985), Jensen (2000), O'Hallerhan (2003; 2009) and Sanders (2009). With the exception of O'Hallerhan, who clearly states that his data are based on speaker meetings, none of these studies specify whether the meetings that were observed were open or closed - important distinctions as we shall see, because much of the emotion work that happens in AA takes place in closed meetings or it occurs outside of meetings altogether in the personal interactions between sponsor and sponsee. Furthermore, there is a problem with observational data of this sort. As I discovered in my research project, the sharing that occurs in AA meetings is carefully edited according to the type of meeting (open or closed) but is also affected by other variables such as the topic raised during a meeting or who is present at a meeting. AA meetings should be viewed as public performances, in the sense that Erving Goffman

described, wherein the alcoholic reports his/ her activities and experiences to an audience of sympathetic listeners. What happens backstage - in locations outside of the AA meetings between and among members of AA is not captured at all in the existing studies. Yet, these backstage interactions between sponsors and sponsees, between old-timers and newcomers, are critical to the socialization of AA members. A closer look at these interactions outside meetings also reveals a great deal about the social world of AA in terms of its hidden social hierarchies, its gender relations and its subtle power struggles.

The social scientific literature certainly adds to our understanding of how culture contributes to the problem of alcoholism and it does shed light on how deviant forms of drinking have become increasingly medicalized - but it does not go far enough in elucidating the social processes involved when a person crosses the line from being a normal drinker to become, in his own mind and subjective state, a 'sick alcoholic' drinker. Nor does the sociological literature reveal a great deal about what the condition or state of recovery or sobriety actually means to those who identify themselves as such - as in "I am a recovering alcoholic." To deal with these deficiencies, I outline below a particular theoretical perspective which will guide this research project.

What members of AA describe as the disease of alcoholism and their attempts to arrest it, to put it into remission, or to achieve what is commonly called recovery, can be conceived in terms of a theatrical presentation. Recovery, in this sense, involves actors becoming immersed into the AA subculture and being exposed to key symbols and social constructs. For example, the first two steps of AA's approach encourage initiates to admit powerlessness over alcohol and to turn to one's higher power as a means of dealing with

the negative emotions of guilt, despair and turmoil that initiates often experience when they first turn to AA. These concepts are not explicitly defined but left open to the subjective interpretation of the individual. Likewise, the official AA position is that alcoholism can be likened to an allergy and that alcoholics can never safely consume alcohol given their hypersensitive reaction to the substance. Recovery thus requires a lifelong commitment to abstinence as well as a lifelong commitment to the AA cure. Yet members are left to formulate, in their own terms, what this allergy or disease means to their own lives and how the spiritually based AA program might be incorporated into their recovery. AA is filled with such open-ended symbols and social constructs, particularly in the formulation of the twelve steps. I will explore the meaning of the twelve steps, which are considered the heart of the AA program, as they are experienced by recovering alcoholics.

An interactionist perspective on recovery also points to the dynamic social processes involving the enactment of rituals. The social world of AA relies heavily on ritual. These have never been explicitly coded into the AA Twelve Steps or the AA body of literature, but nonetheless rituals guide the interactions of members as they individually and collectively experience recovery. To understand the dynamic processes involved in recovery, I intend to draw upon Goffman's sociology of face-to-face encounters (Goffman1959: 1974). Randall Collins' work on interaction rituals (Collins, 2005) and contemporary social psychological studies of emotion by Jack Katz (1999) and Arlie Hochschild (1983). Other research studies into emotional deviance (Thoits, 1990)

and the emotions associated with "illegitimate suffering" (Kenney and Craig, 2012) will be examined in relation to the recovery experience.

Turner's reformulation of the rites of passage, with its emphasis on personal transformation rather than shifting status, provides another conceptual framework through which the experience of becoming a member of AA can be understood as a personal rite of passage. These three major shifts or stages of the AA experience can be identified as: (1) separation, by which the person being initiated is socially disengaged (transformed) from a previous status as mere drinker to alcoholic within the context of AA; (2) marginality or liminality, the transitional and ambiguous threshold at which the novice or initiate AA member undergoes redefinition; and (3) incorporation or aggregation, by which the person is reunited into the group as a new member, redefined and not connected to the previous identity.

We will also consider how emotional labor is mediated by significant others in the AA organization, particularly through the relationship that evolves between the AA initiate and his or her sponsor. These interactions, which occur more often in a private setting are part of what Goffman would describe as backstage preparation. The social dynamics that exist between members and their sponsors will be examined to understand emotion regulation, the processes by which individuals influence which emotions they experience, when they have them, and how they express these emotions (Gross, 1998).

In the next chapter, I will describe the methodology which I use to try and make sense of recovery among members of Alcoholics Anonymous. In the remainder of this study, particularly in the presentation of my findings, I present my subjects' own

descriptions, analyses and explanations as to what constitutes the 'disease' of alcoholism and what it takes to achieve recovery. In interactionist terms, I offer an expanded and elaborated 'definition of the situation' for those who label themselves as recovering alcoholics within the rooms.

Chapter 4: Methodology

4.0 Introduction

This research project aims to present the reader with a richly textured, detailed view of recovery as it is experienced by members of AA in Newfoundland and Labrador. The methodology in this study will focus attention on the place of emotion, symbols, process, others and social interaction as these relate to the phenomenon of recovery.

In this chapter I outline the research methods employed in my study and the procedures I followed in conducting qualitative research on a group of subjects belonging to AA in Newfoundland and Labrador. These research methods include participant observation, in-depth interviewing, textual analysis and secondary analysis of data on addictions. These approaches allowed me to enter into the world of AA and to better understand the phenomenon of recovery from the perspective of AA members. In taking this approach, I was able to probe the subjects' world in an effort to better understand their symbolizations and interactions and the meanings associated with them. Before I describe the research methods used in this study, I will discuss how I entered the field, made contacts with the subjects in my study and how I made decisions about the type of information to include in my analysis.

4.1 Entering the Field and Selecting a Sample

I was already acquainted with many members of AA through my personal involvement with the organization beginning in 2005. Over this period, out of concern for my own drinking habits, I attended closed meetings, open meetings and AA conventions on the Avalon Peninsula of Newfoundland. Although I would describe myself as more of a

peripheral, occasional member of AA, my involvement with the fellowship during this period provided me with an opportunity to meet a number of prestigious old-timers who occupy key leadership positions in the provincial AA organization.

Despite the fact that I knew many members of AA on a personal level, I did not make initial contact with prospective subjects in my study. Instead, I decided to identify a particular AA group in the province with plans to participate with that group in the AA program of recovery. Much of my own exposure to AA was in St. John's so I decided to conduct my research with a new group outside of the capital city. I felt this would reduce my own biases about the AA experience as I had experienced it with one group and allow me to approach my subject matter from a fresher perspective.

I identified such a group on the Avalon Peninsula of Newfoundland, located outside of the city of St. John's in a community of approximately 6,000 people. Other than this basic information I have decided not to divulge more specific descriptions of the group or the community to maintain a level of anonymity for the members. The group itself consisted of approximately 30 'registered' members with 25 men and 5 women, ranging from 20 to 82 years of age. To be registered in an AA group means that individuals sign their names to a group registry which in this case was a little black book listing names (first name and surname initial only) and sobriety dates (the date of the member's last known drink). As I explain later when I discuss the role of the group in individual recovery, signing the book is an important rite of passage since it designates official membership and entitles individuals to hold volunteer positions like General Service Representative or Treasurer. Being a registered group member also allows

individuals to participate in group decision-making and to partake in group rituals such as birthdays which mark ceremonial milestones for sobriety.

In terms of group size and social composition, I felt that this particular group was a suitable representation of the larger provincial AA body. In Newfoundland and Labrador AA reports over 82 active groups (those which meet at least once per week) in operation across the province. The smallest group consists of two members and is found in the community of Summerside; the largest group consists of 45 regular members and is located in Mount Pearl. Total membership in the province is estimated at approximately 700 members. Other than this basic information, the AA central office in Newfoundland and Labrador does not keep demographic information on its membership.

It is difficult to determine whether the group chosen for this study was truly representative of the provincial AA fellowship in terms of social composition because I did not undertake a comparative analysis of all groups across the province. Such an approach would only be feasible if all groups kept accurate records of registered members and information pertaining to their members' ages, gender and other variables of interest. The central AA office, located in St. John's, does not keep such information. However, several of my key informants had many years of experience with AA across the province and across the country and offered the opinion that the group selected for this study had no unusual or irregular features (such as a gross imbalance in terms of gender or age), compared to other groups they had experienced. This anecdotal evidence supported my own view that the group I identified for study was appropriate in terms of my research objectives.

Based on my own knowledge and experience with AA, I decided to make initial contact with the group through the person occupying the role of the General Service Representative, a role established to represent the interests of the local group. I met this representative in person and presented him with a letter introducing myself; outlining my research project and indicating that subjects' participation would be confidential and purely voluntary (see Appendix 1). I further explained how data would be stored and noted that no harm would reasonably come to subjects as a result of their participation.

The General Service Representative was receptive to my research and suggested that I should attend the next business meeting of the group to introduce myself and outline my plans in person. I appeared before the group during their March 2009 business meeting, identifying myself as a member of AA. In accordance with the ethical standards of academic research I introduced myself by my full name (a breach of AA protocol) and read from a letter outlining my research project and my intended aims. I allowed time for questions and discussions about my plans. A lively discussion ensued, mostly around concerns that I might violate personal anonymity. One member felt that it was "totally inappropriate" that I had disclosed my full name, thus breaching the AA code of personal anonymity. I assured all present that I would take standard precautions like erasing tape cassettes and never, under any circumstance, identify a subject by name or describe him or her in any manner that might lead to their identification. After giving assurances around anonymity, the group decided that I was welcome to participate as a member of the group and to proceed with my research plans. I informed the group that I would be with them as a researcher for approximately one year.

4.2 Research Methods

The purpose of my research was to explore the meanings and experiences of recovery for AA members. This would require a focus on the beliefs, language and behaviors of members of this organization. In carrying out my research, I wanted to maintain an attitude of openness to how members construct their social worlds from the ground up and be prepared to take more of an inductive approach to researching the social world of AA.

Below are the particular methods I employed to try to capture the multidimensional nature of the recovery experience.

Participant Observation

The participant observation research method can be traced back to the work of nineteenth-century anthropologists like Boas, Malinowski, Radcliffe-Brown and Mead who traveled to pre-industrial cultures to observe 'natives' in their natural environments (Atkinson & Hammersley, 1994). In the 1920s and 1930s, sociologists from the Chicago School such as Park, Dewey and Mead adapted anthropological field methods to the study of cultural groups in the United States (Bogdan & Biklen, 1992). Today, participant observation encompasses a much broader range of work. Participant observation can vary along a continuum from pure observation, sometimes called outside observation, to active participation in the daily activities of study members (Gold, 1958). Participant observation approaches can also incorporate different theoretical orientations and aims, such as symbolic interactionism, cultural anthropology, feminism, Marxism, ethnomethodology, critical theory and postmodernism (Atkinson & Hammersley, 1994).

The term 'ethnography' is also used to describe the participant observer approach wherein the researcher engages in something extra with their observations: they 'graph' or write about the 'folk' under study (ethno means folk). This simple definition can be expanded as follows:

> Ethnography is the study of people in naturally occurring settings or 'field' by methods of data collection which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner (Brewer, 2000: 6).

> Participant observation, ethnography and fieldwork are all used interchangeably...they can all mean spending long periods watching people, coupled with talking to them about what they are doing, thinking and saying, designed to see how they understand the world (Delamont, 2004: 218).

There are different types of ethnography including confessional ethnography, life history, autoethnography, feminist ethnography, critical ethnography and realist ethnography (Denzin, 1989, LeCompte and Schensul, 1999; Van Maanen, 1988). In my exploration of the AA experience, I have adopted more of a realist ethnographic approach. As Van Maanen (1988) explains, this approach aims to provide an objective account of the situation, reporting on the information learned from participants at a site. Here, the ethnographer narrates the study in a third-person dispassionate voice and reports on what is observed from the participants. The ethnographer may employ the phenomenological strategy of bracketing his/her own past experiences, personal bias, political goals, judgments and perceptions, and focus instead on trying to reproduce the participants' views and life experiences. Thick descriptions of mundane details of everyday life among the people studied are reported along with closely edited quotations from participants included in the study (Geertz, 1973).

Realist ethnographic approaches emphasize objective accounts of the situation, reporting objectively on the information learned from participants at a site. Because my study focuses on key dimensions of emotional display and performance rituals among AA members, I felt that this approach was more suitable than other ethnographic approaches. I felt that detailed descriptions of behaviors I would observe at AA meetings and social events, along with in-depth interviews, would help to better reflect the dramaturgical nature of recovery.

In this research project, I also draw upon the knowledge and experience gained through my own involvement with Alcoholics Anonymous. I have been involved with the fellowship for nearly four years. I have personally worked AA's twelve steps (I use the term working the steps as opposed to completing the steps for, as the reader shall see, in an AA context, the recovering alcoholic never fully completes the steps but continually uses them as a framework for daily living). My involvement with AA provides me with a unique personal perspective as well as certain biases. I find many aspects of the program appealing for my own circumstances, but I certainly recognize that AA is not the only solution for a person who suffers from a drinking problem. Thus, in approaching my subject matter as a researcher, I have tried to adopt the role of detached observer, using the phenomenological strategy of bracketing my past experiences so that I could attempt to understand the full range of experiences of individuals who attempt the AA program, with varying levels of success. I do not see my role in this research as being an advocate or apologist for the AA program or philosophy. My purpose in carrying out this research

is to provide the reader with insight into the structural and personal factors that shape the experiences of becoming a recovering alcoholic.

A special ethical concern related to the type of information I could use as a participant-observer in the meetings. Since I would be participating in closed meetings as a member of a home group, I would be privy to personal information shared by recovering alcoholics. There is an admonition in AA that what is heard in the group stays with the group. I have attempted to adhere to this ethical principle while fulfilling my research objective of gathering data from meetings by describing in a general way - what occurs inside AA closed and open meetings. In my writing I have tried to recreate certain scenes and describe certain interactions, like the conversations described at the beginning, that I have witnessed through my research. My main purpose in writing these descriptions was not so much to reproduce the exact words and behaviors exhibited by subjects, as might be the convention for other modes of research such as conversation analysis. Rather, in describing scenes and interactions as composites and drawing out my own impressions, my aim was to identify particular themes or meanings that members attach to disease and recovery. I have avoided quoting individuals who speak at meetings verbatim, instead trying to relay the meaning of interactions I witnessed or conversations I participated in.

In-Depth Interviewing

While group dynamics would play an important role in the recovery experiences of AA members, I also felt it would be important to conduct interviews with individual AA members. There are a number of books written on the subject of conducting interviews.

Noaks and Wincup (2004), for example, describe three different interview formats and the focus group, in which the researcher acts more as a facilitator of a group discussion than as a questioner. The types of interviews and their requisite skills are as follows:

> 1. Structured Interview - requires neutrality; no prompting; no improvisation; training to ensure consistency
> 2. Semi-structured interview- requires some probing, rapport with interviewee, understanding the aims of the project
> 3. Open-ended interview- requires flexibility; rapport with interviewee; active listening
> 4. Focus group - requires facilitation skills; flexibility; ability to stand back from the discussion so that group dynamics can emerge (Noaks and Wincup, 2004: 80).

No matter what type of interview is adopted, informed consent is also a requirement of this qualitative approach. Prior to conducting any interview with a member of AA, I presented all subjects with a written letter outlining the purpose and approach of the study as well as information about how the data was to be used (see Appendix 2).

Sampling for individual interviews was also carefully planned. Subjects for this study were recruited when I issued a call for volunteers at my appearance at the business meeting. Immediately after I had read my letter of introduction and outlined my research plans that night, six members of the group agreed to be interviewed. Over the next several months, mainly through a snowball technique of using word of mouth referrals, I was able to identify other subjects who agreed to be interviewed. The snowballing was facilitated greatly with a simple request from respondents that if they knew of anyone who might be interested in participating in my research project that they should notify the General Service Representative of the group who would then make referrals to me.

In total, twenty semi-structured face to face interviews were conducted with five female AA members and fifteen male members. Their ages ranged from a youngest of 20 years of age to an oldest of 68 years of age. This sample reflected a diversity of members representing different gender, age, and occupational backgrounds. The sample also allowed me to explore the recovery experiences of both newcomers and old-timers as well as several AA 'drop-outs' since two individuals in my sample decided to quit the AA program altogether (in both cases, after several months of participation) and one respondent who moved to another AA group where he relocated for employment reasons. In the case of the two drop-outs I was unable to conduct follow-up interviews to determine their reasons for leaving the AA program entirely. Two members of my sample, one male with over twenty years of experience in the AA program and one female with close to thirty years of AA involvement became key informants. These individuals were a source of considerable information on the program and the provincial fellowship since they had accumulated a great deal of organizational knowledge and experience in their multiple roles within the fellowship.

Respondents were asked about their history of involvement with the AA program and about their views on recovery. They were asked to share their interpretations and experiences with the twelve steps. They were asked about their relationships with sponsors and significant others within the fellowship. They were also asked about their participation in service work and their involvement with AA social roles like meeting chair, AA sponsor, General Service Representative and AA speaker. Respondents were also asked to discuss their views about the role of the local group in their personal

recovery: how their fellow AA members collectively contributed to their experience of working the program. (See appendix 3 for the interview schedule.)

Interviews, most of which were held in an office setting, lasted between one hour to three hours and were conducted from February 2009 to January 2010. All respondents self-selected into the study by stating their interest either directly to me or to the group General Service Representative who made all other referrals. The objectives of the research were conveyed in a written letter of consent and all subjects signed forms agreeing to be interviewed and agreeing to be tape-recorded (see Appendix 2).

Tape-recorded interviews were transcribed verbatim and data collected through interviews were sorted, coded and categorized. Through inductive analysis, key themes and patterns were identified according to emergent themes around the issue of interpreting alcoholism as a disease and making sense of the phenomenon of recovery.

Textual Analysis and Secondary Analysis

Fetterman (1998) advises that ethnographers should describe the group's history, politics, economy and environment by examining texts, financial records, photos and other cultural artifacts. AA groups have a number of such artifacts in the form of books (i.e. AA's Big Book), pamphlets, websites, collected written stories of members, and the like. Fetterman also suggests that ethnographies benefit from spatial observations of activities. In my research, observations were made of meeting locations, the number of members who spoke during a meeting and whether these speakers were male or female. All of these sources of data were used to complement quotations from interview subjects, along with

field notes, to paint a picture of the organization under study and of the particular AA group that became the site for this ethnography.

To understand the broader history and philosophy of Alcoholics Anonymous I also analyzed AA literature including the book Alcoholics Anonymous (called the "Big Book" by members), the *Twelve and Twelve* as well as several dozen AA pamphlets. My access to AA literature was greatly enhanced when I volunteered to hold the office of group librarian, a position that required me to manage literature for the group's use.

In secondary analysis, researchers use existing material and analyze data originally collected by others. Existing data sources typically include public records, government statistics (i.e. Statistics Canada) or surveys conducted by researchers in universities or private corporations. Two excellent sources of secondary data included the Comprehensive Addictions Survey (CAS) initiated by Health Canada in 2005 as well as the in-house data base maintained by Alcoholics Anonymous. Both of these sources will be described below.

The CAS included 13,909 Canadians aged 15 and older who were interviewed by telephone between December 16, 2003 and April 19, 2004.[1] Highlights from the CAS (Adlaf et al., 2005: Chapters 3 & 4) reveals some of the following demographic trends related to alcohol use in the province of Newfoundland and Labrador:

---

[1]The survey was based on a two-stage (telephone household, respondent) random sample, and used random-digit-dialing methods. In each province, a minimum of 1,000 people were interviewed. In order to assess trends in substance abuse, questionnaire items were typically drawn from existing national surveys. National data on alcohol and other drug use and related harms, findings across provinces, and changes over time in alcohol and other drug use are set out.

- *Provincial Differences:* In the 12 months prior to the CAS. 79.3% of Canadians aged 15 years or older consumed alcohol. The lowest rate of past-year drinking is in Prince Edward Island (70.2%) and the highest is in Quebec (82.3%) Compared to other provinces. Newfoundland and Labrador has the highest number of monthly heavy drinkers[2] at 26.1% compared to a national average of 20.2%. After controlling for all demographic variables. residents of this province were found to be at an increased risk of drinking alcohol in excess of low-risk drinking guidelines. However. despite these findings. drinkers from this province report the least amount of harm done to self over the past year.[3] Drinkers from this province also report the least amount of alcohol harm experienced from others over the past year.[4]
- *Age Differences*: Drinking rates peak among youth 18 to 24 years of age. with about 90% of people in that age range consuming alcohol during the course of the year. Most residents of this province drink in moderation. reporting one or two drinks per typical drinking day with 85% of persons 65 years of age or older reporting this pattern.
- *Gender Differences:* A greater proportion of males than females: drank alcohol in the past year (82.0% vs. 76.8%): drank alcohol at least once a week (55.2% vs.32.8%): usually drank five or more drinks at a sitting (23.2% vs. 8.8%); drank five or more drinks at a sitting at least once a week (9.2% vs. 3.3%) and exceeded the low-risk guidelines (30.2% vs. 15.1%).
- *Rural/Urban Differences*: No difference was observed between people living in rural and non-rural areas.
- *Education Differences*: Persons with a university degree are less likely than persons with less formal education to have engaged in heavy drinking. According to the Alcohol Use Disorders Identification Test (AUDIT)[5]. rates and odds of

---

[2]The survey defines two types of heavy drinkers. Heavy infrequent drinkers (less than once a week. five drinks or more when alcohol is used): and heavy frequent drinkers (more than once a week. five drinks or more).

[3]Includes self-reported harms in terms of friendships or social life: physical health: home life or marriage: work or studies: employment or finances.

[4]Respondents were asked whether these harms included insults or humiliations: arguments/quarrels: family or marriage problems: being a passenger with a drunk driver: being pushed or shoved: being hit/assaulted.

[5]The Alcohol Use Disorders Identification Test (AUDIT). The development of the AUDIT was supported by the World Health Organization to identify hazardous patterns of alcohol use as well as harmful consequences of that use and indications of dependency. It consists of a 10-item questionnaire (including lack of control over one's own drinking. failure to meet expectations. drinking in the morning. feelings of guilt. black-outs. injuries

hazardous drinking are inversely and significantly associated with education. Those who did not finish high school had hazardous drinking rates almost twice as high as those who finished university (21.8% and 11.5% respectively).

- *Income Differences:* Income is inversely related to rates of AUDIT 8+ scores: the lower the income category, the higher the rate of hazardous drinking. Differences in odds of hazardous drinking are not significant, however.

The recently released *2007 Student Drug Use Survey* also gives us some insights into the drinking habits of young people in this province. Highlights from the survey reveal the following:

- In 2007, 30% of students surveyed reported they had never consumed alcohol.
- More than half (52%) of students reported they had used alcohol at least once in the twelve months before the survey, compared to 58% in 2003.
- The average age of first alcohol consumption was 12.9 years.
- Prevalence of alcohol use dramatically increased from 11% in Grade 7 to 50.8% in Grade 9.
- In 2007, 31.1% of students consumed alcohol more than once per month, compared to 37% in 2003.
- Consuming five or more drinks at one sitting was reported by 29.7% of students in the prior 30 days before the survey. About 27.7% of students reported they had been drunk at least once in the month before the survey.
- Patterns of alcohol use were similar between males and females.

---

resulting from drinking, and having someone express concern for drinking.) An AUDIT score of 8 or more indicates harmful use and is an indicator of high-risk drinking.

Another study conducted by the *Canadian Center on Substance Abuse and Addiction Research Foundation of Ontario* (1995) shows that Newfoundland and Labrador has the lowest mortality rates for alcohol-related disorders (15 deaths per 100.000 population), the lowest law enforcement costs attributed to alcohol and among the lowest costs of hospitalization due to alcohol. Using Jellinek's formula to determine the proportion of liver cirrhosis deaths due to alcoholism the same study reported that people in Newfoundland and Labrador actually were on the lower end of the mortality scale for alcohol-related disorders as indicated below.

Table 1: Alcoholics per 100.000 population aged 20 and older

Province	# of cirrhosis deaths per 100.000
NL	2000
PEI	900
NS	1900
NB	1600
QUE	2500
ONT	2700
MAN	2400
SASK	2100
ALTA	2300
BC	2400
Canada	2400

Estimated using the Jellinek formula with proportion of liver cirrhosis deaths due to alcoholism equal to 0.3 and rate of death from liver cirrhosis among all alcoholics equal to 16.53 per 10.000. From Canadian Profile: Alcohol, Tobacco and Other Drugs 1995: Canadian Center on Substance Abuse and Addiction Research Foundation of Ontario.

Alcoholics Anonymous also collects and maintains its own in-house data base. This database can be found on-line and includes information on the 114,000 groups and more than 2,000,000 members in the 180 countries reported in AA's annual survey. The AA Profile section of the website contains information on the age, sex, occupation and ethnicity of its members worldwide. Provincially, AA in Newfoundland and Labrador also maintains its own rather rudimentary database detailing the number of groups and the number of registered members.

Another source of secondary data can be secured through content analysis, the systematic examination of cultural artifacts or various forms of communication shared among the subjects under study. As Reinharz (1992) points out, cultural artifacts are products of individual activity, social organizations, technology, and cultural patterns. There are many such cultural artifacts to be found in AA including books, websites, pamphlets and videos. By far, the best-known AA book is the *Big Book*. The Big Book is now into its fourth edition (Alcoholics Anonymous World Services, 2001) and only the story section has received any substantial editing. The most recent edition includes more personal stories about women and ethnic minorities.

Other texts produced by AA's own publishing company, called AA World Services Inc., are called conference-approved literature and include:

- *Twelve Steps and Twelve Traditions* (1986, originally published in 1953) - consists of Bill W's essays on the content and meaning of these two sets of principles
- *Alcoholics Anonymous Comes of Age* (1957) - describes the events of the 1955 convention, from which it took its name. It also includes the speech given by Bill W. On the history of AA.

- *The AA Service Manual and Twelve Concepts for World Service* (1962)- lays out a detailed description of the organizational structure of AA but focuses more on the structure of AA in the U.S. and Canada.
- *Dr. Bob and the Good Oldtimers* (1980), *Pass it On* (1984), *Came to Believe* (1973), *Living Sober* (1975) - shorter monographs of the experiences of the early members and co-founders along with some practical advice for maintaining sobriety.

These texts were used in several different ways throughout this study. They were used as primary sources for describing the history of the fellowship (see chapter two) as well as providing background information on the steps (see chapter six). More importantly, these texts are used within the fellowship as aids and resources for recovery. Respondents in this study reported utilizing AA literature, including many of these texts, as daily readings, learning guides or meditation material to help them learn how to recover. The ways in which AA literature is used in carrying out the twelve steps will be examined in chapter six.

4.3 Data Triangulation

To resolve the inherent weaknesses of each particular design method, sociologists believe it is best to combine different approaches to data collection and analysis. Triangulation is the term used to describe this approach. Triangulation is aimed not only at addressing concerns over validity and reliability but at deepening and widening one's understanding of the topic under study. As Denzin explains (1989:4):

> Triangulation reflects an attempt to secure an in-depth understanding of the phenomenon in question. Objective reality can never be captured. Triangulation is not a tool or strategy of validation, but an alternative to validation...The combination of multiple methods, empirical materials, perspectives and observers in a single study is best understood, then, as a strategy that adds rigor, breadth, and depth to any investigation.

Triangulation may be best used in positivist approaches that search for generalizations, for laws and for supporting hypotheses. If these are the primary purposes of research, then triangulating is a conservative way of helping to draw conclusions from the data and dealing with the issue of validity. But if the goal of the research is to understand the recovery experience and get some sense of the meanings AA members attach to key social constructs like 'higher power' or 'surrender' to alcohol, then triangulation is less straightforward. In discussing the role of triangulation in qualitative approaches, particularly those which emphasize an interpretivist or constructionist approach to understanding reality, Bogdan and Biklen (1998) suggest:

> It has gotten so that it is difficult to find a qualitative research dissertation where the author does not evoke the word [triangulation] in an attempt to convince the reader that his or her work is carefully done. Unfortunately, the word is used in such an imprecise way that is has become difficult to understand what is meant by it...We advise against using the term. It confuses more than clarifies, intimidates more than enlightens. If you use different data-collecting techniques-interviewing, observation and official documents, for example - say that...In short describe what you did rather than using the imprecise and abstract term triangulation (Bogdan and Biklen, 1998: 104).

While Bogdan and Biklen do make some good points in suggesting that the concept of triangulation is perhaps overused or applied inappropriately, there is still a need to conduct an ethnography in such a way that the reader is left with some confidence in what the researcher says. If triangulation means that a researcher incorporates multiple approaches and sources to confirm hunches or draw conclusions, then I attempted to triangulate the data generated through my study by utilizing the following approaches:

(A) Participant Input - this approach uses member checks or key informants. As the researcher collects and analyzes data, the emerging conclusions are checked

with the participants in the study. What do they think of the research questions? Do they feel the representation of the AA experience or the phenomenon of recovery is valid and adequately described? The form this approach takes can vary. Some researchers invite focus groups to become involved in the mapping of key categories or codes. Others invite key informants, particularly knowledgeable about the phenomenon, to read field notes or first drafts and to offer feedback and suggestions for the write up and analysis. In my case, I invited three key informants to provide feedback on my observations and interpretations of the data. At regular intervals throughout my research, I met with these individuals and I asked them whether they felt I had captured the essence of the phenomenon or experience I was attempting to describe or explain. Their input proved invaluable and helped me to hone my presentation of key experiences and interpretations presented throughout this analysis. However, it is important to point out that the reasons and motivations behind my presentation of accounts as a social researcher may have been different from those of my key informants. I was primarily interested in dramaturgical presentations of recovery as reflected in verbal and non-verbal emotional displays as well as acts of emotional deviance (Thoits, 1990), emotional energy (Collins, 2005) and the role of emotional micropolitics in the AA experience (Clark, 1990). As such, I was more attuned to certain behaviors and perhaps more acutely aware of the social factors involved in the emotions of recovery compared to my key informants. As Harvey et al. (1990) and Orbuch (1997) point out; this is due to the nature of accounts. Sociological studies of

accounts tend to focus on the motivations and reasons behind the presentation of accounts and the influence of others (audience) in the account-making process. Thus, while the feedback and perspectives of my key informants might have informed my own views, the interpretations of accounts and the descriptions of events are grounded in own perspective as social researcher.

(B) Peer Review - a researcher can involve other scholars to become involved in the project at any or all stages of research. Peer review is a standard aspect of publication in scholarly journals but the process can begin much earlier. Peers can be consulted for their opinions on a host of practical matters and issues including: how to access the population, how to analyze the data, how to incorporate different methods, or how to focus on the problem from the perspective of another theoretical paradigm. My PhD thesis committee provided important contributions in this regard.

(C) Reflective Journaling - reflective journals can be used along with observational field notes. Such journals can keep a record of the researcher`s thoughts, reactions, feelings and insights as they proceed through the research. These journals are often helpful in explaining to others how you arrived at your conclusions (Stake, 1995). I made use of reflective journals in my own research by recording my own thoughts, feelings and impressions after attending meetings or after interviewing subjects.

(D) Research Audit Trails - The concept of an audit trail is borrowed from the field of accounting wherein the accountant follows the money to identify gaps.

omissions, overspending and the like. Similarly, a social researcher can keep careful records, outlining important information on when, where, how and why, particular findings emerged or themes were identified. This can later aid the researcher when s/he is ready to write up the study (Lee, 1997). In my field notes and journals I tried to keep systematic, detailed notes outlining dates and times, locations and general observations of the people and situations I encountered throughout this study.

4.4 Conclusion

What is the best method for studying the recovery experiences of AA members in Newfoundland and Labrador? There is no one best research method. Each method has its own strengths and weaknesses. It is the researcher's task to select the methods that seem best suited to the question(s), recognizing that there may be limitations which need to be recognized up front and measures taken to compensate for these weaknesses whenever possible.

Participant observation provides opportunities for the researcher to view from the inside what may not be obvious to an outside observer. It would be difficult to learn about the subculture of AA by simply reviewing statistics on drinking or even by interviewing some members of the organization. If a researcher can spend a considerable amount of time in the field - in this case, by attending AA meetings and social events as well as talking to a number of participants - a richly detailed picture can be constructed of how AA members experience their unique social world. Another strength of fieldwork is that the ethnographer can acquire a much deeper sense of how recovery plays itself out for the

individual as well as for the group by observing key rituals involved in AA social events. These rituals, or etiquette as Erving Goffman (1959) described them, are part of the performance of recovery in AA circles. That is, AA members do not simply experience recovery as a one-time individual event. Rather, recovery is demonstrated as the AA member begins to share thoughts, feelings and experiences at public meetings and as they learn to perform the role of recovering alcoholic before the AA group. The minute details and intricacies of such performance rituals would be difficult to capture in a survey and virtually impossible to record through experiments or other such methods.

A weakness of participant observation is that it is not a method that allows the researcher to generalize to larger populations. Fieldwork is well-suited to capture the experiences of more localized settings but it may not allow the researcher to apply his/her findings across the board to other groups - say outside of Newfoundland and Labrador. It should be recognized that culture will affect the experience of becoming an AA member and it is the task of the ethnographer to explain the relationship between recovery and culture.

In addition to the whole host of pragmatic challenges of gaining access to groups and individual members, there are many ethical issues the researcher has to contend with. I have already mentioned one of these - the issue of obtaining consent at the group level. Since group composition changes over time as members join and others leave, a researcher should develop some protocol or understanding of how consent from the *entire group* is to be maintained. My approach involved having AA group leaders check in with

the group every so often and reminding them that they were being observed, and whether this was still acceptable for everyone who considered him/herself part of the group.

A major disadvantage with ethnographies involves the problem of reactivity, a condition that is always possible when subjects are aware they are being studied. If subjects of a single-group study are aware their behaviors or attitudes will be measured and assessed over time, and that these data might be published, then they may not behave as they would in a natural setting. It was difficult to gauge how the subjects being studied here reacted to my role as both AA group member and researcher. I never personally heard any negative comments about my involvement with AA as a social researcher although I recognize that some may have disapproved of my research project and perhaps kept their views to themselves.

Finally, the amount of data generated through a participant observational study can be overwhelming. As Harry Wolcott argues, it is important for ethnographers to "do less, more thoroughly" as opposed to observing and recording everything that seems fascinating (1990:62). It is important, therefore, for the researcher to try to define his/her research problem, using concepts drawn from a particular theory or model. Having a tighter design and knowing how to detect relevant data are crucial to the success of an ethnography. With these cautions in mind, I can now turn to my findings and focus on how individuals first enter the world of Alcoholics Anonymous.

Chapter Five: The Audition

5.0 Notes from the field December 4, 2009

Tonight was a regular Friday night open meeting, meaning AA members and non-members were in attendance. Jack, a friendly old-timer, was at the door performing the role of greeter as he extended a handshake to everyone entering the room. I haven't been here in a couple of weeks and I'm noticing some new decorations and displays. There is a hand-crafted wooden triangle hung on the door with the words "Service, Recovery, Unity" displayed on each side. Two large banners have been placed prominently on the walls – one with the Twelve Steps; the other with the Twelve Traditions. There is a new display case with the Big Book and other AA publications neatly displayed. The group must have decided at the last business meeting to purchase these artifacts in an effort to enhance the AA message of recovery.

There is a larger than normal crowd here, close to fifty people, because there are some special birthdays. Jane is celebrating her 20th year of sobriety, Scott his second year, and Frank is celebrating his six month birthday. Frank, the junior of the trio, is called first to receive his medallion. Frank appears to be in his sixties. Although he has never disclosed his profession to the group, Frank reminds me of a distinguished school teacher with his neat silver hair, spectacles and pressed shirt and tie which he regularly wears at meetings. I have studied Frank over this past number of months and he comes across as a nervous wreck. His hands shake constantly and his voice quivers whenever he speaks. He often gets up and leaves the room, darting through the door in mid-meeting as

if to escape (I can speculate that this could be delirium tremens or DTs as they are known in the medical literature).

But something has changed with Frank over these past couple of weeks because his hands aren't shaking tonight – hardly at all in fact. He is speaking clearly; he holds his head high. Frank accepts his medallion and begins his recovery tale by describing the "miracles" (his word) which have taken place in his life over the past several months. He met his grand-daughter for the first time several weeks ago because he was able to reconcile with his estranged daughter who described her father as a "good for nothing drunk" according to Frank. "But last week, she finally accepted my apology for being such a terrible dad. She told me that she can hardly recognize the new me, that I'm now speaking without slurring my words, that I seem kinder and more considerate. I have this program to thank for these changes, so this chip means more to me than a million bucks," he says, trying to hold back the tears. "I've been coming to AA for years but never been able to hold it together for very long. The program didn't fail me but I failed the program. I've lost everything because of alcohol - and I mean everything – my family, my job, my house, my dignity. Six months is the longest I've been able to stay sober. So I'm glad to accept this medallion." As Frank exits the stage, there are hearty congratulations extended all around.

Scott is presented with his medallion next. He shares his story of how he suffered a disabling injury after he drove off the road one night in a drunken stupor. He was filled with rage and bitterness and self-loathing after his accident, he shared, even more so when his wife left him months later. He began to drink heavily on a daily basis to drown his physical and emotional pain. He decided to contact AA after a failed suicide attempt.

Two years into the program, he is here to receive his second birthday medallion. Another moving performance.

Finally, there's Jane. Jane is like the Grace Kelly or Katherine Hepburn of our little AA troupe. Indeed, she is a well-respected circuit speaker across the island and recognized by many in the provincial fellowship. Impeccably and elegantly dressed as always - graceful, dignified, articulate and intelligent. It is safe to say that everyone in our group looks up to Jane. There is always silence when she shares and many members have commented about how much they have benefitted from Jane's life experiences, which she generously and eloquently shares with the group on a regular basis. Jane's presentation, as I expect, is the most moving. She begins her story of how she started drinking heavily shortly after the death of her daughter. "I started to drink every day after Susie died. I never missed a day of work but I hit the bottle as soon as I came in through the door at 5:00 p.m. I became an absent mother…I was there in body but not in spirit… and a horrible wife to my first husband. I neglected everybody in my family and became totally self-absorbed in my own pain, in my own grief. It's normal to grieve – especially when a child dies. It truly is the worst thing in the world to experience. I wouldn't wish it on anybody. But I became self-absorbed and selfish in my grief to the point that I could not and would not reach out to anyone else – not even my own family. Not even my other daughters. I wasn't responsible and I hurt my family tremendously during my years of drinking." Jane shares candidly. She turns to her (second) husband, who is here tonight, and thanks him for twenty years of unconditional love. "I'm so grateful God has given me another chance at love. John has been my best friend and together we share a lot of contentment today. Not once has he stopped loving me. He is my rock. He is my best

friend and tonight I want to say publicly how much I love him and appreciate his support as I've worked my program over the years." There are tears in her eyes. Tears in her husband's eyes. Tears flowing down cheeks all over the room.

All in all, the recovery performances are solid - lots of tears, heartfelt emotion and sincere congratulations all around to the performers at center stage. I look at the clock. The awards ceremony has left only about thirty minutes in the meeting for other matters. "We only have a short time left in our meeting," the chair says, "but in accordance with our traditions, I'll ask if there is anyone here for their first meeting or returning to Alcoholics Anonymous?"

There is a newcomer in the room. A tall man, middle aged, neat hair, well groomed and unseasonably tanned. Looks like a businessman or professional; more like a 'normal' compared to many of the disheveled characters I see around me. He speaks up. "Hi everyone, my name is Stan." "Hi Stan," everyone responds. "I don't know if I'm an alcoholic…(pause)…and I have to say that I find this meeting awfully depressing." The room suddenly goes silent. You can hear a pin drop. "I've been listening to these people…" He points a lingering finger at Jane, a few feet away, and Scott, now leaning forward. "I've watched them accept their medals and listened to their little speeches and I keep wondering - why are their stories so negative, so damn depressing?"

Stan is obviously comfortable as a public speaker as he continues in a loud, steady voice. "Really, I don't understand this. I've been sitting here (long pause), waiting, just waiting, to hear something positive but all I've heard are your (he looks around the room, sweeping his hands in a grand gesture to point at everyone), really sad stories." (Is it sarcasm or bewilderment I hear in his tone?) "I've been to several AA meetings in St.

John's over these past several weeks and this is my first meeting here but every time I come to one of these meetings, I feel worse when I leave."

The group looks stunned; like a deer caught in headlights. Bob, an old timer sitting next to me, exhales forcefully and shakes his head in disbelief. Jane is the first to respond. She is such a diplomat. "Stan, haven't you been listening?" she says to him in the gentlest of tones. "What you describe as the sad stories is just part of our recovery. The AA program asks us to share our experiences, strength and hope. Our experiences (she is also a seasoned speaker - pausing with great effect while scanning the room with those piercing blue eyes), are full of misery and sadness. That's why we come here. But if you had really listened..." (Pause, with pitched intonation of 'really'). She repeats the statement one more time, "Stan, if you had REALLY listened, you would have heard the positives. My life was ruined by alcohol. Now I enjoy life. And it's the same story for Scott and Frank." Both nod their heads in agreement.

Stan interjects, violating the norms of 'cross talk.' He interrupts Jane, saying "yeah, but why do I end up feeling so goddam miserable after coming here?" He then goes on to describe his difficulty in assessing himself as an alcoholic. "Look, I did that test, you know, those 12 questions..." Stan reaches into his pocket and pulls out an AA pamphlet. He begins to read from question one:

Is A.A. For You?

Twelve questions only you can answer

IS A.A. FOR YOU?

Only you can decide whether you want to give A.A.a try — whether you think it can help you.

We who are in A.A. came because we finally gave up trying to control our drinking. We still hated to admit that we could never drink safely. Then we heard from other A.A. members that we were sick. (We thought so for years!) We found out that many people suffered from the same feelings of guilt and loneliness and hopelessness that we did. We found out that we had these feelings because we had the disease of alcoholism.
We decided to try and face up to what alcohol had done to us. Here are some of the questions we tried to answer *honestly*. If we answered YES to four or more questions, we were in deep trouble with our drinking. See how you do. Remember, there is no disgrace in facing up to the fact that you have a problem.

Answer YES or NO to the following questions.

1 - Have you ever decided to stop drinking for a week or so, but only lasted for a couple of days?
Most of us in A.A. made all kinds of promises to ourselves and to our families. We could not keep them. Then we came to A.A. A.A. said: "Just try not to drink today." (If you do not drink today, you cannot get drunk today.)

Yes **No**

2 - Do you wish people would mind their own business about your drinking-- stop telling you what to do?
In A.A. we do not tell anyone to do anything. We just talk about our own drinking, the trouble we got into, and how we stopped. We will be glad to help you, if you want us to.

Yes **No**

3 - Have you ever switched from one kind of drink to another in the hope that this would keep you from getting drunk?
We tried all kinds of ways. We made our drinks weak. Or just drank beer. Or we did not drink cocktails. Or only drank on weekends. You name it, we tried it. But if we drank anything with alcohol in it, we usually got drunk eventually.

Yes **No**

4 - Have you had to have an eye-opener upon awakening during the past year?
Do you need a drink to get started, or to stop shaking? This is a pretty sure sign that you are not drinking "socially."

Yes **No**

5 - Do you envy people who can drink without getting into trouble?
At one time or another, most of us have wondered why we were not like most people, who really can take it or leave it.

Yes **No**

6 - Have you had problems connected with drinking during the past year?
Be honest! Doctors say that if you have a problem with alcohol and keep on drinking, it will get worse -- never better. Eventually, you will die, or end up in an institution for the rest of your life. The only hope is to stop drinking.

Yes **No**

7 - Has your drinking caused trouble at home?
Before we came into A.A., most of us said that it was the people or problems at home that made us drink. We could not see that our drinking just made everything worse. It never solved problems anywhere or anytime.

Yes No

8 - Do you ever try to get "extra" drinks at a party because you do not get enough?
Most of us used to have a "few" before we started out if we thought it was going to be that kind of party. And if drinks were not served fast enough, we would go some place else to get more.

Yes No

9 - Do you tell yourself you can stop drinking any time you want to, even though you keep getting drunk when you don't mean to?
Many of us kidded ourselves into thinking that we drank because we wanted to. After we came into A.A., we found out that once we started to drink, we couldn't stop.

Yes No

10 - Have you missed days of work or school because of drinking?
Many of us admit now that we "called in sick" lots of times when the truth was that we were hung-over or on a drunk.

Yes No

11 - Do you have "blackouts"?
A "blackout" is when we have been drinking hours or days which we cannot remember. When we came to A.A., we found out that this is a pretty sure sign of alcoholic drinking.

Yes No

12 - Have you ever felt that your life would be better if you did not drink?
Many of us started to drink because drinking made life seem better, at least for a while. By the time we got into A.A., we felt trapped. We were drinking to live and living to drink. We were sick and tired of being sick and tired.

Yes No

What's your score?

Did you answer **YES** four or more times? If so, you are probably in trouble with alcohol. Why do we say this? Because thousands of people in A.A. have said so for many years. They found out the truth about themselves — the hard way. But again, only *you* can decide whether you think A.A. is for you. Try to keep an open mind on the subject. If the answer is **YES**, we will be glad to show you how we stopped drinking ourselves. Just call. A.A. does not promise to solve your life's problems. But we can show you how we are learning to live without drinking "one day at a time." We stay away from that "first drink." If there is no first one, there cannot be a tenth one. And when we got rid of alcohol, we found that life became much more manageable

ALCOHOLICS ANONYMOUS© is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

- The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions.
- A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes.
- Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

Stan continues, "I only scored 3 out of 12. The AA pamphlet said I need four to be an alcoholic. So I'm not sure if I even belong here…maybe I'm not like you people," he states matter of factly. [1]

Another old timer, Peter, interjects. He is clearly annoyed and agitated as he shifts in his chair. His face is flushed. I watch the blood rise up his neck, like the red line pushing up a thermometer. "I can't believe what I'm hearing… You (he points a stumpy finger at Stan) have no idea of the crap I've been through in my life. I lost everything… EVERRRYTHING (he gasps) – family, job, friends, health – EVERYTHING because of alcohol. And AA gave it back to me and gave it back to a lot of people here." Heads nod in agreement.

Stan interjects again. I sigh. Another violation of the cross-talk rule. Stan clearly doesn't understand that you share once, then shut up. And when you share you don't respond to other shares directly. Neither do you address previous speakers by name. Stan continues in a loud voice that can probably be heard outside of the room "…look buddy, I don't mean to hurt your feelings old man. It's just that I have a hard time relating to people here. Let me read you something…" He places a book on the table and begins to

---

[1] I can relate to Stan's quandary. When I did the AA self-diagnostic test several years ago, I scored 4 out of 12. I am an educator. I have been marking exams for years. Four out of Twelve is not the best score. I remember when I did this diagnostic, I was also uncertain, just like Stan. Does the fact that Stan and I scored so low place us in the bottom percentile of this class? Does it mean I'm roughly 33% alcoholic. Stan a little less: not quite like the thoroughbred alcoholics we both just witnessed. As I've heard many members in the rooms exclaim: "That was the only test in my life that I've ever scored a perfect 100%!"

open the pages. I can't see the book he is attempting to read from but I can tell it isn't the Big Book, the only book which is safe to reference in an AA meeting.

"Close your friggin' book. I don't need to hear it," Peter says emphatically. "I KNOW what AA has done for me and YOU don't need you to explain anything to me from some goddamned book."

Tension rises in the room. The chair finally speaks up. "Stan, we have a rule here about cross talking. This means that we speak one person at a time and we share only once during a meeting. And we share from the heart. We share our own experiences; not our opinions. I would suggest to you my *friend* (said with a note of sarcasm) that you speak to someone here after the meeting, somebody who can identify with what you're saying." Stan grunts something under this breath and slams the book he is holding.

Time has run out. The chair calls for the closing ritual - the holding of hands and the recitation of the Our Father. Stan refuses to hold anyone's hand and stands on the fringe of our human circle like a sulking child. I leave the room and see Stan talking to one of our AA performance team members. Stan remains belligerent. "I can't believe the nerve of that guy…Gerry…Kerry…Gary…whatever the hell his name was…" (Referring to the chair who was called by name several times throughout the meeting…obviously Stan wasn't paying attention to names). I have opinions and everyone here is going to hear them whether they want to or not."

I walk to the parking lot, hearing several other members discussing tonight's performance and how it was ruined by Stan. "Friggin asshole." Joe mutters under his breath. "Yeah." is the collective response of the smokers at the front step. Bob H., the home group's well-respected GSR (General Service Representative), ponders the

situation. "True…but every baby needs a crib and he needs a mommy to clean up his messes and change his diaper. That's what a home group is for. It's a crib for people like Stan and it's our job to help him clean up his shit."

5.1 Introduction

There is a right way and a wrong way to perform within the rooms of AA. Stan performed the wrong way, gauging from the reaction of members of my home group. The group tried to stage a carefully crafted birthday ritual, designed to sell the AA program of recovery and to celebrate the achievements of its members. But Stan wasn't buying. The group enacted various inclusion rituals designed to welcome newcomers like Stan to the home group, beginning with the chair's question "is there anyone here for their first AA meeting or anyone who is returning?" Stan responded to the question but proceeded to violate a number of interaction rituals established by the group. His display of emotions was also all wrong. Instead of being contrite and humble, as members expect a newcomer to be, Stan was perceived as arrogant, unappreciative and insensitive. While his confidence as a speaker and his emotional display might have been tolerated in the context of a lively academic debate in a university seminar, members of the home group clearly perceived Stan's demeanor to be inappropriate and thus rejected his performance.

Of the many dramatic moments I have witnessed within the rooms of AA this was most unusual. In sociology, it is often these unusual, deviant cases that contain the deepest insights and most important lessons for understanding a phenomenon. In interactionist terms, the scene I just described reveals something about the manner in which social norms are maintained by members of an AA home group. Harold Garfinkel (1956, 1967), a key figure in the school of ethnomethodology, couldn't have found a

better subject than Stan to set up a breaching experiment of AA social etiquette, particularly of the norms and protocols surrounding celebrations and awards. If the meeting chair had been a director of a stage drama, he would be shouting "CUT...CUT," in response to Stan's acting, throwing up his hands in despair because the recovery performance came undone. Fortunately, in this case, the meeting chair managed to put Stan in his place and prevented the kind of "depressive spiral" that sometimes happens in self-help groups when members catch the negative, pessimistic and sometimes hostile views which can be spread contagiously by a single member (Dennis, 2003).

In this chapter, I will examine the affiliation process of becoming a member of AA. I view affiliation with AA as something of an audition, where the novice actor presents him or herself to a home group and tries out for the role of recovering alcoholic. This audition is performed at every step one meeting, invoked whenever a newcomer arrives in the rooms or a relapsed alcoholic returns to AA. I argue here that the process of identifying oneself as an alcoholic is not a rational, objective process whereby the initiate uses screening criteria as is found in AA's self-diagnostic tool. Rather, claims of being an alcoholic depend more on whether the initiate can identify emotionally and empathetically with others in the rooms.

In the first section of this chapter I will examine the common story line or script for every auditioning member of AA. I refer to this common script as the drunkalogue. This term is actually used by members of AA as a way of describing their drinking lives prior to joining the fellowship. As a narrative device, every drunkalogue details the experience of hitting bottom - that critical rite of passage whereby the individual passes

through and separates from the drinking culture and awakens to the idea that s/he has a problem with alcohol. Each individual drunkalogue is also framed in such a way so as to conform to the larger corporate message or meta-narrative presented by the twelve steps. As we shall see, AA members pay close attention to the drunkalogue as they evaluate whether the newcomer has the right stuff to qualify as an alcoholic.

Following a discussion of the drunkalogue, I will examine the social role through which the recovery narrative is performed. I refer to this entry level acting part as the penitent role. When I examine the penitent role I will discuss the emotion rules for first stepping, in AA terms "...admitting that we were powerless over alcohol, that our lives had become unmanageable." Newcomers as well as individuals returning to AA after a relapse are expected to behave in a penitent fashion and those who engage in "emotional deviance" are subject to social control measures, some of which I will explore in this chapter (Thoits, 1990).

5.2 The Drunkalogue

The drunkalogue is a historical detailing of the individual's drinking experiences prior to becoming a member of AA. The most common subjects of a drunkalogue involve the retelling of past mishaps under the influence of alcohol, the damage drinking inflicted on the family and significant others and the circumstances that brought the individual into the rooms of AA. As one respondent in this study put it, the drunkalogue consists of the "good, the bad and the ugly" of drinking. Thus, in a sense, the drunkalogue can be understood as a kind of prelude or opening chapter in the recovery narrative leading up to

Step One of the AA program: "We admitted we were powerless over alcohol – that our lives had become unmanageable." As I shall explain, such negative life experiences as being fired from a job due to drinking, experiencing family breakdown, being arrested for impaired driving, or experiencing a health problem – were cited by respondents in this study as evidence for having a life that had become unmanageable due to alcohol.

In the structure of narratives, the point at which the main character enters a new path or sets out in a new direction in life is called the 'turn.' In AA the turn is represented by the phrase hitting bottom. When alcoholics share their drunkalogues, either in monologue form at a speaker's meeting, or in written form (as depicted in the stories section of the Big Book) they create a sense of tension by describing the problems created by alcohol and how these problems lead up to a crescendo of unbearable emotional pain. Hitting bottom is the metaphor most often used to describe this crescendo of pain, which turns the individual away from the bottle. The expression comes from the Big Book and is also heard frequently at Step One meetings, invoked whenever a newcomer enters the rooms or a relapsed alcoholic returns to AA. Hitting bottom is thus a prescribed narrative device used when the AA member retrospectively shares his or her story. It is difficult to say if all members are subjectively aware that they have hit bottom when they arrive at their first AA meeting; nonetheless, the term serves as a useful orientation strategy for the telling of one's story. Framing one's story in terms of hitting bottom is also an essential aligning action to achieve integration into the home group (Stokes and Hewitt, 1976).

Steve's story illustrates the drama of hitting bottom and the pains of coming to terms with the alcoholic identity. Steve is a key informant in this study and was a member

of my home group. He arrived at the rooms in Newfoundland shortly after moving from Toronto. When he learned about my study, he was eager to share his experiences. In fact, Steve was the first person from my home group who volunteered to be interviewed.

Steve grew up in a middle class family in Toronto. His father was a high school principal and his mother a full-time homemaker. He described his early childhood and teen years as "outwardly normal" and "stable." He was a star athlete and straight A student. Steve recalls that he started to drink alcohol at "around the age of fifteen" and within a couple of years, he became a daily drinker, while maintaining what appeared to be a "picture perfect life" for a big city teenager.

> Because I consistently got good grades and I was never in trouble, I never experienced any negative consequences for my drinking. I was the captain of my football team. I had no problems getting girlfriends. We had a nice house, two cars. I had respectable parents. But I drank every day and also started to experiment with marijuana while I was in high school.

Steve suggested that there was no particular reason for experimenting with alcohol and drugs as a teenager. Many of his friends were also experimenting but Steve recalls that he seemed to enjoy the feeling of getting high more intensely than his peers.

At the age of eighteen, Steve left his first year of studies at university to join the police force. He developed a tough exterior, even when confronted with horrific violence and disturbing images of brutality. Drinking became the primary method of debriefing with his colleagues or coping with the stresses of police work:

> From the time I was a constable, I was always the guy who would end up being called to homicides or assaults or car accidents or some violent crime. I remember one investigation of a woman who had been murdered by her husband. He had

> used an axe to cut her head off. I went to her autopsy and watched the coroner take her head and place it at the top of her torso…another time I was investigating a child homicide. The victim was a nine month old girl who had been severely neglected and mistreated by her own parents. She had every bone in her arms and legs broken… I was there at her autopsy as well. And I remember going back to the office after watching this little girl's body being dissected and examined and I went to the vending machine and bought a bag of chips and a Pepsi. I just didn't process or think about what I had just seen…But these were gruesome images which I couldn't get out of my head and my way of coping was to go to a bar afterwards and get shit-faced drunk. I would gather with my fellow officers after a shift at some local bar and drink for hours into the early mornings. Then I would drive home to my family in the suburbs. This became a regular routine for me.

Steve described in our interview how he drank and used drugs just about every day he was on the job as a police officer. To support his expensive alcohol and drug habits, he began to steal the pay cheques of fellow officers, men with whom he had worked with for over a decade. Following an internal investigation, Steve was arrested by his colleagues. The arrest took place on his son's first day of kindergarten. Steve describes the day he was arrested as his personal rock bottom. However, this experience also represented, in his words, a "moment of clarity" when he "fully comprehended the mess I made of my life" and he realized that his social status and his professional identity was about to be radically transformed.

> In September of 1994 I was walking my son to his first day of school and when I came back there were two detectives standing outside my home waiting for me. There was also a van parked nearby with four other officers on stand-by. I was arrested and charged with possession of marijuana. I was suspended with pay and I was referred to our department's Employee Assistance Program. It was here, with the help of a psychiatrist, that I began to open up about my alcohol and drug use. My psychiatrist initially diagnosed me with having Depression and Post Traumatic Stress Disorder and referred me to a local drug and alcohol rehabilitation clinic- a Detox facility, to begin my treatment. At that Detox I went to my first AA meeting. That was another defining moment of my life because

> when I walked into that room I knew that inside there was an answer for me. When I saw those people and heard them sharing, they were using words and language and talking about feelings that I had had for my whole life that I couldn't make sense of and that were driving me insane.

Steve's description of the circumstances surrounding his rock bottom experience fit Denzin's definition of an epiphany, as those interactional moments that leave a mark on people's lives and have the potential to create transformational experiences for the person. At their core, epiphanies are existential crises that occur in those problematic interactional situations where the participant confronts and experiences a crisis. As such, these experiences, while always painful, act as a catalyst in the formation of a new identity (Denzin, 1989: 70-71; 1990: 15-18).

Another respondent in my study was Richard, a fifty five year old native Newfoundlander who worked in the offshore oil industry. Richard's story of hitting bottom involved a near fatal suicide attempt:

> My life became totally unmanageable in the summer of 2007. My marriage was in shambles, I had just declared bankruptcy and I couldn't work because of a back injury. I had bill collectors calling me every day, my wife told me she was leaving and taking the kids and my truck was repossessed. So I went out and bought a bottle of whiskey to drown my sorrows. I waited until I was alone in my house. I went up to my bedroom, drank the whiskey and swallowed a bunch of pain medications for my back. Then I took my hunting rifle and put the barrel under my chin. I pulled the trigger. I remember the boom. I remember blood trickling down over my ears and across my cheeks. I passed out. Somehow, I don't know how, I survived. Don't ask me how - it must have been some kind of miracle, but I only ended up with a wound to my head. When my wife returned home later that evening she found me lying on the bedroom floor, face down, in a pool of my own blood. I was rushed to the hospital and placed on a psychiatric unit. It's awful to say, but it took that kind of experience for me to realize that my life was totally out of control - that I needed help.

For prospective members of AA, hitting bottom is subjectively defined, with some members having dramatic bottoming-out experiences. These are described as major epiphanies because they shatter a person's life and make it never the same again. Other bottoms seem more mundane and ordinary. These are called minor or illuminative epiphanies, involving underlying tensions or problems in a situation or relationship (Denzin, 1990). Having a minor epiphany can sometimes lead to problems identifying with the alcoholic role for the actor with the less exciting story and the less dramatic life turn. Jonas, a middle-aged accountant, shared his bottoming out experience.

> I can't really identify a specific instant in time, an exact moment, when I first realized that I had a problem with alcohol. It was probably in the months following my separation from my wife and my children. When I came into AA for my first meeting, I started to compare my stories to the men and women in the room. I didn't seem to be like them at all. I was never arrested for impaired driving, never been to jail, never been fired because of my drinking. I seemed to be more of a functional alcoholic compared to many in my group. But I knew I had a problem with alcohol because when I started to drink on the weekends I would black out and do and say things that I couldn't remember. I remember sharing my discomfort with an older member of the group and he said to me, 'Jonas, you don't have to fall as low as me. You don't have to be arrested or crash cars or go bankrupt to be an alcoholic. But if you are an alcoholic, then those kinds of experiences are more likely to happen. It's just a matter of time.' So I guess that everyone has a different experience when it comes to having an unmanageable life.

Robinson's research (1989) illustrates the frequent involvement of family members, friends, employers or doctors in the newcomer's recognition that they have a problem with alcohol and that AA might be the solution. My data also suggested that hitting bottom was an experience that was initially framed by a significant other.

> When I started feeling pain around my stomach. I visited my doctor. He told me my liver was enlarged because of my drinking. He looked me dead in the eye and told me I was an alcoholic. I knew at that moment that I needed help. He suggested AA and I took his advice.
>
> My six year old son came into my bedroom one Saturday morning after I had been drinking the night before. I was hung over and feeling sick. I remember the look on his face when he said "Mommy, I'm scared. You don't look well. You need to stop drinking that stuff."

In my fieldwork, I noted differences between men and women in how they presented their stories of hitting bottom at Step One meetings, where members are asked to share how they became involved with AA. Many of the male old timers who shared in these meetings repeated their oft told tales of how much they drank, how much trouble they got into, or how badly they had bottomed out. Displays of humour and bravado seemed to be highly valued during these sharing rituals which involved more experienced AA members. Dennis, for example, stated that he could drink a 40 oz. of rum in less than 15 minutes and then look for more. "I never met anyone who could drink as much as I could," he explained with a sense of pride. Bill, a huge man with tattoos displayed across both arms, would often share how many cars he beat up and demolished when he was drinking and driving, always emphasizing that four or five police officers were required to restrain him because he had the reputation of being a tough guy. Johnny, a diminutive, fast-talking, near toothless fisherman from Newfoundland's south coast, shared his bottoming out experience, which occurred one night when he came home in a drunken stupor.

> I got loaded up on pony piss (referring to Newfoundland's beer brand 'Black Horse beer') wit 'da byes in my crew. I was so shit-faced that I forgot where me bedroom was and I crawled into bed wit me mudder in law who lives in our

> house. Tank God I didn't try to hawl off her drawers (underwear). Now if dat won't turn your guts from drinkin' nothing will.

It was obvious that these stories were popular with many men in the group. During one meeting, when one male member was asked if he wanted to share, he replied, "No thanks, I'll pass. I'd rather listen to Johnny's stories." The response of the group to this comment was also revealing as I noticed that the two women present that night looked at each other and rolled their eyes, while many of the men simply laughed and nodded their heads in amusement. They seemed eager to hear about Johnny's drinking escapades. For the men at least, the drunkalogue was part of the "deviant discourse" that provided entertainment but also served as important status markers in the subculture of AA (Kosut, 2006).

For my female respondents, the drunkalogue seemed relatively insignificant in the overall recovery story. As one female informant told me, the only thing you learn from a drunkalogue is "how much you drank, what you drank, how long you drank, and how much you messed up other people's lives." Jane, a senior member of the home group, complained that many men seemed more preoccupied with their drunkalogues as opposed to the "real message of AA" which was "all about recovery." For Jane, it seems, the drunkalogue has its place but the sharing at an AA meeting should involve something deeper and more meaningful:

> These guys annoy the hell out of me at times. All they want to do is go on with their drinking stories. They don't get that this is a family disease, that their drinking affects everyone around them. All they want to do is compare how much trouble they got into and how many crazy things they did when they were drinking. Yes, we all have drunkalogues. We could all go on and on about our drinking adventures. But what I'm not hearing is how they recovered. I come to

> AA to hear how to recover. I want to find out what people do to get well, to improve their self-esteem and to get over their anger, fears and guilt. I want to learn how they rebuild their lives and improve their relationships.

Jane's views are echoed in several studies that point to differences in how men and women express themselves in AA meetings. According to Vourakis (1989), women tend to express their emotions, including crying, and have a tendency to disclose more intimate details of their lives. Women also speak more candidly than men about their relationships with significant others and tend to focus on emotions more than men, particularly as they relate to building self-esteem (Kaskutus, 1989). Sanders, in *Women in Alcoholics Anonymous* (2009) explored some of the differences found in female only AA groups. One woman in Sander's study reported that "women are less likely to mouth off AA platitudes and are more likely to talk about the applications of AA principles to real life situations." Another woman noted a macho edge to men in AA suggesting "...most men in AA seem concerned with proving that they were the worst drunk of all and are uncomfortable with discussing spiritual matters" (Sanders, 2009: 167). My observations revealed similar patterns among the male and female members of my home group, with no notable differences.

Women were not the only ones to question the relevance of the drunkalogue. Rob also shared this view about the limited therapeutic value of dwelling on the sordid details of hitting bottom. Note how this respondent looks for certain 'proofs' of recovery as presented in speaker narratives – a topic I will explore later in this study:

> I listen to what people are sharing. Are they sharing recovery or are they just sharing for the sake of hearing themselves talk? Is most of their sharing about the

> adventures they've had when they were loaded? Are they going on and on about how miserable they're feeling and how difficult their lives are, or are they sharing what they're doing today to stay clean and sober. Are they working their steps? Are they doing what they're supposed to be doing? In a 24 hour day, I need at least ½ hour or 1 hour to plant these ideas and principles in my life. I'm listening to determine if they're in a positive frame of mind. Are they working their steps? Are they attending meetings consistently? Are they doing what is necessary to stay sober? Or, are they just alcoholics with the cork in the bottle. They've stopped drinking but their lives aren't changing. That's the program. It's about changing your life. If nothing is changing then you're not doing the program.

It was interesting to note that several respondents who were not from Newfoundland and Labrador (Come From Aways – or CFA's) claimed that Newfoundlanders seemed to place more emphasis on the entertainment value of one's drinking story as opposed to the principles of recovery embedded within the twelve steps. One might conjecture that there is a connection here to the story-telling traditions of this province where the ability to tell a good yarn is highly valued and a means to enhance one's social status.

> AA here is just different, not like what I'm used to in Montreal. Yes, I've heard some very humorous stories here and people seem to enjoy sharing tales of their misadventures with alcohol. This is all fine and good but what's the value of this if you're not helping somebody out, not educating them about sobriety.

> I do feel that Newfoundland and Labrador groups are missing something. This is a twelve step program. But people here like to talk about how they're feeling or how their day was or what their emotional state is like or what their past was like. But we all have drunkalogues. I think mine is personally much more exciting than most I've heard here (respondent laughs), but there's no growth from delving into the past. There's nothing to be learned from sharing an extended drunkalogue. And if you're going to focus on your emotions, why don't we just call it Emotions Anonymous. But I want to hear about solutions. How do you stay sober? How do you deal with challenges? How do you use the program personally? I think we need to really study the twelve steps, focus on them, apply them, understand them. But I find here that when I refer to the Big Book, most people don't know it.

> People who have been sober for 25 years in this province don't know certain key passages which we used to read regularly at our meetings back in Vancouver.

Bottoming out is the initial story line of the recovery tale and this part of the AA social script is to be performed within the context of a prescribed social role, what I describe as the penitent role. The idea of a social role is a fundamental feature of sociological theory. Social roles involve the behavioral expectations, the physical demeanor, the attitude, and the appropriate emotional display for the actor (Kemper and Collins: 1990; Turner, 2002). In AA, it is expected that the newcomer, whether s/he is attending their very first meeting, or returning after a relapse, will behave in a certain way and express emotion in a certain manner. Emotions which are construed as more negative, especially guilt, remorse, shame and fear are expected to be displayed by the penitent. If a newcomer acts outside of this prescribed role, with inappropriate emotional displays, the home group will pull the curtain down on the performance or use various pressure tactics to ensure conformity to the penitent role.

5. 3 Playing the Penitent Role

There is a climactic scene in the movie "Indiana Jones and the Last Crusade" that I feel aptly describes the prescribed role for the AA newcomer. In this scene, Indiana Jones has discovered the secret cave which hides the Holy Grail, the chalice supposedly used by Jesus Christ during the Last Supper. The hero must cross a dangerous bridge and defuse various booby traps before he can grasp the Holy Grail. As Indiana gingerly traverses the bridge, he holds his breath and anxiously chants the clues written on an ancient map "only the penitent man will pass; only the penitent man will pass."

In AA, contented sobriety is the Holy Grail and to grasp it one must first learn how to walk as a penitent using the twelve steps as a guide. Just like Indiana Jones crossing the bridge, the body language of the newcomer is expected to be lowly, faltering and humble. His or her eyes should be downcast; the expression remorseful, the energy levels should be low, emotions characterized, in clinical terms, by negative affect. The newcomer should appear beaten and degraded, ready and willing to admit that they have been whipped by an enemy - alcohol. Steve, the disgraced police officer quoted earlier, remembers how he was described as a "winner" during his first AA meeting, despite his appearance and his feelings of humiliation and shame. The irony of this term and its significance for the penitent is captured in Steve's recollection:

> I arrived at the Detox in awful shape. I hadn't slept or eaten in weeks. I hadn't shaved; my hair was long and dirty - not at all like my normal neat and tidy appearance as a police officer. The one thing I'll always remember from my first meeting is this woman, I can still remember her name, is that she called me a winner (respondent starts to cry softly)... And that's a term that is used in the rooms sometimes... winners... and she called me a winner. And at that point, I felt like here I am, I'm a police officer in the Barrie Detox, my family is leaving me, I've been arrested, I'm all over the local news... and she's calling me a winner. And I had tears. And I couldn't understand but I just knew that I was going to get my help here - from these people. That was my start.

Male respondents, many of whom had been members of Alcoholics Anonymous for years, remembered their first meeting vividly and how the warm response of the group helped to alleviate their feelings of shame, embarrassment, and self-hatred when they first walked into the rooms:

> I felt like a piece of shit when I came through the doors. I couldn't find a job. I had no friends. I live in a small outport and everybody avoided me. Even when I walked to the homes of my brothers or sisters, who lived on the same road. I

would see their lights being turned off and their doors being closed… or the men walking away from their sheds. I wasn't welcome anywhere. Everybody knew I was trouble when I was drinking… So when I came through these doors. I remember very clearly the smiles. the hello. the handshakes… this meant a lot to know that I could be accepted.

I was 19 years old when I went to my first AA meeting. I was an inmate at the Pen (Her Majesty's Penitentiary in St. John's). To be honest. I only went there because I was bored and because somebody told me they had free coffee and donuts. So I wasn't serious at all about getting help. I was an angry young man and I would have ripped the face off 'ya if you looked at me the wrong way…so I remember how surprised I was to see these older men volunteer to hold an AA meeting in jail. And I'll never forget the handshakes I received from those guys. I still remember that. Everybody used to be scared of me but these guys seemed genuinely interested in me and shook my hand and smiled and told me that they hoped to see me again.

All of my respondents remembered the shame. fear, loneliness. and guilt that they felt during their first meeting and how their displays of negative affect seemed to evoke supportive. empathetic responses from the group. However. the female respondents in my sample suggested that the negative emotions they felt were compounded even more because of the additional stigma of being a female alcoholic as well as a minority in the mostly male rooms of AA. Such feelings are reflected in a number of research studies that point to prevailing negative stereotypes about alcoholic women within AA. Berenson (1991) reports that female AA members were more likely to perceive themselves as immoral or bad since 'nice' women didn't become drunks.

In this quote. Sue describes some unexpected emotional displays from men during her first AA meeting which she found helped to alleviate her pain:

When I first came into AA. I labeled myself. My mother used to tell me there's only one thing worse than a drunk man and that's a drunk woman. It was not

acceptable for women to get drunk. Only certain types of women drank. So when I came into AA it was all men and I had myself labeled as a certain type of woman. So I had to overcome that… which was hard. I'm in a room with a bunch of men. I'm the only woman. People would have thought, what are you doing there with all those men? That was my view of a woman who drank. So when I turned up at an AA meeting I really felt like the lowest, the smallest, the most worthless type of human being. I was so ashamed to be there and I could hardly hold my head up… but AA allowed me to experience the compassion of men because when I walked into that meeting… even though I was the only woman… just about every man came up to me and shook my hand, looked me straight in the eye and said welcome. And I remember that many of these men were so distinguished looking. I remember at the end of that first meeting when the chair called for the closing prayer, how gently the man sitting next to me held out his hand. And then the man sitting on the other side of me did the same. This was definitely a first for me. I had never seen or experienced men do this sort of thing because I grew up in an alcoholic home where my father and brothers all drank heavily and they were mean, violent drunks…so to have men on either side of me, holding my hands, and saying "Our Father who art in heaven…" and then telling me that they were happy to meet me and hoped I would come back…these were real gentleman and they treated me like a real lady.

A younger female respondent, age 28, shares similar experiences with her mostly male AA group:

The first time I went to the AA meeting, I was the only female there. It was all men. But it didn't bother me being the only girl in a room full of men. I was there to try to deal with my own issues. It was a time in my life when I needed support and they did give support. People there would check in with me after meetings, to ask how I'm doing and that sort of thing. I felt a sense of calm because people there were still going through addiction and yet they were managing. Others seemed to have beaten their addictions or were doing well. This gave me hope - that I could also do it. But all these men were all older and quite laid back. And I liked listening to their experiences. I never spoke during an AA meeting during my first six months I attended except to say "hi, my name is Jennifer." But I enjoyed listening to people's stories of how they overcame their problems. I remember this one guy who was sober for over 30 years. That says a lot that he doesn't drink or do drugs. He was also super friendly and he became almost like a

> grandfather type of figure to me. He would hug me and encourage me at the end of every meeting and say 'keep coming back Jen, keep coming back'.

This female respondent, also fitting the part of the penitent, recalls the comforting effect of having a woman from the group offer her support at her first AA meeting:

> When I came to AA everyone had abandoned me because of my drinking. I was nothing but a nuisance. Child Protection had removed my two children because I was drunk every day. I was angry, upset... very angry at the world... but most of all, feeling so ashamed of what a failure I was as a mother. But when I came into my first meeting, I remember how friendly everyone was and how they greeted me and held out their hands. And I remember how warm Jane was... she offered to sit next to me during my first meeting. That meant a lot, to know that somebody was even willing to be seen with me, to be in my presence.

Unfortunately, not all encounters between men and women in AA are as supportive and empathetic as these quotes suggest. Two women in my sample and three male respondents, reflecting on their experiences with AA in different group settings, witnessed incidents involving men who tried to take advantage of female newcomers who were wracked by guilt, shame, remorse and a general lack of confidence. Such romantic entanglements, sometimes based on exploitation, are described as 'thirteenth stepping' within the fellowship. It is outside of the scope of this study to estimate the rate at which such incidents might occur, or whether it is even perceived as a problem within the provincial fellowship, especially since this information comes from second-hand accounts. However, these respondents suggested that such behaviour is highly inappropriate and potentially harmful, especially for the female newcomer. Notice as well how the groups depicted in these quotes enforced social control measures involving social isolation and direct confrontation for managing this type of behavior:

> I remember one instance where a female friend who had just joined AA started to get text messages from another man in the group. He was leaving messages which were flirtatious in nature and that really made her feel uncomfortable. So she told her sponsor and her sponsor approached that guy's sponsor. His sponsor told him, "Stop this nonsense right now otherwise I'll drop you as my sponsee. I can't tell you not to come to meetings but I'll guarantee you that you won't get everything you should be getting out of this group."

Mark, a CFA (Come From Away) reflected on his own experiences in AA groups in other provinces and makes an interesting comment about how social control measures in this province tend to be more subtle:

> Sometimes you do get relationships that happen in AA. We call it step thirteen. Some female newcomers are vulnerable when they arrive at the rooms and certain men know this. So you get some guys leering at women or saying things to them that are harassing. You can't ban people from an AA meeting but we have told people in my group that NOBODY appreciates their behavior. We used to watch out for this behavior in our group in Winnipeg. I remember telling this guy, "Look, stay away from these women. Take your dick and put it someplace else." That needs to be done. But especially in an AA group because newcomers are hurting and vulnerable and they don't need some guy preying on women. And the groups here in Newfoundland - do all this monitoring and intervention but it's more subtle than what I'm used to. Usually, an old-timer or a sponsor will take the person aside and say 'look buddy, give that girl some space.' So there seems to be a gentler approach here.

Karen, a respondent with nearly 15 years in AA, sees herself as a 'mother hen' of younger women who come into the rooms:

> I feel protective when I see another woman entering the rooms for her first time. I remember how vulnerable I was and so I see how vulnerable she is. So I try to make contact, say hello and try to keep an eye out for her. The men here in this group are okay... they're fine and generally respectful... but I've been part of other groups where I've had to warn women about certain men, to say "watch out for Bill there."

Newcomers who fail to play the penitent by engaging in boastful drunkalogues, or blaming others for their drinking, or failing to demonstrate remorse and regret for their harmful actions, are sometimes publicly challenged in the rooms. Joe, a member of AA for over 20 years, recalls a time when he publically challenged a female member who appeared to him to be anything but penitent. Joe's observations may also point to different standards for evaluating the performance of the penitent role as it is performed by women.

> I was part of a group and this very large, very intimidating woman showed up. She was well over 200 pounds and stood over six feet tall with short cropped hair and a constant scowl on her face. She was vicious. She could stare right through you… She would come to meetings, go out and get drunk, come back in and this went on and on for weeks. And she was there one night and mouthing off about how her husband was an asshole and that's why she needed to get drunk… and how her boss was a real prick… and on and on. I spoke up during a meeting, right after she shared, and told her "are you serious about getting sober?" And she looked at me as if to say "who the fuck are you?" And I told her, "I've been listening to you for a while now. Why are you wasting our time if you're not serious about getting sober? Why don't you just go and get drunk instead of coming here - pissing and moaning. Why do you keep hurting yourself?" I could see right through her. She was angry on the outside but hurting like hell on the inside. Nobody was paying attention to her and everyone in the group was just listening to her rant and roar. Everyone at the meeting stayed out of her way because she was so angry and intimidating. I said all of this during the meeting after she had shared. And she came to me after the meeting and said "Joe, will you be my sponsor?" I told her yes. A couple of weeks later, she stood up at a meeting and said 'You know, I've got a male sponsor and I don't mind saying it. I've been coming here for a few weeks and I've been having a difficult time and nobody ever challenged me or spoke up to me but he did. And I admire him for that.' And she's been sober now for seven years.

In playing the penitent role, it appears that anger and aggression expressed by women seems particularly out of place in an AA meeting. In my observations of first step

meetings involving male 'first steppers,' displays of anger and aggression seemed to be more tolerated and certainly never evoked a challenging response as illustrated in the quote above.

The concept of emotional deviance is helpful in analyzing such emotional displays. According to Thoits (1990) there are four components of emotional experience, all of which are interconnected so that a change in one component will trigger changes in the other components. Thus, whenever an individual experiences an emotional reaction there is a situational cue, a physiological change, an expressive gesture and an emotional label. This provides the basis for Thoits' typology of emotional management which allows change directed at one component to result in the management of the emotional experience. We see this dynamic in the case of Stan, described at the beginning of the chapter, who offers an alternative interpretation of the awards ceremony. Stan's interpretation of the situation is different from the award recipients and the rest of the home group and it is this interpretive factor which results in his feelings of frustration, impatience, and apparent boredom with the AA meeting.

We also see emotional deviance in the case of the female alcoholic described above because showing up at an AA meeting under the influence of alcohol is an obvious breach of AA social norms, even more so by an apparently angry woman, and a sure indication that she was not playing the part of the penitent. On another occasion, I observed a male newcomer show up at a meeting whose breath reeked of alcohol. He started to speak but his speech was slurred and rambling. As I listened to the incoherent ramblings of this man, I observed a number of other members rolling their eyes, shifting

uncomfortably in their seats and a couple of male old-timers expressing their disapproval with audible "tsssk, tsssk..." sounds. At the end of the meeting, this man left the room after several members were observed shaking his hand and encouraging him to return. However, since this was the only occasion I observed such an obvious display of drunkenness inside of an AA meeting, it was difficult to identify any established norms for dealing with cases such as this. In an interview with one senior AA member of over twenty years, he described newcomers whom he had sponsored who habitually turned up at meetings hung over, possibly inebriated and smelling of alcohol. However, he said that they "had the good sense to shut up and just listen..." The same respondent recalls incidents where he had acted as a meeting chair and asked drunken attendees to leave the meeting, before inviting them to return when they were sober, or declining their offers to share. Based on these limited observations, it may be that AA groups show a certain acceptance of drunken comportment inside of a meeting but there are probably limits to how much the group is willing to tolerate.

The drunken 'stigmata' of certain newcomers, particularly the stench of alcohol, disheveled clothing and scruffy appearance, also serves as a stark visual reminder of the damage and heartache that alcohol can bring. Ironically, it may also serve as a reward for conformity to those AA members who appear to be more clean and sober and respectable looking. Erikson (1966) refers to the "rewards of conformity" that can arise with the public shaming of deviants. In AA, attempts to overtly shame a disheveled drunk would be considered contrary to the AA message of acceptance and non-judgment, but I have heard comments from more established AA members like "there go I but for the grace of

God" or "thank God, I'm not at that stage in my recovery." Behind such messages is a certain amount of sympathy for the relapsed alcoholic or the newcomer who is just coming to terms with their drinking problem, but there may also be a sense of relief, pride and satisfaction that the alcoholic who is clean and sober is no longer as bad as that person.

Certainly, the penitent newcomer is expected to convey honesty and transparency in describing their struggles to maintain sobriety. It is assumed that the newcomer will struggle in the early stages of sobriety and claims to have "their shit together" early on, as one respondent put it, are challenged. In fact, a number of my respondents suggested that old-timers had a special responsibility to put out their bullshit radars to test an AA novice's claims that they are recovered or cured or claiming contented sobriety at such an early stage of their recovery. Goffman (1974: 83) refers to this inclination to deceive as fabrication, "the intentional effort of an individual to manage activity so that...others will be induced to have a false belief about what is going on." Notice how this female member of AA uses fine-tuned observations of verbal and non-verbal behavior as she tries to verify who is being honest and transparent with their recovery presentations and who might be engaging in fabrications:

> When I look at other people I notice some outward signs: fidgeting, agitation, anxiety. For me, I pick at my fingers, especially my thumb, not because I'm drinking but because I'm stressed out. People who are in denial, who are still using alcohol or drugs, don't like to look at you, look up and look you in the eye. Sometimes, it's really obvious if they're still into the booze or maybe just switching to drugs. The person has stringy hair, they haven't bathed, they're skinny and haven't eaten in a week. In AA meetings, I've seen people come in reeking of booze. That's a big no-no. But I notice their body language and their

> faces. I listen to what they're saying. Some people trip themselves up. They say "I missed the meeting because I went to the park on Monday night" and then two hours later they say "I was at the movies on Monday night." So sometimes, your memory gives you away.

Another respondent shared how he became involved with AA with the hope that he would receive a reduced sentence in an impaired driving case. As he puts it, he failed to "get honest" in the early part of his program but other members of his home group quickly challenged him:

> I had some friends who were police officers and they told me that the judge would look more sympathetically upon me if he knew I got involved with AA. So I started going to meetings before my charges of impaired driving were heard in court. I wasn't going because I knew I had a problem and I wanted to get better. I was doing AA to get a better outcome in court even though I found out later it didn't really affect the outcome. When I first started to come to AA meetings I really wasn't serious. I didn't listen. I would tell the group I was off the bottle but I really wasn't. And within the first few months, a couple of older members called me on my bluff. They said, man, you're going nowhere in this program. You just picked up a six month medallion but now you're sharing you relapsed one month ago. Start getting honest with yourself and you'll start to recover.

In rural Newfoundland there are always risks to presenting the honest truth in an AA home group as confidential information can be transmitted more easily through a small community. In this quote, a female respondent describes her strategy of self-monitoring her own verbal and non-verbal behavior:

> The honesty is the main thing. There are times in meetings when I'll try to avoid talking because if I talk I'll have to lie because people are assuming I'm clean and I'm not. That's not a good recovery...when you're using but you're hiding it. But I feel that I have to lie because I'm afraid that if anyone finds out that I'm still struggling with my drinking, the news will get out into the community and I'll lose my little girl because everyone knows that I was in trouble with Child Protection Services. It's such a dilemma. I tell on myself all the time. I can't get

> help for myself unless I tell on myself and unless I deal with the consequences. You can't recover unless you deal with the consequences of your behavior. I'd hear people lie and I couldn't take that. If I relapsed I'd say it. I wouldn't say that I've been clean for one month when really, I've only been clean for two days.

The desire to practice what AA members call rigorous honesty is an essential component of the recovery performance. As these quotes demonstrate, members listen to each other's presentations carefully, subjecting them to their collective 'bullshit radars' in the hope of discerning who is experiencing an authentic recovery and who is not. Behind such scrutiny is the recognition that a good performance at a meeting does not necessarily equal an authentic recovery.

When respondents reflected on their early experiences with the AA program they suggested that besides being honest, the most important task for the newcomer was to listen. It was suggested that listening was perhaps the most important aspect of learning how to recover.

> When I first came to AA my sponsor advised that I should come to meetings, clean the shit out of my ears and keep my mouth shut. And that I should do this for at least a couple of months. I took his advice and I'm glad because I realize now that all I had to share were my wild stories and all the trouble I caused. I didn't have much to say about how to stay clean and sober.

Jane, one of the old-timers in the home group, stated:

> You can't learn much from somebody who has only been sober for a few months and, in fact, I really worry about the newcomer who seems to have everything figured out after a couple of weeks. They're always talking about how much their life is improved and how much better they're feeling and how much they've learned. I think it's better for them to say less and listen more because their recovery may be premature.

Another member, Mark, describes how his former group in Ontario established orientation meetings for all newcomers. Such meetings were required of new members

and had to be attended for a period of three months before being admitted into regular AA meetings. While this kind of regimented, primary socialization into the AA subculture may occur in other provinces in Canada, I have never heard of such orientation meetings in Newfoundland and Labrador.

> I was part of a group on the mainland where newcomers were referred to special 'newcomer's meetings.' They were referred there after their first AA meeting. In the newcomer's meetings, people would be taught a little about the twelve steps, they would be shown the Big Book; they would be taught about the rules of cross-talk and sharing. And after about three months, they would then be referred back to the regular meetings. This worked very well but here in Newfoundland, I haven't seen this kind of set up which I think is unfortunate.

5.4 Conclusion

The scientific, positivist literature emphasizes the diagnosis of addiction or alcoholism as a rational, objective, detached, clinical process. In the world of AA the diagnostic process involves a subjective, individualistic, emotional identification with the role of recovering alcoholic. My data suggest that the more one can identify with others in the rooms, the greater the chances one will self-identify as an alcoholic.

Affiliation with an AA home group requires the newcomer or the prodigal alcoholic (who is returning after a relapse), to act within an appropriate emotional range of guilt, remorse, shame, embarrassment, anger and fear. Along with these displays of negative emotional affect, the penitent is expected to demonstrate honesty, transparency and humility. It is not expected that they will get the program right away. In fact, claims of recovery, that one "has their shit together," are viewed by the group with suspicion. As an AA novice, the actor is encouraged to listen and learn from significant others within the fellowship.

More seasoned, experienced members of an AA home group are responsible for enacting various inclusion rituals designed to socialize the newcomer into the penitent role. Smiles, hand-shakes, saying "welcome" or displaying AA literature or posters in the rooms – such gestures and props are important for creating an inviting space for the person who enters the rooms. One respondent remembered the strong impression that a poster had on him during his first AA meeting. "When I walked into the rooms and I saw the poster which read 'You're no longer alone' that really had an impact on me. I really felt it was true."

The penitent role relies heavily on the emotion work performed by the entire AA home group. There is a reciprocal emotional energy exchanged between the newcomer or the relapsed member and the rest of the group. The newcomer brings a display of guilt, remorse, shame, fear and humility and in exchange s/he receives from the group compassion, warmth, support, encouragement, empathy and acceptance. This is the positive emotional energy that is created inside of AA meetings and it depends upon the correct performance of interaction rituals. Ultimately, the release of positive emotional energy is what the newcomer feeds off and it instills a desire in him or her to return to subsequent meetings. Some newcomers have problems identifying with the role of alcoholic or fail to properly perform the penitent rituals and ultimately fail the audition. As a result, they eventually exit the rooms of AA (as was the case with Stan, described earlier, who disappeared shortly after his performance).

Recovery in AA is often described as a journey or process of transformation. The means to this transformation is the twelve steps. As I shall explain in the next chapter, the

twelve steps offer a structured program of change that helps newcomers to get into the role of recovering alcoholic.

Chapter Six: The Twelve Steps

6.0 Profile of a Key Informant

Michael has been a member of AA for over twenty years but joined this home group only two years ago. He retired from his career as an executive manager in the civil service and, along with his "long-suffering wife" of over 30 years, as he described his partner, decided to make rural Newfoundland his retirement home.

"Work hard and play hard" was Michael's motto in life. Working hard earned him a great deal of success as an executive. He earned a good salary and rose through the managerial ranks because of his intelligence, ambition and leadership abilities. "I had every toy, luxury and privilege in the world," Michael shared in our interview, "...boats, trailers, vacations around the world. I had a big, corner office on the top floor of our office building in Toronto, two private secretaries and a staff of over 60 professionals who reported directly to me. I had a padded expense account and a fancy title displayed on my office door. To everyone who knew me, I had it all."

But there was a downside to Michael's outward successes. Michael was a "high functioning alcoholic" as described in the research literature on alcoholism.[1] Even though Michael had all the trappings of success and privilege, he felt miserable and his home life was in shambles. Michael managed to climb to the top of the professional ladder but his rock bottom came after a weekend binge with some friends from work. He arrived home in a drunken stupor, smelling of perfume and booze after a night of carousing. "My wife

[1] For an excellent review of this literature see *Understanding the High-Functioning Alcoholic* (2009) written by psychologist Sarah Benton, a self-described HFA.

and two young children saw me stagger in through the door. I was a complete mess. I crashed through a glass table in our living room and couldn't even stand straight. I lied again and told them it would never happen again... but this time my wife told me to get out of the house. My kids stared at me and then started to cry. I knew in that instant that I needed help. The next day I attended an AA meeting. It took a long time and many years of hard work, but today I have contented sobriety."

Today, Michael describes himself as a committed member of AA. He has lived in every province in Canada because of his career and he has been involved in over twenty different home groups. He is a favorite AA circuit speaker in his home province of Ontario and he sits on advisory boards for professional groups and Employee Assistance Programs across the country, eager to share his personal experience and knowledge of treating addictions in the workplace.

In my home group, Michael is a respected old-timer who regularly attends the meetings and is active in the local fellowship. When I asked him about his contributions to AA, he emphasized that nothing was more important to him than teaching others about the twelve steps. "Those steps are the key to my recovery," he emphasized. "Without them, I wouldn't be here. I tried every type of counseling – psychotherapy, cognitive therapy, medications – been to psychologists, psychiatrists, social workers, rehabilitation clinics – but only the twelve steps made a difference in my life."

Michael's unwavering faith in the steps was the reason why he volunteered to facilitate "step meetings" in our home group. These special meetings were held during

the last Monday of each month. Every meeting was orchestrated in the same way: to encourage members to reflect on how they experienced each step of recovery. As such, these meetings proved to be wonderful opportunities for the members of my home group to 'free associate' on the meanings each step held for them, the challenges and difficulties they experienced in carrying them out, and the ultimate benefits they experienced in working the steps.

To start each step meeting, Michael would share his story to qualify as an alcoholic. He would always end on this note: "If you want what I have, then work the steps. Learn everything you can about them but most importantly, live them. The twelve steps are the heart of AA. They are the heart of recovery and our blueprint for living."

6.1 Introduction

As a researcher, I was extremely grateful to participate in, and observe these step meetings. In the twelve month period during which I undertook this study, I participated in every step meeting which focused on each of the twelve steps of recovery. Michael was a skilled facilitator for these meetings, which served as a type of focus group for my purposes. In addition to the meetings, I also conducted in-depth interviews with subjects who shared their experiences in 'working the steps,' as described in the fellowship. A couple of key informants, Michael included, also provided follow-up interviews whenever I wanted to discuss my interpretations or needed feedback. As such, I was able to triangulate data as they emerged during the course of the interviews and again, during the discussions and sharing at step meetings.

In this chapter, I will examine each of the twelve steps of recovery and consider how they are to be performed within the social role of recovering alcoholic. As I have described in previous chapters, newcomers arrive into the fellowship exhibiting negative emotional affect. They are expected to act humbly and contritely, entering the rooms in a walk of shame. They take their lead from other, more experienced members of the home group, as they begin their journey to contented sobriety. Just as there is a right way and a wrong way to enter the rooms, I learned that there are norms regulating how one should work the steps of recovery.

The twelve steps allow the actor to get into the role of recovering alcoholic by teaching him or her a way to transform the overwhelming, negative emotions of fear, guilt and shame into contented sobriety. In this chapter, I highlight some common themes or patterns which emerged in my interviews and observations. My findings are organized around the conceptual framework developed by Van Gennep (1909) and Turner (1974), whose anthropological work on rites of passage can be applied to understand the personal transformation and shift in social status accompanying membership in AA.

Victor Turner's reformulation of the rites of passage, with its emphasis on personal transformation rather than shifting status, provides a conceptual framework through which the experience of 'working the steps' can be understood as a personal rite of passage. These three major shifts or stages of the AA experience can be identified as: (1) separation, by which the person being initiated is socially disengaged (transformed) from a previous status as mere drinker to alcoholic within the context of AA; (2) marginality or liminality, the transitional and ambiguous threshold at which the novice or

initiate AA member undergoes redefinition; and (3) incorporation or aggregation, by which the person is reunited into the group as a 'new' member, redefined and not connected to the previous identity. My intention in using this conceptual framework is not to debate whether the twelve steps have all the structural elements of a rite of passage as set out by Van Gennep at the turn of the century. I am more interested in using the concept of a rite of passage, particularly as it has been reformulated by Turner, to focus on personally transformative experiences taking place outside of the regular social structures - as a theoretical lens providing insights into the experience of working the twelve steps.

6.2 The Separation Stage and the Surrender Steps - 1, 2 and 3

Step 1: "We admitted we were powerless over alcohol – that our lives had become unmanageable," marks the beginning of the process of recovery. Members of AA often call this the first of three 'surrender steps' in the journey of sobriety. As such, the first step of this journey was often the most difficult, yet crucial, in the work of recovery.

The crucial rite of passage at this stage of the transformational process is the first time members tell their story before the group, beginning by acknowledging, "I am an alcoholic." There is a parallel here to rites of passage seen in religious communities. Students of conversion and commitment have sometimes pointed out the importance, for the commitment process of a "commitment act" which symbolizes the initiate's incorporation into the group (Gerlach and Hine, 1968; Wilson, 1978). For example, speaking in tongues or receiving the baptism of the Holy Spirit is the commitment act for

members of the Pentecostal movement. In AA, the admission "I am an alcoholic" is delivered before witnesses, many of whom are veterans of the program and who welcome this commitment act with empathetic verbal and non-verbal displays (nodding heads, extended eye contact etc.). In subsequent meetings, the ritual utterance is used again and again, whenever the novice member speaks at meetings. "Hi, my name is _ and I'm an alcoholic" becomes a powerful signifier of inclusion within the group, aligning the speaker with other (sick) alcoholics in the room. This verbal confession, shared in a community of witnesses, also shatters any self-illusions that one is like ordinary drinkers. Hines refers to this process of demarcation or separation from previous statuses as a "bridge-burning act that separates the old identity from the new" (Hine, 1970: 56).

Dave, a senior member of the group, spoke about the significance of saying "I am an alcoholic" at meetings:

> When I first came into the rooms, I would say, 'hi, my name is Dave and I'm an alcoholic.' But I never really believed it. I said it more to fit in… but the more I heard myself say it and the more I learned about this disease, the more I believed I truly had a problem. I really was an alcoholic.

The Big Book divides the first step into two sections, the first being "we admitted we were powerless over alcohol." The key term here is powerless. A common theme, brought up by a number of respondents during interviews and also at step meetings, was that alcoholics lose their power to choose once they consume their first drink. This capacity to make choices about drinking is what separates the alcoholic from ordinary drinkers of alcohol.

Respondents spoke of the emotional pain surrounding this sense of powerlessness over alcohol. Feelings of despair, loneliness, self-loathing, guilt and shame existed deep within the alcoholic but these feelings were never shared with others for fear of being misunderstood or being blamed for bringing this misery upon themselves. Kenney and Craig (2012) call this type of suffering "illegitimate pain" because these negative feelings are often disguised or veiled from others for fear of possible consequences. According to these authors, illegitimate pain exists on a continuum from legitimate suffering (suffering seen as sympathy worthy) to the opposite extreme where suffering is misunderstood, neglected or even viewed as just punishment.

Comments such as these reflected the pain behind powerlessness, a pain that could not be appreciated by normal drinkers or "earth people" as this respondent put it:

> The powerlessness was that one drink was too many and a thousand wasn't enough. Once I started to drink I couldn't stop. I had to drink until I got drunk. I was going to find it somewhere. I had no power to control my drinking. I tried many, many times to stop on my own but I couldn't do it on my own. Drinking was the only thing that ended my pain.
>
> I couldn't drink and I couldn't not drink. To me, that's powerlessness. I had no choice. There was no power of choice. That's a really important part of it. When I take that drink, I lose that power of choice. And that's something that non-alcoholics, some people call them 'earth people', don't fully understand - that loss of choice.

Wanting to stop drinking and being unable to do so meant that the alcoholic had no control or power to make rational choices when it came to alcohol. The Big Book frames this sense of powerlessness as a symptom or manifestation of an allergy:

> Alcoholics have one symptom in common: they cannot stop drinking without developing the phenomenon of craving. This phenomenon, as we have suggested, may be the manifestation of an allergy which differentiates these people, and sets them apart as a distinct entity (AA World Services Inc., 2001: xxx).

The craving/allergy concepts came up often during respondent interviews, with many respondents suggesting they were born to be alcoholics, or that their brains or physiology predisposed them toward alcoholism. This biological explanation was expressed in many ways:

> I believe my body reacts to alcohol differently from other drinkers. I had my first drink when I was twelve years old, when I stole a sip from my father's alcohol stash. Even then, I couldn't stop until there was no booze left in the bottle. I had to drink, even at that age, until I became drunk.

> I don't think that alcoholics are wired in the same way. Some people can go out and drink and get drunk every once in a while. They don't go to bed planning for that next drink in the morning. There has to be something in our brains that make alcoholics different.

Other respondents rejected the notion that one could be born an alcoholic but embraced the idea that there was a biological basis to their powerlessness over alcohol. These subjects emphasized the necessity of avoiding that first drink of alcohol. The first drink, the first sip of alcohol, was enough to trigger the so-called allergic reaction, and respondents reported that they were completely powerless against its effects. Therefore, the key to exercising personal power over alcohol was in the moment of choosing whether or not to take that first drink:

> I think it's total bullshit when I hear people say they were born alcoholics or they have no choice. Choice is the only weapon we have to get well… in AA there's a saying that we don't choose to be alcoholics but we do choose recovery. And I choose recovery on a daily basis by not taking that first drink.

Being able to admit powerlessness was more difficult for some respondents than others. It meant admitting personal weakness, which was difficult for subjects who considered themselves as powerful, influential or important. This necessarily required self-deflation, humility and an awareness of a loss of control. Bill, a giant of a man, put it best when he stated:

> There's not much I'm afraid of...I'm 6'7" and over 300 pounds. But as big as I am and as strong as I am, I realize that that little brown bottle is much stronger than me. It will beat me every time.

Benton (2009) points out that high-functioning alcoholics (HFA's) like Michael (featured in the profile at the beginning of this chapter) seem to struggle more with the admission of powerlessness since they may perceive themselves as having power in the domain of work and they often have the outward appearance of success. As long as they have good jobs, impressive homes, cars, incomes and the semblance of a normal life, they are reluctant to admit that their lives are being impacted negatively as a result of drinking. HFA's are more likely to compare their situations with others in the rooms, and if they perceive that their lives are more manageable than the life stories they hear, they hold on to the illusion of being in control of their drinking. But eventually, as this respondent put it, the bottom eventually arrives and the alcoholic is forced to admit that the pain is so unbearable that they need help:

> I made the mistake of comparing my story with others in the room. So when I heard these guys speak about losing jobs because of drinking, or losing their licenses to drive, or being thrown in jail I thought, that's not me. But I realized that everyone has a different experience of what unmanageable is... for me it was the feeling of being ashamed of myself and totally fed up... with wanting to stop drinking but being unable to do so.

The second section of step one – admitting that our lives had become unmanageable – required recognizing the negative consequences of drinking. Having an unmanageable life could be measured in an objective, external way but there was also a subjective, emotional quality that came with this realization. Some of the external experiences and events associated with an unmanageable life included divorce, bankruptcy, incarceration, and health crises. These painful life events provided evidence that drinking had become so problematical and out of control that they constituted a 'bottoming out' as discussed in the last chapter. Other respondents experienced less obvious catastrophic events, but experienced an emotional bottom characterized by extreme pain or negative emotional affect. Respondents reported that it was important, even mandatory, for them to hit some type of bottom, to realize they had a problem with alcohol.

> The stress of having bill collectors calling me every day finally got to me. I knew then, that if I didn't get a grip on my drinking, I'd lose everything that I worked so hard for.
>
> I had to lose everything – my marriage, my kids, my house, my job – everything… before I could admit I had a problem. I hate myself that it took losing everything for me to admit I was an alcoholic even though it was so obvious to everyone who knew me that I was.

Step 2: Came to Believe that a Power Greater Than Ourselves Could Restore Us to Sanity

In Step two the alcoholic is encouraged to turn to an outside force to help him/her to recover. In the "Big Book," Bill W uses a stage-manager metaphor to explain how the alcoholic must surrender control in Step 2:

> Each person is like an actor who wants to run the whole show; is forever trying to arrange the lights, the ballet, the scenery and the rest of the players in his own way. If his arrangements would only stay put, if only people would do as he wished, the show would be great...What usually happens? The show doesn't come off very well...He becomes angry, indignant, self-pitying...Our actor is self-centered, ego-centric...selfishness is the root of our troubles...We had to quit playing God (AA World Services Inc., 2001: 60-63).

This respondent carried his Big Book to our interview and had highlighted many passages from Bill's story. He too could relate to the drama analogy, indexing content from his own story to the principles of recovery described by AA's founding father:

> When I was an active alcoholic, my life was one big show which was completely out of control. I experienced one battle after another because of alcohol. When I realized that I had a problem with alcohol, I learned I had to surrender control. Surrender is not a cool word. I'd been trying to fight my alcoholism but then I realized that fighting my urge to drink just made it worse. What I needed to do was give up fighting. I needed someone or something more powerful than me.

The challenge for recovering alcoholics is to become *willing* to believe in a higher power. A number of respondents, and many others who I heard during step meetings, reported extreme difficulty with this step because they struggled with preconceived ideas about God and higher power and organized religion. This male respondent adopted a feminized higher power to work step two:

> I don't believe in a religious God. I've tried to go back to my childhood religion which is Catholicism but it's never felt comfortable for me. My higher power is Mother Nature/Creator. I really latched onto this idea when I met a lot of Aboriginal people through AA because my first exposure to the program was in Winnipeg and there were a lot of Aboriginal People in my home group. Females are more caring and nurturing and that's what I associate with a higher power. She cares, nurtures, forgives me and understands that I'm human. I pray to this entity and it works.

Another female respondent also struggled with preconceived ideas about her higher power:

> I was brought up in a semi-religious home: I was made to go to church when I was young. I didn't like the church I was brought up in. When I finally started to get the spiritual part of the AA program I had to give up the control of God, or the thought of controlling God. So I changed my way of praying just as I tried to change my way of thinking. I never tell God now what I want; I'll tell him what I need and I seek his will. And I'm content enough to say "Your will be done." I don't struggle with it anymore.

Other respondents were afraid that AA would impose its own version of a higher power or would inflict a religious "brain-washing program" on new adherents as this respondent put it:

> My family thought I had joined a cult when I told them I was in AA. My language changed. I used to curse and swear a lot. Then I started using phrases like 'easy does it' and 'let go and let God.' The changes in my life were so dramatic that everyone thought I was brain-washed.

On the other hand, some respondents were much more comfortable with the spiritual language of AA because of their prior religious upbringing or current involvement with religion. These subjects, both from conservative, evangelical Christian backgrounds, brought their own faith constructs to step two. These quotes demonstrate how individuals index material from their own lives into the concepts, ideas and principles of the AA program:

> Turning my will over to God wasn't really a problem for me - at least what this means on an intellectual level. It was something I'd been exposed to in my Pentecostal faith. To me, this means saying God, I can't but you can. I'll leave my life in your hands today.
>
> It's so counter cultural to the idea that you're supposed to fight the good fight. Surrender doesn't mean that I'm giving up my life like when people say 'that's it.

> I can't handle it anymore.' I'm actually taking back my life. It reminds me of a song by one of my favorite contemporary Christian singers - Carrie Underwood. She wrote "Jesus take the wheel because I can't do it anymore." And that's what Step Two means to me - that I can't do it anymore.

The word 'sanity' in Step Two has mental health/mental illness connotations. However, for respondents, the term was used much more broadly to describe a range of alcoholic behaviours. Jen's description of insanity was a common refrain I heard often in the fellowship:

> Insanity for the alcoholic means doing the same thing over and over and expecting different results. For me, this meant binging just about every weekend, going home with men I hardly knew and hoping that my life would somehow turn out differently. Change didn't come to my life until I stopped drinking and changed everything about the way I lived including how I get into relationships with men.

Another respondent framed insanity as "stinking thinking" a common euphemism heard in AA circles:

> My insanity had to do with my thinking. In AA, we call it 'stinking thinking.' My mind was always racing… always afraid of the future… or always stuck in victim mode, thinking about how much everyone else was making my life miserable.

"Doing the same thing over and over again" reflects the compulsive nature of alcoholic behaviour and "stinking thinking" in AA parlance describes the cognitive style of recovering alcoholics. Denzin (1987a, 1987b), in his studies of alcoholism, described stinking thinking as a cognitive style that is repetitive, obsessive, isolated, often resentful and fearful. In the *Twelve and Twelve*, Bill W. suggests that the twelve steps offer a pathway to a sound mind and an antidote to the insanity of alcoholism:

> What can we believe in? AA does not demand belief: Twelve Steps are only suggestions…like pulling the ripcord on the parachute when you jump…Defiance

> is an outstanding characteristic of alcoholics. Step Two is a rallying point to sanity…sanity is defined as soundness of mind…Right relation to God (Bill W., 1952:53-55).

Step two directly deals with the acknowledgement of a higher power, which some respondents chose to call God, but others acknowledged with different spiritual terms. In Step three, recovering alcoholics are encouraged to turn to a God of their own understanding, which, as we shall see, is wide open to interpretation.

Step 3: Made a Decision to Turn Our Will and Our Lives Over to the Care of God as We Understood Him.

The Big Book begins its discussion of Step three with these words, which is known in AA as the Third Step Prayer:

> Many of us said to our Maker, as we understood Him, "God, I offer myself to Thee- to build with me and to do with me as Thou wilt. Relieve me of the bondage of self, that I may better do Thy will. Take away my difficulties, that victory over them may bear witness to those I would help of Thy Power, Thy Love and Thy Way of life. May I do Thy will always!" We thought well before making this step, making sure we were ready; that we could at last abandon ourselves utterly to Him. We found it very desirable to take this spiritual step with an understanding person…But it is better to meet God alone than with one who might misunderstand. The wording was…optional so long as we expressed the idea, voicing it without reservation (AA World Services Inc., 2001: 63).

Step three is considered a more drastic and all-encompassing surrendering of personal will. The second step implies a willingness or openness to spirituality; to some higher power. Step three now asks the recovering alcoholic to go one step further: to turn their will over to this higher power of their own understanding; thus making spirituality the core of self. It is a turning away from a destructive power – alcohol - and a turning

towards some higher power that is constructive, life-affirming and based on spiritual growth.

A number of respondents reflected that their sponsors were critical in helping them understand and implement this step. Mary, an AA member for 15 years, remembered saying the Third Step Prayer with her sponsor after being part of her local home group for several months. Saying the prayer was another important rite of passage which signaled Mary's commitment to the philosophy of AA:

> My sponsor invited me to kneel down next to her and we recited the Third Step Prayer together. She explained that in doing this, I was demonstrating my readiness to do the work of the twelve steps. And she also explained that I was free to choose my own concept of God as I understood Him. This was very comforting for me.

Another respondent recalled spiritual advice from significant others within the fellowship on how to work step three:

> When I first came into AA I really struggled with this idea of a higher power. I'd listen to people talk about God and it was obvious that I couldn't relate. Finally, some old-timers took me aside and said "Joe, we can see you're really struggling with this... seeking help for your higher power is different for everyone. Your higher power can be anything you want it to be. Maybe you can think of the group as your higher power." And that's where I started. I became open to the idea that the group knew more than I did; that the group could be my higher power and help me get better.

The first three steps involved a surrendering to the idea that one was an alcoholic and in need of a higher power to recover. The appropriate emotional display of the newcomer or 'initiate' as s/he separates from the drinking culture and enters the world of AA is reflected in the penitent role, discussed in the previous chapter. Displays of shame,

regret, guilt and humility carry into the next stage of the transformational process but these are gradually replaced with feelings of hope and optimism that one can recover from the ravages of alcoholism.

6.3 The Transition Stage and Steps Four to Eleven

The fourth step reads, "*Made a Searching and Fearless Moral Inventory of Ourselves.*" This step was described by respondents as a turning point in the AA program of recovery. Step four required a different type of work, one that required the recovering alcoholic to turn inward to continue the transformational process. At this stage, the AA member is betwixt and between physical sobriety and the ultimate goal of contented sobriety which is the promise of working all twelve steps.

According to Turner (1973), at the liminal stage group bonding is reinforced as the initiates undergo standard processes of testing and humiliation. Respondents in this study suggested that step four was perhaps the most difficult and humiliating step to complete because it forced them to examine the misdeeds of their pasts. As a test, many respondents pointed to step four as the point at which most people are most likely to exit the program. This old-timer reflected this sentiment:

> When I started this journey by doing the steps, one of my biggest hang-ups was step 4. I would say at least 50% would get caught up with step 4. Now the first three steps, there's no physical work whatsoever. It's all in the mind - how you think, how you feel, how you see. But step 4 tells us we have to write out our moral defects. For most of us, this includes anger, greed, pride, gluttony, lust, sloth, envy - the seven deadly sins. Then we list the people we resent, we fear and hate, we lust after etc. When I did my fourth step, I had many resentments. A resentment is like smoldering anger, and I had many people who I hated and who I was angry with....so I had to write their names down, along with a brief

> description of what they did to me that made me angry. Likewise, I had used a lot of women sexually in my life. I lied to them, cheated on them or was just plain selfish sexually. So I had to put this on my list as well…who I had harmed sexually and how I harmed them. I also had lists for other harms: property I destroyed, money I'd stolen, debts not repaid…by the time I finished this step, I had about 20 pages of items related to my character defects.

Step four offers a practical and highly structured exercise for self-transformation compared to the first three steps. Chapter five of the Big Book describes how to do a searching and fearless moral inventory and the internet contains many websites devoted to explaining this important step. Among my respondents, there was a considerable range of methodologies for compiling an inventory. The majority tabulated their moral shortcomings and flaws or 'defects' as they are described in the Big Book. There were tables for each of the following categories: resentments, faults, fears, sexual injury and harms. These respondents explained the processes they undertook to work this step:

> That dreadful step… I made a searching and fearless moral inventory. To me, that means looking back over your life and taking an inventory of everything that has happened to you and that you've done, identifying any main factors or figures which impacted your life - such as parents, siblings, girlfriends, friends, wives, employers and all of your significant relationships and trying to find your responsibility in it but also finding things that they may have done that you have a resentment towards and bitterness towards. And you need to put this on paper so you can see your patterns of behavior.
>
> People make that into a big thing. It's the 4th Step. It's horrible. It's going to make you do this. It was explained to me by my sponsor that the 4th Step would show me my patterns and it's written in front of me on paper.

Other respondents wrote out their life stories in autobiographical form to complete step four. Some respondents reported that this step took them several days to complete; others reported it took years! Some respondents completed step four completely on their

own; others with a sponsor or professional counselor. Comments such as these reflected the broad range of experiences in working step four:

> Step 4 became easier with time. But it took professional help for me to get to this step. I couldn't do that on my own. I did this work with my addictions counselor. I asked her to help me with my AA program and she was quite willing. So I would say it took me a couple of years to work through the first four steps of recovery. She encouraged me to write a letter to my mother who died when I was 8. I wrote it and asked her to read it and we talked about it. I cried and cried. Then I took the letter to the graveyard and I read it out loud to her. And I cried some more. I spent two and a half years in counseling reliving all of the hurt and pain I experienced... it was like staring into a pit but it had to be done.
>
> I spent three months in a treatment center in Ontario so this step came out mostly through talk therapy. I did much of this by talking but I also did psychodramas and art therapy. The treatment center didn't call this step four work but I definitely saw a correlation to it. I saw that at a very young age I began to shut my heart off and be cold. I saw this happening from the age of 2. I saw it again when I was between 7-10 years old. I saw tragic events.

During a step meeting, there was a lively discussion about the right way and the wrong way to work step four. Participants at the meeting reported that it was important to be as thorough as possible and to practice rigorous honesty. It was also suggested that the sooner the recovering alcoholic can get their defects out of their heads and onto paper the sooner they would start to feel sane. Aside from these guidelines, I recorded some observations on the wrong way to do a step four in my field notes:

(a) Spending too much time writing out your story or compiling your inventory. As one AA member put it, "it's not about writing a best-selling novel. It's about getting the junk out of your head in the fastest, easiest way possible." The danger

with spending too much time writing your story or compiling your inventory was getting stuck in the past.

(b) Omitting character defects because of shame, fear, embarrassment or guilt. Failing to practice rigorous honesty.

(c) Failing to keep the inventory private and out of view of prying eyes. One participant shared how his wife found the papers he had used to write his inventory. As he said, "I had a lot of explaining to do when she saw the names of women I had had affairs with."

(d) Not seeking help from a sponsor or an experienced AA member when the person is not sure how to work step four.

(e) Skipping ahead to step five and confiding in your sponsor without having made a list first.

Respondents reported other difficulties with step four work during in-depth interviews:

> Step four is not about beating yourself up. It's not about focusing on your negative traits. Some step four guides suggest doing a positive inventory as part of this step; that is, writing about your strengths of character, your gifts, your contributions, your virtues. I think that's a good idea and my sponsor suggested this in my case. He was a store owner and the way he explained it was that his store inventories required him to account for everything in his shop: goods that were spoiled or damaged or goods that were in good condition. Same thing with a character inventory - so this helped me to get a more balanced and realistic assessment of myself.

Another respondent saw unbelief or a lack of faith as a barrier for completing step four:

> I didn't want to do a list of my character defects. But if I had done the first three steps completely and thoroughly I wouldn't have any problems with the fourth step. But my problem was step 3 - making a decision to turn my will and my life over to God as I understood Him. I turned my will and my life over to God but I

> took it back again, almost instantly. If I faced some problem or stress I would turn it over to God and say "ok God, this is in your hands now...You take care of it." But then fear would set in and I would take the wheel. And I would do that with so many situations in my life.

For those who reported having completed step four, there was a sense of catharsis and relief in acknowledging their pasts and identifying their moral flaws and character defects. Some described it as "cleaning up my side of the street," or "cleaning the wreckage of my past." It is also a humbling step as the AA member investigates his or her past with an aim to identify behaviour patterns that negatively affect their lives. Step five continues this process of self-discovery.

Step Five: Admitted to God, To Ourselves, and to Another Human Being the Exact Nature of Our Wrongs

Step 5 involves a confession of the Fourth Step inventory. As an act of confession, it is an admission to self, to one's higher power and to another person about one's past misdeeds and wrongdoings. The Big Book recommends that individuals working step 5 should carefully choose whom they should confide in. Once the person discloses their personal inventory, they are then instructed to return home and meditate for one hour and to contemplate if they have left anything out of their inventories. After this period of meditation, individuals are to return to their confessor if they discover there are parts of their story or their inventory which might have surfaced and that need to be discussed in more detail.

The completion of step 5 should result in a type of psychic cleansing as it is described by Bill W. in the *Twelve and Twelve*:

> Provided you hold back nothing, your sense of relief will mount from minute to minute. The damned-up emotions of years break out of their confinement, and miraculously vanish as soon as they are exposed. As the pain subsides, a healing tranquility takes its place. And when humility and serenity are so combined, something else of great moment is apt to occur (1952: 62).

All of the respondents who completed step 5 acknowledged the healing benefits of sharing their stories. For many, step five resulted in a reduction or removal of stigma and shame associated with their pasts:

> Talking to another human being gave me joy, comfort and peace that you don't have these secrets inside anymore. It's shared.

> In order to be satisfied with my moral inventory I shared my love, my anger, fear, hate - I shared all of that with my counselor. That in itself relieved me from the bondage of self. When I wrote out my life story and I shared it with my counselor I was a free man. It was a load lifted off my shoulders.

Fear and anxiety were common emotions which had to be worked through in order to complete step 5. After all, as this respondent suggests, the person who is asked to hear a moral inventory will end up hearing very private details and information about that person's past; details which are sometimes not known even by the most intimate significant others. This respondent noted some of the things that can go wrong with step 5, especially when the sponsor is the person who hears the confession:

> You're sharing your life and your most intimate secrets and the person hearing your inventory could share it with somebody else. I've seen this in AA and it's devastating. And this is why it's so important to choose your sponsor carefully because you are encouraged to do these steps with your sponsor. I've seen people come into the rooms of AA and after two days they have a sponsor. They don't know this person, they just heard this person speak, they didn't know nothing about them and they share stuff with them and it backfires on them. I'm really careful who I share my life with.

Another respondent identified the personal qualities one should look for in a confessor and the need to find someone who can identify with your story:

> It tells us in the Big Book that we should be careful about who we choose to take this step with and that they should have an idea of what we are trying to do. And if I do it with someone who is not aware of the program or who doesn't appreciate the goal of the fourth step, then I'm not going to get the full benefits of this step. With my sponsor, he knows what's involved with this step, he's done it himself, and he can help. And he can be honest with me too and call me out on stuff and help me realize what's beyond what I just said, that my words belie something deeper than what I've just related to him. Also, he's able to share with me his experiences with alcohol, with this disease. That's really important. To know that I'm not alone, that I'm not the worst person in the world, that the things I've done have been done by other people. There's a type of mutual disclosure in this. I say, "this is the worst thing I've ever done." Then he says, "well, you think that's bad," and immediately, this gives me a sense of relief.

From the sponsor's perspective, helping a sponsee with step five was an equally humbling experience. It puts the sponsor in the role of confessor and confidante but also provides an opportunity for the sponsor to share part of their story to connect with, and identify with their sponsee:

> I've heard a couple of fifth steps too. And to be able to do that is a gift. To think that the worst thing that I've thought I've done can actually be used to help somebody. That's one of AA's promises - to discover that no matter how far down we've gone, we have experiences that might be able to help other people.

Another female sponsor recalls an occasion of hearing the fifth step from her sponsee:

> My sponsee did her fourth and fifth steps with me. I know everything about her - about her history, her relationship with her mother, her children, her relationship with her ex-husband. For her to trust me with that was a privilege. I had to assure her that her story would stay with me. I told her there would be no benefit to me talking about her, about divulging her story to anyone. In AA, it's called anonymity but to me it's about trust. If I shared her story with anyone, she might relapse and start drinking again.

There was some debate during step meetings, and reiterated during interviews, about the best person to confide in and to share a personal inventory - whether that person should be a sponsor, counselor, clergy or friend. This respondent selected a priest out of concerns that his privacy might not be respected by a sponsor:

> During one of my forays into church, I contacted a priest and did my fourth and fifth step with him. Personally, I don't think you should do this step with a sponsor. Your sponsor could get drunk and divulge your secrets. But a priest seems to have more accountability and there's probably less likelihood they will share your secrets.

Another respondent also selected a minister to work steps 4 and 5, choosing a road trip to St. John's as a venue for confession:

> A friend of mine gave me a guide to doing step four. It suggested writing out your resentments, fears and character defects. So I wrote down my resentments and I went over them with my minister during a road trip. We would travel to St. John's from our home community and back (about 2 hours) and I used one of those trips to discuss my resentments. Another 'road trip' covered my character defects. I travelled with my minister to town and talked about my character defects. And I had to go back to my minister and ask for another road-trip to deal with the sex part. I figure this one is probably going to take at least three trips to town.

In addition to admitting your wrongs to a human being, Step 5 suggests that the recovering alcoholic admit their character defects to their higher power; to the God of their understanding. These two respondents offer reasons for this practice, based on their interpretations of Christian theology.

> I admitted it to God. That's a funny concept because God is all-knowing anyway so my story is not a surprise to him. He still wants me to admit it to him. It's like in the New Testament where Christ asks Peter, "Peter do you love me?" He asks him three times. God knew Peter loved him but he wanted him to say it. And it's powerful when you say it yourself. Peter needed to hear his own voice. And I

needed to hear my own voice tell my story. There's a certain emotional tone that I have with God that I don't have with anybody else and a lot of times it's a tearful one because He understands my heart so I choose to open my heart to him and let him in. It's admitting it to him and admitting it to myself because when I say it out loud to him I'm also hearing it myself.

I found it easier to confess to God because I could stand in a room all by myself and talk out loud. Nobody else is there. But it's not enough to just pray to God about your past. Because for the first two years of AA, I was avoiding steps four and five. I used all kinds of excuses. I told myself "I'm a Christian. All of my sins are forgiven anyway." But the point is the twelve steps are suggested as a program of recovery and if I don't do all twelve steps I'm afraid I'm going to go back out. And I believe these steps are supported by the bible with the command to confess your sins one to another.

The Big Book recommends a period of meditation after the confession takes place. For this respondent, the failure to take some time to reflect and meditate resulted in an incomplete healing and, in his mind, contributed to a relapse:

> The Big Book says that you should go home immediately after this step and give thanks to God and spend some time reflecting on how far you have come. But I didn't do this. I had done what I felt was the hardest step and I felt that I had arrived. And right then and there, I stopped. I didn't progress beyond this. I did a little bit of one and a little bit of twelve. I'd share at meetings and I'd do a few twelve step calls. And I stayed sober for four years on this basis. It was just the fellowship that kept me going. I used to go fishing with my AA pals, play sports, socialize. So after my relapse, I came back to the steps again. I did another four and five. This time I wrote it all out. I saw another priest and came out of there. I had that same euphoria after confessing. But this time I went back to my home. I took out the Big Book and I did exactly as it recommended. I reflected on everything that I had done and then I moved on and did step six.

A number of respondents reported that after Step five, they experienced a spiritual experience or awareness. Many felt for the first time that their minds were no longer mired in guilt and shame from past misdeeds. This old-timer described steps four and five

as the beginning of serenity and peace, emphasizing that the work of the remaining steps still had to be completed:

> Step Five was a real turning point for me. I had been carrying around all of this pain. My mind was never quiet or settled. I was always dwelling on the past or my thoughts would be swirling with all kinds of fears and worries about the future. I would remember things I had done that made me feel ashamed. But writing out my inventory and sharing my story with another human being allowed me to deal with the wreckage of my past and get ready to build a new future.

Another respondent also emphasized the spiritual nature of these steps, and like many others in the fellowship, recognized that these steps are meant to be practiced on an on-going basis. They were never meant to be performed as a 'one-shot' deal but would have to be revisited, perhaps many times, over the course of a lifetime:

> Steps four and five are very important. I did these steps 8 or 9 years into my sobriety. At the time, I felt really good. But I'm way overdue to do another step four and five because I've been sober for over 30 years and I'm now more aware of my character flaws and defects and feel the need to talk about more of my mistakes. This time when I do it, it will be much different. This time I can be more honest with myself. I realize that no matter how professional or well educated your helper is, you can only be helped if you're willing to be helped.

Steps four and five were described as major challenges in the transition to becoming a recovering alcoholic. Many respondents observed that AA members seemed more likely to drop out of the program at this point than at any other stage. It is impossible to determine whether or not this perception was accurate since no study has tried to identify the step at which attrition from the AA program is most likely to happen.

The data relating to these steps demonstrate how AA members indexically read things from their own lives and social milieu into the principles of the AA program.

particularly as they relate to the work of these important steps. As a liminal experience, these steps also symbolized a break from the past and a new orientation toward the future. This focus on the future is reinforced in the rituals associated with steps six and seven.

Step 6: Were Entirely Ready to Have God Remove All These Defects of Character And Step 7: Humbly Asked Him to Remove Our Shortcomings

Steps six and seven are performed together. The Big Book offers very little guidance on how to perform these steps, devoting only two short paragraphs to them, compared to the pages and even chapters devoted to the other steps. While the first five steps can take considerable time and effort, sometimes lasting years, steps six and seven can be performed in a single day. The work of steps six and seven involves reciting a prayer, known in the fellowship as the seventh step prayer:

> My Creator, I am now willing that you should have all of me, good and bad. I pray that you now remove from me every single defect of character which stands in the way of my usefulness to you and my fellows. Grant me strength, as I go out from here, to do your bidding. Amen.

The time initially spent saying this prayer does not accurately reflect the difficulty of working this step. In fact, many respondents reported that steps six and seven proved to be the most challenging throughout their recovery. This respondent's experience with these steps illustrates this point:

> When my sponsor explained steps 6 and 7, I thought he was joking. All I had to do was say a prayer to complete these steps? The first line of step 6 says something like "this is the step that separates the men from the boys". And when I first came around to AA, I stopped at step 5 and couldn't continue on. To my mind, step 6 & 7, along with 8 & 9, are critical. That's where the changes happen. Just as I needed help with my alcohol, I need help with these defects of character.

> It's now part of my morning meditation. I say the serenity prayer. I say the 3rd step prayer and I say the 7th step prayer. You know, I'm willing that God takes away every single defect of character that gets in the way of usefulness for service to others. And I start my day that way because I need help.

The ritual of saying the seventh step prayer is a continuation of the intense transitional/liminal experience through which one is "revitalized," and "inwardly transformed and outwardly changed" (Turner, 1992: 48-49, 129). Identifying character defects and working to remove them - takes a lifetime of work. This respondent sums up the necessary requirements to work these steps: willingness and humility.

> Those steps - 6 and 7 read "we were entirely ready..." There are only a few lines in the Big Book describing this step because it's so simple. The key word here is ready. We have to be ready to remove our defects and to humbly ask God to remove our shortcomings. My shortcomings involved my impatience and my anger. Ordinary things like standing in line-ups or having to exchange items at the department store. Those things used to drive me crazy. I would become enraged. I still do have a quick temper if I allow others to rent space in my head or get under my skin. But it happens a lot less.

Recognizing that steps six and seven involve a life-time commitment to self-improvement, some respondents developed a systematic strategy to work on their character defects. One respondent announced publicly on his AA birthday celebration which defect he was going to tackle:

> Every December, when my birthday rolls around, I tell my group which defect I'll be working on. I want them to know that my life is still a work in progress. So last year I told them I'd be working on my impatience, especially my impatience behind the wheel. I'm learning to relax more behind the wheel. And when it comes to waiting for my wife, I make sure I always have something to read...it makes waiting a whole lot easier. These changes tell me that I'm growing.

Another respondent took a similar approach, targeting his "foul language" as a character defect he wanted to work on. However, he reserved the right to use profanities for strategic effect:

> Step six involved me writing out my character defects and I try to shrink it every year. I started out with about 30 defects I could identify. Every morning I reflect on these defects during my morning meditation. For example, I identified cursing and swearing as a defect. I'd use the f word about 50 times a day. Now I might use it once every two weeks. A lot of times it comes out at AA meetings. I'll sprinkle my language with the f word. There are bankers, teachers, lawyers but there are also drug addicts, bikers and criminals in the rooms… and once in a while, everyone needs to hear the word fuck.

Step 8: Made a List of All Persons We had Harmed, And Became Willing to Make Amends To Them All And

Step 9: Made Direct Amends to Such People Whenever Possible, Except When to Do So Would Injure Them or Others

Steps eight and nine are listed together in the Big Book and deal with the need to make amends to others who have been harmed in some way by the alcoholic. One dictionary defines amends as "reparation or compensation for a loss, damage, or injury of any kind: recompense" (dictionary.reference.com). In AA, making amends means taking responsibility for one's actions and attempting to make right a wrong.

Step eight also involves another written assignment. It simply asks that the person complete a written list of all persons harmed. It is a completely subjective experience as it relies on the individual's perceptions and memories of others who might have been harmed. For many respondents, the work of compiling the list of potential victims already started earlier with step four:

> I made that list and part of that list came from step 4. That's all step 8 asks. So I reviewed my inventory from step four. drew up a list and I added a few more names of those I remembered hurting or was aware of hurting.

For other respondents, the list of all persons also included organizations and institutions. Steve, a former police officer, identified the police force on his list for step eight. Others included their employers and even government agencies:

> I had to list the police force in my list of harms because I disgraced the force because of my addiction. I stole pay cheques from my fellow officers. My story was featured all over the news and I know I discredited a lot of good police officers in the process and damaged the reputation of the force. So I had to come clean and owe up to my harms.
>
> I stole money from my employer years ago. I had to list this company on my amends list as persons I had harmed.

The first part of step eight simply requires making a list. The second part asks the recovering alcoholic to "become willing to make amends to them all." Some respondents appreciated the fact that they could first compile the list of all persons harmed, even if, at this stage, they were NOT willing to make amends. For these respondents the willingness came later:

> I had quite a long list of people and groups I had harmed. I would write down a name and ask myself "did I really hurt that person? Maybe I was just defending myself? Maybe they deserved the treatment they got from me? And I had a good talk with my sponsor about this and he suggested that I was making it too complicated. Just make a list first, he said. If you think you harmed them, write it down. He pointed to the word "all" as the guideline here. I needed to list "all harms" – whatever came to mind: real or imagined. That's all this step asks of you. And I took his advice and came up with this big list. Then I spent about the next week just asking myself, "am I at least willing to make amends?
>
> When I first started step 8, I began to worry. What will this person say when I ask them to forgive me and try to make amends? What if I'm drudging up old wounds? But I put these worries aside long enough just to identify those names.

> And this was important because I could no longer deny the harms I had created with my drinking.

One respondent opted to make a mental list to cover his marital infidelity, fearing the consequences of his wife finding a written list:

> I had a mental list for sexual harms. I didn't want to write anything down because I thought it would be too incriminating. I had a lot of affairs with a lot of women. My wife knows about most of them but I didn't want for her to ever find a written list.

Once the list is completed, step nine requires that direct amends are made to those who were harmed by the alcoholic. Respondents reported that they experienced initial fear and resistance to this idea for various reasons. Some were concerned about others' perceptions:

> When you write down the names of people you hurt or offended, you admit to being an asshole in your own mind – to yourself. And then when you approach them to make amends, you're admitting to them that you're an asshole which is a different thing altogether.
>
> Step 9 is like coming out of the closet on so many levels. I not only admitted to myself but in seeking to make amends with others, I basically admitted to them that I was a thief, an adulterer and a liar because I had initially denied all of my wrongdoings.

In discussing how to carry out step nine, the Big Book recommends that the recovering alcoholic seek guidance and support from his or her sponsor because a number of things can go wrong. The wording of the step is significant in this regard as it points to the possibility that, in the attempt to make amends, "to do so would injure them or others." For some respondents, this meant living with the guilt of having committed a

wrong and acknowledging that the victim would have to find some sense of closure in their own way:

> There's a reason why you don't do 8 or 9 right away. Because you need time to reflect and to go over your character defects so when you get there you don't rush into it because you could hurt more people. In my case, I would have affairs and throw these women aside. My concern was that if I called these women one of them might call my wife back. That would hurt my wife. Step 9 advises that sometimes you'll have to carry certain guilt and misdeeds with you. You just have to leave these amends in the hands of God.
>
> I had one bad experience. A couple of people took a while to come around and grasp what I was saying. One told me to fuck off and get out of here. But I did my part. I attempted to apologize but he didn't want to accept it. So I just said, thanks for listening and walked away. But I cleaned off my side of the street. His unforgiveness is his issue to deal with.

Respondents reported a number of different ways of making amends: making direct personal contact, making a phone call or writing a letter or email. In some cases, amends could be made during a single visit or encounter. In the case of making amends to family members, respondents reported that this required on-going, sustained efforts:

> With my wife and my children I also apologized but I have to show them that I'm sorry. I make amends every day. I go out of my way to do something extra for them. I still feel a lot of guilt as a father. My daughter was three when I got into AA and began my recovery so I've got at least three years to make up for in her life. So instead of saying "I'm sorry, I'm sorry" each and every day I just try to show it and make up for it in special ways. I do the same thing with my son who's now 9 years old. At night time, I turn off the TV and the games and I'll lie on his bed and talk with him for 30 minutes or so. So that's my way of making amends to my son.
>
> I damaged the careers of some colleagues because of my resentments and vindictiveness. I was well known and widely admired within our organization and had written papers and policy manuals and held senior administrative positions so when I called someone a screw up or questioned their competence this definitely

had an impact on their professional lives. But after a few years in AA, others started noticing changes and asked me to become a training manager. I had more compassion and more faith in people and that was reflected in the way I behaved as a manager. And I decided to go back to all my colleagues and I apologized to all of them, especially the managers and supervisors who I had belittled in front of everyone. I had to apologize to these colleagues and express my sincere apologies.

The timing involved in making amends was another issue which respondents had to address in working this step. For some, it seemed appropriate to contact the offended party(s) right away; others recognized that it would be better to wait so as to avoid potential injury. These comments reflect some of the considerations around when to make amends:

> What I've learned is that you need to go in order. There are certain things that you shouldn't jump into right away...like step 9 - making amends. If I tried to do that right away I believe I would have hurt them. I've heard some members tell me to wait at least one year before making amends but I had to make one yesterday morning. It involved a relationship in my church with a man who I had deceived two years ago while I was actively using drugs and alcohol. I had asked him for a loan of some money and lied to him about how it was to be used. I told him it was to help pay for rent and food for my family. I used it to buy drugs and alcohol. So that was really eating away at me since I returned to church and I felt I needed to clear the air between us to remove the awkwardness between us. I couldn't keep facing this guy every Sunday, knowing I had lied to him and taken his money. So I apologized to him and admitted everything. In that situation, it didn't seem like a good idea to wait.
>
> The only people I really focused on were close family members. There might have been other people I harmed but chances are, they probably contributed to the harm. I remember when I was 18 years old I got into a fight with this fellow. I could be losing sleep over that because I'd have to find him and apologize. But he moved away over 20 years ago! So I had to remind myself that I'm not God and that after 20 years he probably doesn't even remember me smacking him in the head. He's probably moved on with his life so should I. So I can't dwell on that.

The ritual of making a list of those harmed and proceeding to make amends was described as a humbling experience for respondents. It was this shared experience of humility that also helped to forge a sense of community among AA members. Turner (1967: 99) emphasizes that the breakdown of the social distinctions which delineate people and separate us from one another leads to a strong sense of connection between participants during the liminal phase. Through such rituals as acknowledging those harmed and making amends, AA members engage themselves in an intense experience characterized by a sense of "the generic human bond" and "a strong sentiment of human kindness" which Turner calls "communitas" (Turner, 1969: 97, 116). The shared experience of working Steps ten and eleven continue to strengthen these bonds of communitas.

Step 10: Continued to Take Personal Inventory And When We Were Wrong Promptly Admitted it

Step ten is often referred to as the first of the three "maintenance" steps which also includes steps eleven and twelve. The instructions for this step are as follows:

> We continue to take personal inventory and continue to set right any new mistakes as we go along...This is not an overnight matter. It should continue for our lifetime. Continue to watch for selfishness, dishonesty, resentment, and fear. When these crop up, we ask God at once to remove them. We discuss them with someone immediately and make amends quickly if we have harmed anyone. Then we resolutely turn our thoughts to someone we can help (AA World Services Inc. 2001: 84).

Respondents reported that they carried out the tenth step in a variety of ways: some said prayers, others kept a journal or wrote out their tenth steps on a daily basis.

Some consulted with a sponsor to find a method which seemed to work for them; others after a period of experimentation:

> So the key word in step 10 is promptly. If I do something wrong, if I don't fix it or make amends promptly, right away, I won't sleep. I'll worry about the person I offended and it will be on my mind. If I don't make amends I'll try to avoid you, I'll be ashamed and feel guilt. That makes me cranky and irritable with my wife and family. That's a burden, a festering sore I create for myself. I become a walking time bomb ready to explode at anybody I perceive to be doing me wrong. So if I fix it right away, I can put it away. That allows me to move on and be helpful to others.

Several respondents in my study were involved in therapeutic services outside of the fellowship and they perceived this involvement as working the maintenance steps. These subjects viewed AA as "part of their medicine" for the treatment of their addiction. Two respondents, in particular, cited the enormous benefits of their E.A.P. plans (Employee Assistance Program):

> I was fortunate as a police officer to have so many resources put in place to help me with my addictions. In that sense, I'm extremely lucky. Within the police department, I had speedy access to a departmental psychiatrist, a psychologist and a social worker. They were all very instrumental in helping me to beat my addiction and to get well.
>
> As a federal employee with the Department of Transportation I had a very good EAP program. It offered free, confidential and competent professional help. I used these services for three years while I was also attending AA meetings and doing the steps. I don't know if I would have made it without these additional resources.

In the step meeting devoted to step ten, many participants emphasized that this step should be performed on a daily basis. Michael, who facilitated the meeting, read a passage from the Twelve and Twelve to make this point: "It is a spiritual axiom that every time we are disturbed, no matter what the cause, there is something wrong with us" (Bill W. 1952: 65). He went on to say that alcoholics have only a daily reprieve from their

disease and that sobriety is contingent on the maintenance of one's spiritual condition. Others picked up on this theme and made further comments that step ten encourages them to be watchful and vigilant every day because the disease of alcoholism can be so "cunning" and "baffling." Therefore, the alcoholic must look at their shortcomings and behaviours on a daily basis in order to maintain their recovery.

Step 11: Sought Through Prayer and Meditation To Improve our Conscious Contact With God as We Understood Him, Praying Only for Knowledge of his Will For Us and the Power to Carry That out.

Step eleven is another maintenance step which is designed to be worked on a daily basis for a lifetime. Carrying out this step is presented as a remedy for the "racing, unquiet alcoholic mind" referred to in the Big Book. In terms of how to pray and meditate, the Big Book encourages individuals to look at their own religious background or current affiliations as a starting point:

> If we belong to a religious denomination which requires a definite morning devotion, we attend to that also. If not members of religious bodies, we sometimes select and memorize a few set prayers which emphasize the principles we have been discussing. There are many helpful books also. Suggestions about these may be obtained from one's priest, minister or rabbi. Be quick to see where religious people are right. Make use of what they offer (AA World Services Inc. 2001: 58).

Respondents reported practicing this step in different ways and with differing frequency. Comments such as these reflect the variety of experiences with prayer and meditation:

> I didn't practice any kind of religion growing up. I would try cutting deals with God as if to say "well God, if you get me out of this, I'll never do it again." But when I got sober, I started praying "give me the strength to get through this day without taking a drink." And I would get through the day and then I would kneel

down by my bed and say "thank you for giving me the strength for getting through the day." And then the next morning I'd repeat that. I've been doing that now for 20 years.

If I talk to God, it gives me a sense of security. Many times in a day I might say "Well God, if you're there help me with this problem or this person." Sometimes I'll wait for an answer and sometimes the answer is right in front of me. Sometimes, just by stopping and taking that little time to think and meditate and to ask for guidance, the answer comes. So it was always there but I was moving too fast to recognize it. So when I slow down, step back and think, the answer is often there.

One respondent was an avid outdoorsman and sought time alone in nature to fulfill this need for prayer and meditation:

Step 11 has become easier for me over time. Even before I became involved in church, I had always been pretty good at taking time for myself by going into the woods, enjoying nature, even taking a few moments in bed or out on my front deck. But I appreciate nature. I would look out over the ocean...these quiet times would be my times for meditation. I would say out loud or quietly, "thank you Lord for giving me this quality of life. It's second to none." I'm on disability but I'm so lucky. I can still be fairly active by going fishing, riding my ski-doo and enjoying the outdoors...These are ordinary things that I didn't fully enjoy before. But now I do.

Some respondents developed highly habitual, ritualistic methods to pray and meditate: others adopted more of an 'ad hoc' style. I discovered during interviews and heard at step meetings that many individuals incorporated AA prayers, readings and texts into their spiritual rituals and routines:

For Step 11 I use the step 3 prayer, the step7 prayer. I use the St. Francis prayer from the 12 & 12 I use the "Our Father" sometimes, but this sometimes turns me off. I use the Serenity Prayer. I provide good thoughts and I pray for people who are going through hard times. I've also learned that when I focus on another person's fault, the fault is usually present in me.

> I don't have a ritual like some people. When I'm alone I'll read my literature with my tea. When I wake up I ask God that He will give the courage and strength to face whatever the day brings. And at night I'll thank God and review my day and sometimes I'll fall asleep before I finish. Somebody told me that means I'm contented.

Steps ten and eleven reflect important dimensions of the liminal experience. Many aspects of the AA experience are encompassed in Turner's (1969: 96) descriptions of communitas – sacredness, humility, simplicity and an altered sense of time. The rituals of prayer, meditation and the tenth step inventory are to be performed on a daily basis, in accordance with the AA principle that sobriety is lived one day at a time. When the AA member maintains his or her program by working these steps on a consistent basis, the sense of communitas manifests itself as intense, positive feelings of "connection" and "being alive" (Turner, 1974: 202).

6.4 The Incorporation Stage and Twelve Step Work

Step twelve reads, *"Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs."* This step implies that the recovering alcoholic will experience a "spiritual awakening" as a result of having worked the preceding eleven steps. In the *Twelve & Twelve*, Bill W writes:

> What is a spiritual awakening? A new state of consciousness and being is received as a free gift. Readiness to receive gifts lies in practice of Twelve Steps...Joy of living is the theme of the Twelfth Step. Action its keyword. Giving that asks no reward... Love that has no price tag (Bill W., 1953:109-11).

As a rite of passage, the decision to become involved in twelve step work marked a new phase of recovery for the alcoholic and was a sign that one was fully incorporated

into the world of AA. In steps four to eleven, the AA member is engaged in a series of transformational exercises designed to help him/her make peace with the past and to take personal responsibility for the harms they have committed. In step twelve, AA members are called to focus on the other as opposed to the self by giving back to the fellowship. This focus on helping others in the fellowship would intensify the feelings of communitas and allow the AA member to return to the world outside of the rooms empowered by "...renewed creative energy, an expanded worldview, and a greater sense of hope..." in the words of Victor Turner (1974: 105).

For many respondents in my study, and from others I heard from in meetings, the key to maintaining recovery was in "carrying this message to alcoholics" or being of service. Service provided a release from the selfishness of addiction; the preoccupation with meeting your own needs at the expense of others. This philosophy was reflected by this respondent:

> We have a slogan, "in order to keep sobriety, we have to give it away." Since my first year of sobriety, almost 20 years ago, I got into service work. I got involved in the structure of the program and starting giving back to AA. Some of that service work goes from making coffee at meetings to doing 12 step work which involves picking up newcomers, taking them to meetings and sitting with them for hours and listening and sponsoring them. And I still maintain that part of the structure for my own sobriety as well as for others. I had to stay grounded with AA.

There are many ways to do step twelve work: becoming a sponsor, chairing a meeting, making coffee for a meeting, assuming a voluntary role (service roles will be discussed in the next chapter) or providing a ride to or from a meeting. Respondents gave me a number of examples of service work:

> I'll bring the Grapevine (an AA publication) to clinics and community centers. You can save somebody's life just by handing out a piece of paper.
>
> I volunteered to attend a service weekend. And I learned about the bigger picture of AA at this conference, about the role of the GSR, DCM (District Committee member) district offices, area delegates, New York and the General Service Office. AA has a multimillion dollar budget. If you're not involved in service work you might think AA is only about your little group. You might see your loony in the basket and think it only covers coffee and donuts. But part of your dollar goes to intergroup, the district or the GSO.

One special type of service work is the twelve step call. This work happens when a member of AA visits a person who has not yet joined AA but who appears to be a prospect. Referrals for twelve step calls might come from family members, counselors or friends. The Big Book offers some advice on conducting twelve step calls:

> Our twelfth suggestion is simply... carry this message to other alcoholics... discover a prospect; learn all you can about him; if it looks like he might want to stop drinking, talk to his wife; wait till he goes on a binge, then when he's in bad shape, talk to him; approach him not through his family but through a doctor or institution; see him alone if possible (that is, without his family, doctor, nurses); tell him about your own drinking career; make sure he's willing to believe in a power greater than himself; outline the program of action; if he's interested, give him the "Big Book" and tell him to read it; after he's read it, if he's prepared to go through the steps; if he is, make yourself available to hear his story – and here's the fundamental point: Burn into the consciousness of every man that he can get well regardless of anyone. The only condition is that he trust in God, and clean house... After all, our problems were of our own making. Bottles were only a symbol. Besides, we have stopped fighting anybody or anything. We had to (AA World Services Inc., 2001: 89-103).

Twelve step calls can present certain risks for AA members and for that reason, not all respondents were comfortable doing them. These two respondents described their experiences which involved risks of violence:

> I don't like doing that work. It's part of my recovery because I look at this person and I think "this was me or it could be me again." When you go to someone's house on a 12 step call it's like visiting a family which has just had a death. It's like a funeral but nobody died. The man might be sitting down at his table crying. His wife is crying. The children are crying. The house is in shambles. All I can do is visit and try to give a little bit of hope. I'll tell them a little of how bad I was of what I experienced. I tell them that they can change, that they don't have to feel like this. I'll ask 'do you really want help?'
>
> I had a fellow pull a knife on me and another beat up the furniture. But I just looked at them and asked "are you finished? Are you ok now?" My problem is that I'm not afraid of nothing or nobody so I put myself in those situations all of the time. But that's my comfort level. I function quite comfortably with violent men, with knives and stuff. I grew up like that. I used to have a vicious anger problem and I would sooner slug someone than talk to them. I've left many guys unconscious on the floor. So I'm comfortable dealing with individuals who are like me. I know them from the inside out.

Respondents offered many reasons for doing service work. For some, the business of twelve step work meant that they had little time to think about drinking:

> I knew my sponsee was really struggling with sobriety early in his recovery so I'd call him up all of the time and volunteer both of us to take on some project. One time, we helped a neighbor re-shingle her roof, another time we repaired a door for the local church, another time we stocked the shelves at the local food bank during Christmas because I knew he really struggled with the compulsion to drink around that time of the year. My reasoning for all of this volunteering was that we wouldn't have time to drink or even think about drinking if we were helping someone else. Plus it takes us out of our own head-space: our own selfishness.

Other respondents talked about how service work kept them grounded and helped them to cultivate greater humility, especially for those recovering alcoholics whose jobs provided a great deal of power and prestige outside of the rooms:

> I'm the boss at work, so I put myself in positions where I'm not in a leadership role. I rarely chair meetings. I'm not inclined to hog the limelight as a speaker. So I do the little jobs – I put a pot of coffee on: I set out chairs: I clean the garbage up

after a meeting. That suits me fine. More importantly, it helps me to work on my character defect of pride.

Service work also allowed AA members to accumulate social capital within the fellowship which was not dependent on job, income, or educational level. As such, anybody within the fellowship could do service work, regardless of their socioeconomic status. This respondent, a high school dropout and ex-con, remarked on his qualifications to do service work:

> There are lots of people out there who have great intellects and impressive education and impressive jobs but they don't have good, strong sobriety. Is their sobriety good enough that they can still help a suffering alcoholic? I took on that role because it didn't require a whole lot of education or intelligence. All it took was to share your experience, strength and hope with another human being. That is the bottom line. I can do that easily and I've done it many times.

A number of respondents further suggested that the invocation to practice these principles in all our affairs, meant that the philosophy of service should be extended to all aspects of life: at home, at work and in the community. Comments such as these reflected this sentiment:

> I see 12 step work as extending into my entire life. I coach a softball team for kids, I help with the Christmas parade, I clean up garbage around the community. All of this is building character.
>
> I try to volunteer for extra duties at work. Sometimes this is a pain in the ass but it helps me to give back. Otherwise, I get into my own little world and quickly become selfish. It's all about what my work can do for me. So I take what I've learned in A.A. and try to give back a little to my fellow employees. So I'll help organize parties and get togethers and I'll get involved in fundraisers.

6.5 Conclusion

The twelve steps are presented as a comprehensive program of recovery that takes time, work and effort. The steps are not successive assignments with a clear end goal but are designed as on-going exercises or disciplines which are practiced over a lifetime. Thus, as we have seen, AA members may revisit the steps as necessary, doing a step four inventory and a step five confession as the need presents itself. Likewise, the maintenance steps – 10, 11 and 12 – are presented as daily exercises to be worked on over a lifetime.

Not everyone who joins AA experiences the twelve steps in the same way. The language of the steps are presented in such a way that individuals can impose their own meanings and interpretations, particularly when it comes to ideas like higher power. As we have seen, the idea of surrendering to a higher power carries multiple meanings for individuals in the fellowship. Some perceive the group as their higher power while others have spiritual experiences which are grounded in established religions and faith traditions.

Some self-professed alcoholics have never even attempted to do the steps. I met several such individuals in my home group. None of them agreed to be interviewed so it is difficult to surmise their reasons for not doing the twelve steps but, at the same time, wanting to participate in the fellowship. Some respondents speculated that fear of change, discomfort with the religious overtones of AA or the inability to connect or identify with the group – could be at the root of their refusal to work the steps.

One possible explanation is that such members may be replacing one addiction for another – that is, replacing alcohol with the positive feelings that arise from participation

in the AA rituals and meetings. This correlates with Collins' (2005) notion of the "emotion junkie," the person who gravitates toward interaction rituals simply because of the positive feelings they generate. Could it be that AA members become dependent upon, perhaps 'addicted' to the meetings, particularly those hard-core types who are heavily involved with AA?

Within the fellowship, AA members who focus primarily on the meetings, without doing the work of the twelve steps, are referred to as 'dry drunks' or untreated alcoholics. Kevin Griffin, recovering alcoholic and author of *One Breath at a Time: Buddhism and the Twelve Steps* believes that when sober alcoholics are resistant to doing the Twelve Steps:

> ...the problem isn't really the steps or the program or the meetings or 'those people.' The problem is that getting clean and sober and rebuilding your life is difficult and painful work. Whether you use the Twelve Steps or some other system, it's going to be hard. Choose your poison – or I guess I should say, choose your antidote (2004: 167).

Griffin (2004) suggests that a twelve step program becomes unbalanced and unhealthy when individuals devote themselves so much to AA meetings and activities that their relationships outside of the rooms begin to suffer. Another writer who describes himself as a "former AA member" warns against people becoming so obsessed with being in AA that they have to go to a meeting every day, sometimes two or three meetings a day, or they feel like their life will go to pieces (Halliwell, 2009). These authors imply that such individuals may simply be creating a new addiction, and that is not at all healthy. After all, the purpose of attending meetings and participating in the AA

program is to create sustainable, transformational change that translates into a better, more balanced and more joyful life outside of the rooms.

In this study, I employ Turner's reformulation of "the rites of passage," with its emphasis on personal transformation rather than shifting status to understand the experience of recovery. Turner's work provides a conceptual framework through which the twelve steps can be understood as a personal rite of passage. The first three steps, the so-called surrender steps, involve a distinct separation from the normal social order. Through the meeting, the AA member becomes socially, spatially, and temporally separated from their regular world. In the AA meeting, the individual assumes a new identity as a recovering alcoholic and joins other participants at regular intervals to participate in the program.

The decision to continue working the steps, beginning with the inward work of step four, is a transitional (or "liminal") phase in the AA member's life, during which s/he is -to adopt a phrase coined and used extensively by Turner - "betwixt and between" their ordinary social roles and expected norms of behaviour and thought (1992: 132; 1969: 95). Steps four and five require the AA member to examine the 'wreckage of the past' as is often heard in the rooms. Subjects report that these steps mark the most difficult and demanding transition in the AA program and is likely the point at which many alcoholics give up and leave the fellowship. The remaining steps are oriented toward the present and future and involve committing to on-going self-improvement (steps six & seven): making amends to others and restoring damaged relationships (steps eight & nine) and practicing prayer, meditation and other spiritual disciplines (ten & eleven).

Finally, AA members claim that when they arrive at step twelve, they feel transformed as a result of having had a spiritual experience. This sense of inward transformation often manifests itself through noticeably altered behaviours and dispositions - outward change - in members' lives when they return to their regular surroundings. This marks the final rite of passage, where AA members are reincorporated into the social structure from which they came.

In the next chapter, I offer an analysis of the key social roles found in an AA home group and discuss how these various roles contribute to the maintenance of the fellowship.

Chapter 7: The Home Group as a Performance Team

7.0 Notes from the Field, January 13, 2010

When I arrived at the AA meeting tonight I was greeted by Tom, a regular old-timer who was assigned as the meeting chair. Tom asked if I had ever chaired an AA meeting. I replied that I had not. "Well buddy, you've been here long enough and I won't take no for an answer." And so it was that I ended up as the meeting chair for our regular Wednesday night closed meeting.

I proceeded through the welcoming rituals and the recitation of the Steps and Traditions, cued another member to do the daily reading, managed the collection of money, and asked if anyone was there for their first meeting. There were about 40 people present and I noticed a young man, whom I guessed to be in his twenties, sitting quietly in the corner. He raised his hand in response to my inquiry. "Yeah, I'm here for my first meeting. My name is Dennis." I was familiar enough with AA protocol to recognize that tonight's meeting would be a Step One meeting. As such, I proceeded to advise all members that we would focus on AA's first step, "We admitted that we were powerless over alcohol, that our lives had become unmanageable." I asked everyone to describe their first encounters with AA and to reflect on the first step.

As the meeting progressed I grew more comfortable in my role as meeting chair. With very little prompting from me, the men and women shared their stories involving their first encounters with AA. Close to the one-hour mark, I prepared to close the meeting. "Thank you to everyone who shared in tonight's meeting," I said, "now… would you join hands with me and say the Lord's Prayer." Suddenly, I felt a kick to my shins

from beneath the table. Startled, I looked up to see Don, a fellow member of the group, lean in towards me. Don whispered in a somewhat irritated tone, "... hey dummy... you're supposed to give the newcomer the last word... Ask him if he wants to share." Don grinned and shrugged toward the newcomer as if to say, "excuse Terry, he's still new to this group and doesn't have a clue about how to chair an AA meeting."

7.1 Introduction

Goffman suggests that members of an organization work together as a "performance team" to manage impressions, engage in face work, enforce group norms and orchestrate interaction rituals (Goffman, 1959). An AA home group can certainly be considered, in a Goffman sense, as a performance team, with its specialized roles such as greeter, meeting chair, General Service Representative, Group Treasurer and AA sponsor. Don's kick to my shin was a not-so-subtle reminder that everyone in a home group shares in the performance of recovery, especially when a newcomer arrives, and that I had strayed from the social script in my role as meeting chair.

In this chapter, I will discuss how respondents in my study experienced different social roles within their home groups. Some of these roles will be familiar to any reader who has participated as a member of a voluntary board or formal organization. The role of secretary, for example, is similar across many different organizations as it involves note-taking, record keeping and writing up reports. In AA there are certain key roles, which in my estimation, are instrumental for the performance of recovery on the front stages – at meetings, at AA conventions and socials, and at other public gatherings. I will

examine four such front-stage roles – the greeter, the meeting chair, the General Service Representative (GSR) and the AA speaker.

Each of these roles contributes to the maintenance of the group as a whole and are important sources of status and inclusion for individual members. However, these roles can also contribute to feelings of disdain, resentment and disappointment if members perceive the roles to be performed inappropriately. Such feelings are part of the "emotional micropolitics" of the home group, a potential source of division and tension among AA members (Clarke, 1990).

Other roles within the fellowship are performed back stage - in the private interactions among AA members. As I shall explain, much of the coaching and mentoring of new members happens in the sponsor-sponsee relationship, outside of the rooms of AA. In these private interactions, a sponsee learns how to perform the twelve steps and begins the emotion work of transforming negative emotional states like fear, guilt and shame into contented sobriety. Sponsors are critical to the socialization of new AA members but as we shall see, the role also comes with a unique set of challenges.

Finally, in the last sections of this chapter, I will examine the criteria used by members of the performance team as they evaluate each other's performances on the front and back stages of AA. I also examine the criteria used by members to evaluate the effectiveness of the home group as a whole, recognizing the fact that some performance teams work better than others in the presentation of recovery.

7.2 Front Stage roles: Greeters, Chairs, GSRs and Speakers

During the interviews, I asked respondents to reflect upon their experiences in voluntary positions within their home groups. Key themes related to the performance of recovery emerged for respondents who had experiences as Greeters, Chairs, General Service Representatives and AA Speakers:

The Greeter

At first glance, the role of greeter might be considered an insignificant part of the AA performance team. In my home group, the role of greeter was typically assigned on a rotational basis during regular monthly business meetings. The primary task of the greeter is to spot newcomers and to offer them a warm welcome prior to the start of the meeting. The greeter is also responsible for setting up chairs and keeping the door closed, once the meeting begins, to maintain privacy. These contributions help to create a safe, welcoming environment for the newcomer or the person who is returning after a relapse. Rob, an AA member of three years, regularly volunteers to be a greeter at meetings because he remembers the impact of his own lukewarm first encounter with the fellowship:

> The Big Book makes it clear that the most important person in an AA meeting is the newcomer. Unhealthy AA groups don't welcome newcomers. If you walk into the rooms and nobody comes up and shakes your hand and says hello, that's not a good group. I've experienced it in church as well where you're left with the impression, this is a cold church. In AA you should go up to the new person and say hello and try to make them feel welcome. I've walked into AA meetings on the mainland where I've seen the slogans on the wall "welcome, you're no longer alone" but nobody comes up to say hello. That feels damn lonely. So I ask - are

> you living what you're preaching? At the very least, there should be that one person who is assigned as a greeter. Hell… they do it at Wal-Mart… why not AA?

Respondents also suggested that a warm greeting was a positive way to start an AA meeting, particularly if a person was having a bad day. To reference Collins' observation on positive emotional energy (Collins, 2005: 15), the simple inclusion ritual of a handshake and a verbal 'welcome' helped to build up positive feelings prior to the formal opening of the meeting.

> It's such a small thing…but I like this group because there's always somebody sitting at the door who is there to greet you when you come in. Last week was tough. My wife was nagging me, the kids were driving me crazy and things were stressful at work. So to see a smile and to have a hug from Sue, who was the greeter, just made my day.

Another respondent suggested that in playing the part of the greeter, he was forced to 'wear a smile' and 'act friendly' even though he considered himself to be anti-social and unfriendly in most other social settings.

> There's a saying in AA that you got to fake it till you make it. My sponsor told me that the best way for me to practice contentment was to volunteer to be a greeter as much as possible… to fake being happy and friendly… possibly because I tend to be grumpy and crooked as sin most of the time (respondent laughs)… So now I force myself, for those 15-20 minutes before a meeting, to be friendly, to smile, to act interested in somebody, even if I'm really feeling miserable and judgmental and unhappy…. and you know, it's had some benefits. I'm beginning to laugh at myself more and I feel more at ease coming to meetings. I used to be very shy and insecure but now I know everyone here quite well… maybe it does have something to do with putting on that happy face as a greeter.

Playing the greeter can generate more positive feelings within the actor but it also gives the impression to newcomers that they are encountering a friendly group (and at least one apparently happy individual). In the sociology of emotions, this ability to lay

aside feelings of sadness, depression, guilt and shame and perform to more positive emotional affect is "surfacing acting" at its finest (Hochschild, 1983).

Meeting Chair

The official AA website offers few guidelines regarding who is qualified to chair a meeting or what the responsibilities and duties of a chair entail. The home group in this study established the norm that a chair had to have at least one year of sobriety and that the position of chair would be rotated on a regular basis. However, I observed that only a handful of AA members volunteered for this position so meetings were most often chaired by three to four male old-timers from the home group. When nobody volunteered (which rarely happened during my period of observation), a junior member might be approached by a senior member just prior to the meeting and encouraged to take up the challenge of leading a meeting. In such situations, an old-timer might say, "it's good for you to chair. It's good for your recovery. It's a way of serving the group. Go on...give it a try." Usually, this sort of gentle coaxing would result in the junior member accepting the chair position.

Essentially, the chair is responsible for conducting the flow of a meeting. S/he calls the meeting to order, qualifies as an alcoholic, cues and directs other members to do the readings, manages the collection of monies, and facilitates sharing and discussion among members. The chair is also expected to begin and close the meeting. In my home group, a written agenda, placed at the head table in the room, helped to guide the chair through the procession of a meeting.

Experience and familiarity with the AA program were cited as the most important attributes of a good meeting chair. Problems around knowing how to perform the tasks and responsibilities of this key role was a common theme that emerged from my interviews.

> Some chairs don't know what the hell they're doing... they don't have the experience in AA to even chair a meeting or know how to respond to something when it comes up. I remember this one chair who allowed this obnoxious new guy to curse and swear and rant and rave during his share. This was after he had read 'please refrain from using foul language in the meeting.' This happened during an open meeting when younger children were in the room. The chair couldn't or wouldn't enforce the rule.
>
> A meeting tends to run more smoothly under the guidance of an old-timer. Less time is spent figuring out who's doing the readings or what the topic for discussion is going to be. An experienced chair also knows how to call on people when everyone seems reluctant to talk or he can gently shut somebody up who seems to be hogging the floor.

Another subject suggested that being familiar with the members of a group is an important requirement for a chair:

> It helps if the chair knows the Big Book, is familiar with all of the twelve steps and the traditions and knows all of the members of the group. That way, if somebody has a particular problem or seems really stressed out, the chair can call on a particular member and draw out his experiences. He might say, 'I know that Frank there had that same problem. Frank would you mind sharing how you handled that?' Or, if a member is having difficulty with a personal issue, the chair might reference a relevant passage from the Big Book.

A number of subjects pointed out that the personality of the meeting chair affected the general tone of the meetings. This respondent identified one of his favorite chairs as a man with a good sense of humour:

> Jim is a funny guy and loves to tell stories so when he chairs, he is quick on his feet and always has a comeback. Even when somebody is going through a rough time, Jim has a way of putting things in perspective by finding the humor in the situation. When one guy started to share about the pain of going through a divorce and how he was tempted to drink, Jim used this as an occasion to poke fun at himself. He looked at the guy who just spilled his guts out and replied, 'look buddy… my first wife and I used to have a quiet home life when I was drinking… I'd never talk to her and she'd never talk to me… how's that for quiet? Now I'm remarried and sober and I gotta say that I can actually enjoy a conversation with my second wife… so hang in there… it might be rough now but it gets better.' So I find that meetings chaired by Jim tend to be a little more fun and light-hearted.

Makela et al. (1996) drew a broad composite picture of AA meetings from observation and data from different countries. They point to a number of primary rules of speaking in the meeting:

- Do not interrupt the person speaking.
- Speak about your own experiences.
- Speak as honestly as you can.
- Do not speak about other peoples' private affairs.
- Do not profess religious doctrines or lecture about scientific theories.
- You may speak about your personal problems in applying the program but do not attempt to refute the program.
- Do not openly confront or challenge previous turns of talk.
- Do not give direct advice to other members of AA.
- Do not present causal explanations of the behavior of other AA members.
- Do not present psychological interpretations of the behavior of other AA members.

In my observations, I noted that these speaking rules were adhered to in my home group, with one notable exception. This exception had to do with giving direct advice. On several occasions, I observed that advice was given to members who shared a personal problem openly with the group. This usually happened when the speaker would seek input from the group with a plea such as "you gotta help me out

with this problem" or "I'm open to any advice that anyone here might have for me." On such occasions, members would address the person seeking advice and share their own experiences as a way of connecting with the speaker and offering insights into how they handled a problem. This situation seemed to present challenges for the chair as s/he then had to prevent the meeting from being all about the needs of one individual. I noted that on those rare occasions when such a situation happened, the chair did manage to contain extended discussions around the exclusive needs of a single member by encouraging the speaker to seek help from a sponsor or to talk to a senior member of the group after the meeting for some follow-up advice.

Although the study by Makela et al. (1996) did not explicitly identify the responsibilities of the meeting chair, my observations supported the view that the chair was responsible for the enforcement of many, if not all, of these speaking rules. Indeed, the ability to manage difficult, challenging or unusual behaviours that might occur during a meeting was cited as a requirement to chair effectively. Subjects suggested that a chair should be able to deal with individuals who might try to monopolize the floor or, conversely, call on individuals to share if there are silences during the meeting.

> There's nothing worse than when somebody drones on and on with a long, long sob story. There's a difference between allowing a newcomer or somebody who's really struggling to have some extended time sharing their story because, at times, people need this. A few weeks ago, I was at a meeting and one of the members lost her husband to cancer.... and she was sharing and crying... and not saying a lot. It took about 20 minutes or so... and the chair was very patient to wait until she was finished. That sort of thing is okay. But when some asshole is going on and on about what a bitch his wife is, and how shitty his job is, and how rotten his

> life is... and it's all pity, pity, pity... then the chair should interrupt and ask if anyone has a way to respond to the speaker, as in 'has anyone had to deal with the same problems Bob is experiencing?' Bob, let's hear how others have dealt with those types of problems. Because if the chair doesn't interrupt, it can prevent a lot of others from sharing their stories, or even worse, the entire meeting becomes a bitching session.

Chairing a meeting also provided opportunities to earn social capital and enhance status within the group. In my home group, a member who was marking his or her first birthday was usually asked to chair their first meeting. Such an occasion can bring out a sense of pride and accomplishment for the entire group, especially the celebrant's sponsor. I was present on one such occasion when John chaired his first meeting. In a halting, stuttering voice, John exerted great effort to string his words together as he described how he had sustained a head injury after a near-fatal car accident. Drinking became his primary way of coping with the effects of his injury. It took John over fifteen minutes to share how he qualified as an alcoholic, whereas normally, it might take 2-3 minutes to qualify. Because of his stutter and apparent cognitive disability, John's story was unusually brief, but the group clearly appreciated what John had to say. When John tried reading the announcements, he would hesitate over certain words and show the paper to his sponsor who sat nearby. His sponsor assisted in helping John pronounce the words and the group patiently waited and listened intently, like a parent listening as their child learns to read. When John invited members of the group to share, a number of senior members used the occasion to congratulate John on his personal growth and accomplishments and complimented him on his performance as the meeting chair.

Learning to chair a meeting is a significant socialization experience in the AA subculture. It not only provides an opportunity to develop leadership skills, but it provides the AA actor with a more visible stage to display his or her recovery. The chair was also in a position to recognize and praise member contributions but also had the difficult task of bringing into line those members who engaged in acts of emotional deviance (Thoits, 1990).

The General Service Representative

The General Service Representative (GSR) is elected to represent the home group in the broader AA organizational structure and acts as the first point of contact for outside groups and agencies such as when local media wish to interview a recovering alcoholic or a school requests an AA speaker. The GSR relays concerns and information from the home group to the AA central office located in St. John's or to the larger district associations representing the entire province. For example, if a member of the home group is celebrating an auspicious occasion like a 25th birthday, this information might be relayed through the GSR to other home groups in the region. Or, if a new home group is being established in a remote region of the province and requires additional assistance to help stage a meeting or it requires start-up money to pay rent, requests will be made through the GSR.

The job description of the GSR is outlined in an AA Conference approved pamphlet called "The General Service Representative":

> When you are the GSR you are linking your group to the whole of AA. You transmit ideas and opinions and facts and you become part of the collective

> conscience of AA. The GSRs of the U.S. and Canada are the very foundation of our general service structure. Through your GSR, you can make your group's voice heard at district meetings and area assemblies and eventually at the General Service Conference in New York.

The GSR is expected to attend meetings and conferences at the local level with other GSRs from across the province. GSRs are elected for two-year terms. The AA pamphlet recommends that a GSR have two to three years of sobriety, be an active member with prior service experience and possess character qualities such as patience, understanding and a firm determination to place principles before personalities.

A number of respondents in my sample held the position of GSR. In addition to the character attributes listed in the AA pamphlet, respondents suggested that a GSR should be a "good talker" "a bit of a diplomat" "comfortable dealing with the media" and "able to work with others in a team."

While the GSR position afforded members of a home group with opportunities to expand their horizons within the world of AA and to gain more organizational knowledge and experience in a leadership role, the position did present certain challenges. The worst part of being a GSR according to the subjects who held this office were the number of meetings one was expected to attend. Joe put it best:

> Being a GSR can be a real pain in the ass because you're expected to attend meetings at the local and district level. It can get pretty boring and monotonous, sitting around in a church basement every other Sunday afternoon listening to each GSR from the district provide updates on the activities for each home group. Everyone is pretty much doing the same thing except for the occasional special event like an AA social or round-up which might involve a special speaker. The GSR is probably the worst position to take in AA if you're not keen on meetings.

The more positive aspects reported by respondents had to do with the opportunity to travel, network and meet new friends through the fellowship.

> When my group elected me as a GSR, it was a great honor for me. I have never been elected to anything in my life; never been asked to speak at a meeting or to represent people. So when my name was put forward and I was voted in, it made me feel great... like I had the respect of people in my group. And I've learned so much from this role. I've traveled over the island, met lots of good people. Now I can attend meetings in St. John's or Grand Falls or St. Anthony and know different people because the GSR position has allowed me to make so many contacts. And I've learned from more senior GSRs how to go about doing an interview with the media. Last year, during Addictions Awareness week, I gave a radio interview. That was pretty cool.... I've never done anything like that before and I find that as a result of these opportunities, I'm more comfortable with public speaking and sharing information about myself.

One respondent reported that the opportunity to travel across the province, and sometimes the country, did elicit suspicions and hard feelings about the perceived benefits and perks associated with the position. In this quote, Jim talks about the "grumblings" of fellow AA members:

> I'm into my second year now as the GSR. Every few months I get to come into town (St. John's) or go to Corner Brook for an event so I'll stay in a hotel and take my wife and kids. It's kind of nice. It's a nice little perk having your vehicle expenses and meals and hotel covered from the home group's expense account. But there's always some group politics at play because some members of the group think the GSR position allows you to take these free holidays. Last year, I went to Halifax and I took my wife along... and I heard the grumblings and mumblings from certain members that I must have enjoyed 'dining out' on the group's dime. So that kind of attitude can piss you off a little bit.

Candace Clark (1990) describes such displays of disdain and disapproval as part of the "emotional micropolitics" of groups. Clark might interpret the "grumblings and mumblings" of certain AA members as a micropolitical strategy that involves displaying

and/or invoking emotions to negotiate/enhance place in interaction. In the case of the GSR, there are potential status rewards for the AA member who holds this position as s/he can expand their social network in the provincial and national fellowship and gain a level of notoriety as the representative voice of the home group outside of the rooms. However, the micropolitical squabbles and disputes that sometimes emerge in the fellowship can also be a source of discouragement for those who occupy this role.

AA Speakers

Many AA groups have a Speaker's Bureau made up of members who are interested in sharing their personal stories of recovery from alcoholism. The speaker is thus the personal face representing AA to the world outside of the Rooms. Requests for AA speakers may come from schools, colleges and universities, professional organizations or community groups.

There is no formal training or coaching in AA for members to learn how to become speakers so those who gravitate toward the role seem to have a penchant for public speaking and a comfort with self-disclosure. Public speaking skills are honed, of course, in the context of AA meetings since all members are expected to talk and to share. Room (1993: 171) points out that "the heart of AA is a quintessentially oral occasion and that much of how AA operates is carried on in an oral rather than a written tradition." However, speaker meetings involve a lecture or top table style, with a podium or table, where a speaker faces the audience and tells an extended version of her or his recovery story, different from the sharing circle style where participants face each other (Borkman,1999).

Despite the many opportunities that AA members have to practice their public speaking skills in the rooms, the respondents in my study did point out that the role of AA speaker was not necessarily an easy one to fulfill:

> It only makes sense that you need someone in this role who is comfortable with public speaking. But I've seen cases where a school or an agency asks for an AA speaker and somebody volunteers who has great sobriety and they're sincere in their recovery but they don't know how to deliver the message. They're nervous wrecks, they're boring as shit on a stick, and the audience says 'what the fuck' at the end of the talk… so we have to be careful as a fellowship to put the right people in the right offices.

An AA speaker must possess more than just good public speaking skills. Gerry, a professional musician and entertainer, recalls how he gave a "fantastic speech" at a regional AA convention. The problem was, according to this respondent, was that his message lacked credibility and substance, not to mention humility:

> I know how to do a great show and dance. So I volunteered to share my story at this event. I was truly fantastic. The audience, many of them professionals like doctors, lawyers, teachers and social workers with no AA experience, thought I was King Shit. I got a standing ovation. The problem was I was new in my sobriety… I was only sober a couple of years… and I ended up relapsing a couple of weeks later. And the truth was, I really hadn't contributed anything to the fellowship or made meaningful changes in my life up to that point. It's just that I could speak with passion and enthusiasm and keep the troops entertained. I've learned now that if I'm not living the program and living right, then I have no right to get on a stage and give the message. A few months ago, I had an invitation to speak at a circuit in Toronto but at the time, my wife and I were having awful problems at home and I was being an asshole. So I had to cancel. I had to call up the convention organizer and say, "look pal. I'm not living my program the way I need to and I need to get back into it so I'm not going to be giving that talk. It would be utter bullshit if I did.

Another respondent confessed that his desire to give speeches and publically perform was motivated by what he called his "character defect of pride":

> A couple of years ago, I was asked to speak about alcoholism at a high school. I accepted and I did a great job. Lots of cheers, lots of hugs. Kids were coming up to me and saying 'you're amazing because of the things you've overcome.' The principal came up to me afterwards and said 'you're an inspiration.' Teachers came to line up and shake my hand... it was all heady stuff. What they didn't realize is that I had only relapsed about a week before that speaking event... and I was still struggling. My recovery was not solid. But I've always been attracted to a crowd. I guess I love to hear myself talk and I get revved up by a crowd. I recognize this now. I've been sober for a little over a year this time and I've taken my name off the speaker's bureau list. I know I've got lots of stories to share, lots of adventures and crazy stuff... but I don't have a lot of insight into recovery... how to live well. I'm realizing now that the right place for me to serve is in more humble ways. Now, I make the coffee for a meeting or clean up afterwards. I occasionally chair a meeting. But I try to stay out of the spot light because I now recognize that need to be up front is pride and it's not healthy.

Speakers usually begin their careers at the local or district level, but if their stories are particularly compelling and the speaker is a skilled presenter, s/he may be asked to travel to special conventions and gatherings held on national or even international stages. Such career advancements are not only a source of prestige within the fellowship but it also provides practical opportunities to travel:

> I was always comfortable telling a story so it was only natural that I would become a speaker. It started out small when I would be asked regularly to share at local conventions. After a couple of years I started to get invitations from all over the island. I've done radio interviews and television interviews and had the opportunity to travel all over North America and throughout Europe with AA. I couple of years ago: I spoke at an AA convention in Moscow. I had an interpreter. I also spoke at a convention in New York. I never thought I would get to see so much of the world because I'm a former drunk!

The role of AA Speaker, like the GSR role, both gives opportunities for the AA actor to represent the fellowship outside of the rooms. As such, there are social rewards attached to these positions which may not be apparent in the relatively low-key Greeter position or even the Meeting Chair which is confined to the home group. An AA Speaker who masters this role has opportunities to travel to conventions and meetings, sometimes on international stages. It is a badge of honour to become a circuit speaker, but in the micropolitical environment of the home group, it is expected that such badges will be worn with humility (Thoits, 1990; Clarke, 1990).

7.3 The Back-Stage Role of Sponsoring

The *Big Book* of Alcoholics Anonymous suggests that the heart of the AA program is simply one human being helping another by sharing their experiences, strength and hope. Nowhere is this statement more true, especially in the sharing of personal experiences with recovery, than in the relationship between a sponsor and a sponsee as the mentoring relationship is described in the fellowship.

Alcoholics Anonymous provides few formal written guidelines for the role of the sponsor. The main literature pertaining to this important social role comes from the short pamphlet "Questions and Answers on Sponsorship" (available at www.aa.org). The pamphlet details the history of sponsorship and its role in recovery:

> Alcoholics Anonymous began with sponsorship. When Bill W., only a few months sober, was stricken with a powerful urge to drink, this thought came to him, 'you need another alcoholic to talk to. You need another alcoholic just as much as he needs you.' He found Dr. Bob, who had been trying desperately and unsuccessfully to stop drinking, and out of their common need AA was born. The word 'sponsor' was not used then; the twelve steps had not been written; but Bill

> carried the message to Dr. Bob, who in turn safeguarded his own sobriety by sponsoring countless other alcoholics. Through sharing, both of our co-founders discovered, their own sober lives could be enriched beyond measure. What does AA mean by sponsorship? To join some organizations, you must have a sponsor – a person who vouches for you, presents you as being suitable for membership. This is definitely not the case with AA. Anyone who has a desire to stop drinking is welcome to join us! In AA, sponsor and sponsored meet as equals, just as Bill and Dr. Bob did. Essentially, the process of sponsorship is this: an alcoholic who has made some progress in the recovery program shares that experience on a continuous, individual basis with another alcoholic who is attempting to attain or maintain sobriety through AA (http://www.aa.org/lang/en/catalog).

The pamphlet goes on to explain that sponsorship is essential for the maintenance of the group as a whole:

> ...sponsorship can also mean the responsibility the group as a whole has for helping the newcomer. Today, more and more alcoholics arriving for their first meeting have had no prior contact with AA... sponsorship activity is unwritten and informal but it is a basic approach of the AA approach to recovery from alcoholism through the twelve steps (http://www.aa.org/lang/en/catalog).

Of the twenty respondents who provided in-depth interviews for this study, eighteen reported that they had an AA sponsor. Two reported that they were interested in obtaining a sponsor but had not yet identified a suitable mentor. A smaller number, fifteen, described themselves as active sponsors at the time of the interview. Collectively, their number of sponsees ranged from one to fourteen. The respondents reflected on a number of important dimensions of the sponsor-sponsee relationship:

The purpose of sponsoring

Several key themes relating to the purpose of sponsoring emerged from the data. For most respondents, the primary purpose of the sponsor was to help a sponsee with the 12 steps of AA. Jane, a well-respected senior member of the group reflected this sentiment:

> You need to find a sponsor who has good sobriety. A newcomer needs guidance. This is the duty of a sponsor - to do their steps with a sponsee. I've observed in our group that there are a couple of people with good sponsors but they don't seem to be doing their steps. And this is something that a good sponsor will do. I can share how the steps worked for me and I can make suggestions. But if you choose not to, it's no good in calling me again. I don't have tolerance for this. If I ask, " did you try this?" and she says "no," that frustrates me… because doing the steps of AA requires a lot of soul-searching and it requires so much personal change that it's overwhelming for some people.

Another respondent echoed the sentiment that the primary purpose of sponsoring was to facilitate personal change in the sponsee through the twelve steps. As we saw in the previous chapter, the sponsor is particularly active in helping the sponsee with steps 4 and 5, which involves self-examination and auricular confession:

> The steps should lead to positive growth. They might be painful to work through but the end result should be positive and constructive. The only step we're supposed to go over with our sponsor is step 4 & 5. You do feel good after step 5 because after sharing your story with another human being, out loud, it seems to lighten the load. But if tomorrow or next week, something keeps coming back to the person, some regret or resentment or feeling of guilt, then they need to ask "what am I doing wrong?" This is why the sponsee can then go to his sponsor to receive his strength, hope and encouragement. The sponsor should be able to direct the sponsee if they're still struggling with a step. Perhaps they might need to direct the sponsee back to the Big Book on How It's Done. That's how we get people to work the steps.

Another important purpose of sponsoring is to model recovery both inside the meeting rooms of AA as well as outside:

A sponsor must have worked the steps themselves and they must be continuing to work the steps because it's not just a one-time thing. You might have to work these steps many times. They must have a sponsor themselves. They must be working a good program themselves. Not someone who misses a lot of meetings or someone who swears a lot when they're sharing. They need to be talking recovery in the rooms… not just sharing a drunkalogue. They have to be positive role models.

I speak with my sponsor on a daily basis. She calls me every day. If she doesn't call me by 3:00 in the afternoon I'll check with her. And she knows by the sound of my voice if something is wrong. That's comforting and supportive. You need to have faith in your sponsor. It doesn't mean that your sponsor is ideal or perfect. Newcomers may think that a person who has many years of sobriety is wise and is able to help. But there are people in the rooms with many sober years who are really suffering. For example, one of the older men in the group was asked to read the steps the other night at a meeting. He said "yeah, I can read them with my eyes closed." In the meantime, he can't find any contented sobriety. So, he can read them but can he do them? He needs to be told that that's a stupid thing to say. Anyone can memorize the steps or repeat them if they've heard them thousands of times over the years. But try doing them. So I looked for somebody who seemed to be enjoying life and thankfully, my sponsor fits the bill.

Knowing when to give advice directly to a sponsee or withholding it to encourage independence and to foster personal growth was something that a number of sponsors struggled with:

The most important thing about being a sponsor is being able to listen. Oftentimes, my sponsor wouldn't give me the answers to my problems. Even if he had some advice, he wouldn't give it to me because he thought I should find it myself. I take the same approach today as a sponsor. I'll listen to my sponsee as he describes some problem or issue he's dealing with and I'll ask: what part did you play in creating this mess…and what do YOU need to do to clean it up?

As a sponsor I'm not there for advice because I'm not qualified to give advice. I have a couple of sponsees who I talk to a couple of times a year. When they're in trouble they call but I can only offer suggestions and tell them what's worked for me. I tell them to go to the Big Book and study it… I might be a little too tough on them. They're looking for the answer but if I tell them my answer they might end

up blaming me for the outcome. So you have to keep yourself covered all the time. As long as I remember that I'm here to share my experience, not necessarily my advice or thoughts about a problem – I'm doing okay as a sponsor.

A number of sponsors were actively involved in helping sponsees with the work of making amends and restoring personal relationships. Sponsors acted as mediators or go-betweens between sponsees and their spouses and family members when there were interpersonal difficulties:

> If it wasn't for my sponsor, I'd be divorced today, probably still drunk or dead. Because he talked to my wife and he felt the need to convince her to give me one last chance. One alcoholic to another, he could understand my seriousness. He felt that this time I was serious. And he did convince her. After that, he was involved very much in my recovery. We did wood-working at his house. I could tell this guy anything. I could tell him about the relationships I had and the things I did when I was drinking. He understood and I knew it was safe with him. And he also encouraged me to get professional help and to stick with my counselor. So at that time, in 1988, until 1994 it was truly a road to recovery. I read the book, did book studies, got together with people from AA, and used my counselor and my sponsor to begin dealing with all of my issues.

> It's helpful for the sponsor to know about your family life, about your wife and kids. I can go to my sponsor and say everything is great at home; I'm happy and so on. And if it's not, a good sponsor will spot the bullshit. He will call you out on your lies and say it doesn't sound great… my sponsor has told me on many occasions that I'm full of shit… in a loving way.

Respondents noted important differences in the social roles of sponsor-sponsee as opposed to the professional roles established between counselor-client. Giving food, money and housing to sponsees was something several sponsors reported:

> I have one guy who I've been sponsoring. He's celebrating 9 months sober today. I gave him clothes, a place to stay and some money until he got back on his feet after being in jail.

> I give my home number and my cell number to my four sponsees. I've had calls at 2:00 or 3:00 or 4:00 in the morning from a sponsee struggling, often in his first year of sobriety. I had one sponsee live with me for a month… my wife is very supportive of this… she doesn't complain when I have to leave the house to go help a sponsee because I've experienced the same thing in my recovery. I realize that not all AA members could do this, but for me, it's my way of giving back.

A number of sponsees in the sample also reported that they benefitted by having frequent contact with a sponsor as opposed to the time constraints imposed by a professional therapeutic relationship:

> My sponsor told me that the first year would be the toughest but that he would be there for me to encourage my sobriety. He promised that he would call me every morning for one year. And you know… that man did call me every morning at 8:00 a.m. for a full year and asked how I was doing and he would tell me to stay sober for the day and to do my best to live the AA program just for today. And before you know it, I had a full year of sobriety under my belt and I attribute that accomplishment to the help of my sponsor.

> My sponsor was alcoholic and he could relate to me on that level. My counselor was significant to me because she had had a lot of clinical experience based on working with so many different clients over the years and she assured me of confidentiality. Nothing would go outside of that counseling room. That was a reason to go to counseling twice a week for three years. I looked forward to it. That was a long journey of sobriety. When I was in recovery, I became a real father. I was there for my kids… so I used my counselor to deal with problems related to finances and parenting and I used my sponsor to help me stay clean and sober while I was rebuilding my life. Those two – my counselor and my sponsor – were my main supports.

The sponsor-sponsee relationship was described as a helping relationship, but not necessarily as a friendship. These respondents note some important differences between friends and sponsors:

> A sponsor is not your friend. I have friends. Once you cross that friendship barrier it's hard for a sponsor to speak into your life. They have to be given the

> right to speak into your life and to tell you "something is off with you... you're not right... what's going on?" They need to guide you through the steps. to listen to you. to share with you and really get to know you. They need to know your bullshit and be able to call you on it.
>
> There's a difference between a sponsor and a friend. I can't say that I always enjoy my sponsor's company... it's not always fun and I can't say I experience the pleasure that I do with a friend... because when I meet with my sponsor. our discussions and conversations usually revolve around my problems... whereas I like to get together with my buddies just for fun or just to hang out for the sake of hanging out.

Selecting a Sponsor

The choice of a sponsor would seem very important to a sponsee's recovery. While AA emphasizes the seriousness of this partnership, some sponsors and sponsees in my sample viewed the relationship and the role much more casually and didn't appear to put much thought into the selection process:

> When I first joined AA I didn't really know what a sponsor was. And when I asked a guy to be my sponsor I didn't utilize him at all. I told my wife I had a sponsor just to keep her quiet and the meetings gave me an excuse just to get out of the house. I wasn't working the steps. I talked with this one man and asked him to be my sponsor. He said yes but we never really talked. He never initiated anything either. The sponsor thing was just a label. I could say he's my sponsor. He could say Bob is my sponsee. Now I see the seriousness of it. And now that I'm back in the program I'm going to take enough time to identify the right sponsor for me. I'm searching for a sponsor and I'm also searching for the right home group.

A number of respondents suggested that sponsor-sponsee compatibility should be based on similarities of personality. education. gender and lifestyle. Comments like those below were typical in this regard:

> It's so important to choose your sponsor carefully because you do these steps with your sponsor. I'd never share my story with another woman in AA because it

could develop emotional ties. I would never share it with somebody who I don't know intimately. Or it might just be a gut feeling that I can't trust this person. I recognize that there's always a risk in disclosing. There are no guarantees that this person will respect my privacy. If they've told me things then I feel I can tell them things.

I needed to find a sponsor who could give me a good kick in the ass when necessary. I've served time in jail so I wanted someone who knew those ropes. No good in teaming me up with some straight family guy who wouldn't know his head from his arse hole.

However, not all respondents selected a sponsor based on social similarities. This 35 year old male respondent reflected on the differences between himself and his sponsor and saw these differences as a way of challenging his own assumptions about recovery:

My sponsor and I didn't seem compatible at all. I'm an only child who grew up in a middle class home and I have a university degree. My sponsor is thirty years older than me, he's the youngest of 17 children and he grew up poor and on the wrong side of the law. Really, we have nothing in common socially, professionally, personally – nothing! He's a retired bus driver from a tough neighborhood in St. John's. He is not particularly sympathetic and he's tough and menacing looking. My friends describe me as easy-going and mellow. My sponsor and I were driving home after a meeting one night and I was spilling my guts out about this problem I was having with my girlfriend. I was on the verge of tears. And he started laughing. Then he called me an asshole. Then he started offering some suggestions based on his own experience with relationships. And as I was listening I thought, 'has he heard anything that I've just been saying. Are we on different planets?' But after thinking about his comments I realized that he was just offering a very different perspective on my problems and I ended up following his suggestions and my problems worked out.

Outside of some basic guidelines – like choosing someone of the same gender or choosing somebody who appears to be working a good program – the choice of sponsor came down to individual preference; what this respondent describes as a 'gut feeling' about compatibility:

> I think sponsorship has to be founded on complete trust and that feeling comes from the gut. There has to be some reciprocal sharing between a sponsor and sponsee, some give and take, to develop that trust. There are certain criteria for me to be a sponsor. The sponsor has to have experience with the program and they must have worked the steps. They have to be working a healthy program. They have to have a sponsor themselves. It took me a long time to find a sponsor. I had to really listen to people at meetings and know that they have the same values in life and have a similar line of thinking as mine. Some people suggest you should get a person who is your opposite - that a sponsor should be able to give you a good kick. But I don't believe that. A sponsor should be understanding and compassionate and be able to tell me where I'm going wrong without hurting me.

Rewards and Challenges of Sponsoring

The work of sponsoring has its rewards and challenges. One source of satisfaction was the sense of having contributed to a sponsee's recovery:

> Seeing how far a sponsee comes in a short while is inspiring. When someone comes in and they're beaten and battered, physically and emotionally, then after three months they're looking better, there's a bit of a shine on their face and three months after that, they're starting to get a little bit of contentment. As time goes on, they're getting back into their hobbies. Their attitude is beginning to change. It's almost like Jekyll and Hyde. At first they have no hope, now they have the look of hope on their face and they're speaking about doing things for the future. Just knowing that you've contributed to these changes makes you feel good as a sponsor.

For many respondents, being asked to be a sponsor was seen as a compliment and honour: an affirmation that the sponsor must be doing something right to play a part in the sponsee's recovery. In my estimation, the social capital of sponsoring was in part related to the number of sponsees a member worked with. As such, I observed that some senior members of the home group seemed to derive more prestige by having a large possee of sponsees. This also had the effect of creating certain cliques within the meeting space as a

prominent sponsor might be sitting on one side of the room with his possee while on the other side of the room. another sponsor might be sitting with her possee of sponsees:

> It can be a problem if a person has too many sponsees. In our group, Dan has three sponsees. They usually drive together in the same vehicle and sit around the table together. Then there's Jane with her three girls. And Dan has his little philosophy about the program and his take on sobriety and Jane has hers… and if you listen to what their sponsees share in the meeting, it all sounds like they're reading from the same hymn book.
>
> When somebody tells me they have five or six sponsees, I feel concerned because that's time consuming. I wouldn't be able to sponsor that many people and I'm retired. I have lots of time but not to waste.

Sources of dissatisfaction with the sponsor role related to the emotional and time demands imposed by needy sponsees:

> Satisfaction with sponsoring depends on your own mind set. I could say when someone calls me at 2:00 a.m. "Why are you calling me at this hour?" And believe me, I've had lots of calls like that, but I've never refused any person who did make that call in over 20 years.
>
> It takes a lot out of you when you hear your sponsee struggle with the same old problems day after day and week after week and month after month… I sometimes feel depressed and despondent myself just listening to the messes my sponsee finds himself in and I get frustrated that he's not working his program the way I might want him to work it.

One respondent reported that he preferred to co-sponsor as a way of reducing the demands of the role. Co-sponsoring could also provide opportunities to blend personality styles in the helping relationship:

> I prefer to co-sponsor. This works really well. I did this with a very happy-go lucky guy and I was the serious guy. Like good cop-bad cop. One time our sponsee was telling us how he was planning a big party and he had bought some alcohol free beer. So I smacked him across the head and said "are you out of your

f** mind." And Joe, the happy guy, gave the sponsee a hug and said gently, "maybe you should re-think that plan."

Violence was a particular risk cited by a couple of respondents in this study. This sponsor describes his experiences relating to sponsees who were prone to violence:

> I had a fellow pull a knife on me and then he beat up the furniture. But I just looked at him and asked "are you finished? Are you ok now?" My problem is that I'm not afraid of nothing or nobody so I put myself in those situations all of the time. One of the AA guidelines for sponsors is that you never visit someone alone if the person is an active drunk, that you should always have somebody else with you. But it's just my way of doing things. But if I get burned one day then I'll probably change. But that's my comfort level. I function quite comfortably with violent men, with knives and stuff. I grew up like that. I used to have a vicious anger problem and I would sooner slug someone than talk to them. I've left many guys unconscious on the floor. So I'm comfortable dealing with individuals who are like me. I know them from the inside out. Maybe that will change now that I'm getting older but for now, it works for me.

When a sponsee relapsed, this often caused the sponsor to examine his or her own contributions, or lack thereof, to the setback:

> When your sponsee relapses you question yourself. I've asked myself "should I have done this or said this or noticed something was going wrong?" Should I have seen them more? Those are the thoughts that I've had. But now I realize that I can only carry the message; I can't carry the drunk. I can bring him the message and hopefully he won't go out drinking. I can't sit with him 24/7. That's impossible.

One source of dissatisfaction for sponsees related to the breaching of confidential information. One respondent in this study described being "burned" by a sponsor who had "loose lips":

> Sponsorship in Newfoundland has a lot of problems. I would not feel comfortable talking to a lot of people in this fellowship. At meetings I'm careful about what I say. I don't say everything I'm feeling or thinking because I know it's going to be repeated outside of the rooms. Because I've experienced that - information being

> shared outside of the rooms that should have stayed in the meeting. That's a trust issue with me. So I'm cautious about who I talk to. I don't care what people think they know. I don't want to be the subject of gossip.

Sponsors and sponsees sometimes become so dissatisfied with their relationship that one or both may come to the decision to terminate the sponsorship. This is a delicate emotional issue, and respondents noted the potential for disappointment and hurt feelings. The reasons given for terminating a sponsoring relationship related to perceived incompatibilities, judgmental attitudes or unfulfilled expectations:

> I've heard sponsors tell their sponsees, "Well, if you don't listen to what I say, I don't want to be your sponsor anymore." It's hard to build up trust like that. That's why our home group tried to develop a temporary sponsor list... But you should be able to say to a sponsor, "look, this relationship is not really working out for me." You don't have to criticize that person but it might not be a good match for a whole bunch of reasons. So everyone should be able to say that...but it doesn't work that way in reality. Sponsors here would feel really upset or hurt if they heard their sponsee say that.

> I felt judged by my sponsor. I never felt comfortable telling her things about my past or about my current struggles... so I decided to get a new sponsor... maybe I was uncomfortable because my sponsor reminded me of my mother. She was older and her daughters were about my age... so I was careful to choose a female sponsor who was more my age and had more things in common with me.

Studies of the guru-devotee relationship offer some insights into the social processes involved in the pairing up of sponsors and sponsees. In his study of the guru-devotee relationship in the Radhasoami/Divine Light Mission tradition among Hindus, DuPertuis (1986) suggests that devotees often project the personal quality of charisma to their guru on an unconscious level. According to DuPertuis, this projection represents a desire to find within the guru an "idealized self" which the devotee hopes to achieve through the disciplines of prayer, visualization, chanting and trance induction. Data from

my interviews reveal a similar tendency to project an idealized self when sponsees perceive personal qualities and attributes in their sponsors that they hope to cultivate in themselves. This respondent reflected this sentiment to be more like her sponsor:

> I look to my sponsor for direction. I've heard her story many times during meetings and I listen closely to her experiences so I can find out how to get some contentment in my own life. It seems to me like she has her act together so I'm trying to become more like her.

Sponsors may also be aware that they are displaying a potential "ideal self" to their sponsee. Another male respondent reflected this idea that he must be doing something right if he is asked to become somebody's sponsor:

> I guess you're doing well in your program when someone comes up to you and they want what you have. It's a boost to know that you must be doing something right.

Another parallel between sponsor-sponsee and guru-devotee can be seen in the roles as teacher and guide (Kakar, 1985: 846). Lubin, in his study of Hindu gurus, reports that one of the principal roles for the guru was to be interpreter of holy texts to the devotee (Lubin, 2002). Likewise, as my data demonstrate, AA sponsors sometimes direct their sponsee to key passages in the Big Book for guidance on how to properly carry out the steps. Sponsors also instruct sponsees in the rites of discourse for a meeting such as how to frame subjects, or what to disclose and what not to disclose.

Of all of the social roles described in this chapter, the sponsor is perhaps the most significant other when it comes to the socialization of the AA member. Novice AA members look to their sponsors for clues about how to act out recovery – to demonstrate that they are 'getting the program.' In the next section, I will present more data

illustrating how actors evaluate each other's performances on the front and back stages of AA.

7.4 The Evaluation of Recovery Performances

Recovery is experienced on a subjective level but it is also performed before others in the rooms. A convincing recovery performance should thus leave the audience with the impression that the actor can live in the present; experience a full range of emotional expression; and be freed of the bondage of self-concern in order to focus on others. How do members of AA judge each other's performances? To answer this question, it is helpful to apply the concept of framing as it is used in dramaturgical theory:

> It has been argued that a strip of activity will be perceived by its participants in terms of the rules or premises of a primary framework, whether social or natural, and that activity so perceived provides the model for transformation...It has also been argued that these frameworks are not merely a matter of mind but correspond in some sense to the way in which an aspect of the activity itself is organized - especially activity directly involving social agents. Organizational premises are involved, and these are something cognition somehow arrives at, not something cognition creates or generates. Given their understanding of what it is that is going on, individuals fit their actions to this understanding and ordinarily find that the ongoing world supports this fitting. These organizational premises - sustained both in the mind and in activity - I call the frame of the activity (Goffman, 1974: 247).

The primary framework for the acting out of recovery is the AA meeting. Each and every AA meeting becomes a venue through which recovery is ultimately performed and the work of constructing a new identity as recovering alcoholic is continued. On these *front stages*, respondents pointed to the behaviour of AA members during meetings as containing important clues as to whether they are getting the program and thus experiencing an authentic recovery. Missing meetings, failing to socialize before and after

meetings, sharing in gossip about fellow members, not volunteering for AA events were some of the behaviours indicating that a member might not be recovering. Outside of the rooms, members looked for behavioural changes in how members related to significant others (family, friends, others in the community). Thus, an AA member was not only scrutinized on the front stages during meetings and AA social events (dances, speaker meetings, conventions etc.) but the *back stage* domains of work, family and community were also examined for proofs that a member was living out their programs of recovery:

> If I go to meetings five nights a week, I see who's at the meetings. I see people who are there and who speak and who participate. They take part. I get to know them on a personal level. Then I go outside the meeting room and I will see where they work and what they do in the community - their involvement. And then I get to know their family. To me, that's where the fruits of recovery can be seen. That's recovery. The person who shows up once a week and sits in the back of the room, and leaves right after the meeting - I watch that person for a long time and I worry about his recovery. That's different from the person who shows up a little before the meeting, shakes hands with people, gets to know others in the group and who shares and who stays after the meeting. You can pretty much tell based on this who is going to 'go or grow.'

Even the manner in which the actor exits the stage is fair game for evaluating the recovery performance:

> Someone might sound great in a meeting. He might know the Big Book inside out but if I see him drive out of the parking lot with his tires screeching...or I go out the doors and he's talking about somebody else…these are signs that the person may not be recovering.

Respondents also pointed to important dialogue or script indicators of recovery – again, looking for active references to the authoritative Big Book. Speaking explicitly about the steps, about one's higher power were indexical markers of recovery. Attributing

success to one's own efforts (as opposed to the steps or higher power) were negative indicators – that one wasn't getting the program. Also, as I have shown in previous chapters, sharing drunkalogues with no redemptive themes was an indicator of not being in recovery. The following respondent highlighted such considerations when he was in the process of selecting a sponsor –someone he hoped was working a good program:

> I asked a guy in this new group to be my sponsor last night. And I asked him for a couple of reasons. When he spoke it was about helping others. It was about getting out of yourself. It was about service work. It was about the Steps. It had nothing to do with him. He wasn't talking about himself and he didn't speak very often. That tells me that this person has achieved a sense of humility; that he doesn't have to speak at every meeting. He doesn't have to tell everybody how great he is or how well he's doing. He's sharing how he got that way. And when I see somebody who is gaining health in their recovery I look at the way they're living their life. I see how they act, how they perform. When I came here, I was watching people. I needed to know who was working their program because I knew that I needed to find somebody. Members who are not working a good program never talk about the steps. Or they never talk about a power greater than themselves. Nothing burns me more than hearing a guy with 20 years speaking at a meeting and not mentioning God once. It just burns me because that's what AA is all about. To give the message of AA without pointing to God – I feel very impatient and intolerant when I see that. But that's what I look for – somebody who is focused on the steps, working their program and they're doing well and they're healthy. I look for people who are quiet but when they do speak, it's useful information. It's not self-serving; it's to help other people.

Seniority in the fellowship was also a factor in evaluating performances. Vocal newcomers who readily dispensed advice, who appeared to know it all and who claimed to "have it all together" were perceived with suspicion. One member referred to 'one year wonders' to describe the phenomenon of the newcomer who claims to be making progress but who fizzles out after a year of initial enthusiasm:

> One of the things I've seen here is that newcomers can be so full of pride and enthusiasm. They feel they really get it. I'm so happy to be here. I'm saved. things are coming together. Life is perfect. I call these people 'one year wonders.' I see countless people in this category. When I hear people say "my life is great...life is really fantastic," that really worries me. Life's not like that. They're not being honest. This disease isn't like that. You can't talk yourself into recovery. You can't get up in the morning and read a positive affirmation "I will not drink today. I will not drink today." "I'm a good person. I like myself." That's not going to work.

Respondents seemed reluctant to attach a time frame to recovery but several did point out that it seemed impossible to claim recovery after a relatively brief period of working the program. Comments such as these were typical in this regard:

> There's no way you can recover in two months. And there's people who show up in meetings and they say that everything is great. They got their marriage back. their job back. their finances are stable. I haven't had a drink in 2 months and I'm never going to drink again. I can't see it getting to that point that quickly. It's a time healing process and time is the biggest factor.

In the evaluation of recovery performances. members try to "spot the cons" – in Goffman terms (Goffman,1967) – as they tried to assess truth claims about recovery. This respondent discusses the rationale for trying to verify whether others appeared to be getting the program:

> It's tough to know who's getting it and who's not getting the program. It's really none of my business. But if I want to be of some help. I need to know these signs and go and talk to that person and share what it was like for me. Because when I first came to AA. I was so enthusiastic but so green. I thought - the Big Book says I can have every single defect of character removed. But that just sets me up for failure. I've done this countless times - set impossible goals that I can't achieve. And so I fail again. It's not about achieving perfection. It's dangerous to think that way. You can't do this program perfectly. You're going to fall. you're going to get angry. you're going to get lonely. you're going to get sad - all those

> experiences and feelings that normal people have. Just because you're a recovering alcoholic doesn't mean you're exempt from these things.

This quote is significant because it highlights how judgments about recovery are made on the basis of accounts. From an interactionist perspective, accounts are the ways members signify, describe or explain the properties of a specific social situation (Garfinkel, 2002). They can consist of both verbal and non-verbal objectifications and are indexical to the situation in which they occur (Orbuch, 1997). That is, the evaluation criteria used to judge whether a member is getting or not getting the program, depends on the context of the account. As this respondent puts it, an individual can give a compelling account that s/he is working a good program in the context of sharing at a meeting, but as we have seen previously, if that same individual drives carelessly after the meeting or engages in gossip or back-biting outside of the rooms, then there may be little validity attached to the account of recovery. Thus, giving a good performance inside of the rooms does not necessarily equate with experiencing an authentic recovery outside of the rooms.

7.5 Effective and Ineffective Performance Teams

AA belongs to the mutual aid movements where activities promoting self-improvement are performed in a group context. One respondent captured this sentiment with the succinct motto "there is no I in these steps...only we." As we have seen, roles like the meeting chair or the sponsor contribute to group maintenance as a whole, and to the socialization of new AA members. However, it is important to recognize that not all AA home groups perform with the same level of effectiveness. This raises the issue of what constitutes an effective or healthy home group.

An effective home group is good at staging rituals and takes great care to ensure that rituals are performed correctly. As members of a home group reflect upon their collective performances, particularly as they relate to the presentation of recovery rituals, they are practicing a form of reflexivity. In sociology, reflexivity is regarded as an essential capacity adjusting the actors to situations, or to the specific contexts of social phenomena (Tsekeris and Katrivesis, 2008: 3). In an AA context, functional, effective groups create a sense of order and consistency through rituals, the regularly repeated and carefully prescribed forms of behavior that symbolize the beliefs and values of AA.

The rituals embedded within an AA meeting must be followed with precision. According to Collins (1982:34), "In rituals, it is the forms that count. Saying prayers, singing a hymn, performing a primitive sacrifice or a dance, marching in procession, kneeling before an idol or making the sign of the cross – in these, the action must be done the right way." Collins reminds us that "ritual is a body process" starting by the movement of bodies into the same place (2005: 53). The gathering of individuals in a common location with a common focus helps to start the ritualization process of an AA meeting.

When the home group was not perceived to be "doing what it is supposed to be doing" and performing dysfunctionally, interaction rituals were at the heart of the matter. The lack of inclusion rituals, like shaking the hand of a newcomer, is an important rite which many groups assign to the greeter. The omission of this ritual can be associated with an unhealthy, dysfunctional group:

> If you walk into the rooms and nobody comes up and shakes your hand and says hello, that's not a good group. In AA you should go up to the new person and say hello and try to make them feel welcome. A good group will ensure everyone is welcomed warmly.

More recent work in ritual theory points to the idea that rituals and traditions can be "invented" by groups as a method to establish social order and to make linkages to the past that are not necessarily present (Hobsbawm, 1984). On the occasion of a business meeting, I made notes on a lively discussion concerning what members called the "cake-cutting ceremony." Ceremonies are very important human activities that can strengthen the bonds of group members (d'Aquili, 1985). This particular occasion involved the awarding of the one-year medallion and the presentation of a cake to AA members who celebrated their first year of sobriety. "We need to get this right," argued Jane, a senior member of the group. "Otherwise the person celebrating their first year of sobriety won't realize how special this occasion is."

Other senior members supported Jane's view. "Yeah, she's right," interjected Bob, another old timer, "the cake cutting ceremony is pathetic." Bob went on to describe how the chair used to announce birthdays at the beginning of the meeting and then encouraged everyone to stay after the meeting for cake. Bob lamented that most people would just leave as soon as the chair ended the meeting. Barb, an AA member of three years, and one of Jane's sponsees, commented "but we also tried awarding the chip and cutting the cake at the beginning of the meeting and that would drag out the whole meeting, not giving everyone in the room time enough time to share." The group seemed stalled around this issue: how to create the most meaningful, compelling cake-cutting ceremony possible. Finally, the group agreed on a compromise: they would present the medallion at

the beginning of the meeting and just before the meeting formally closed. the meeting chair would make an extra effort to remind members that there was a birthday cake being offered and that everyone should stay.

The extended discussion around the cake-cutting ceremony at the business meeting was revealing because it emphasized the important role of rituals for the maintenance of the group. As Turner (1986) points out, ritual performances reinforce and increase the level of attachment between participants. Wuthnow (1988) also makes the point that the group may be utilized in consciously orchestrating rituals to commemorate or initiate an event that is important for a community and its collective life. Sharing of meals in ritual settings can increase the bonds that participants feel toward each other (Mintz and DuBois 2002) and events like the cake-cutting ceremony also help to distinguish in-group and out-group boundary distinctions (Tajfel 1982). My observations revealed how old-timers are invested in birthday celebration rituals because seniority is important in AA and the cake-cutting ritual is a reminder to everyone in the home group of how important one's accumulative sobriety years are in the fellowship. Thus, rituals like the cake-cutting ceremony establish status hierarchies, create a sense of community, and help establish mechanisms of social control against those who violate norms (Thoits, 1990). The fact that some members were leaving the rooms without partaking of the cake, and paying homage to the birthday recipient, was an assault on the established social order and a further demonstration of the intense micro political environment of the home group (Clark, 1990).

Involvement with self-help groups undoubtedly meets various social and psychological needs for the individual. Research has indicated that important communities of choice can replace and/or supplement more traditional religious, neighborhood, kinship, and occupational groups in terms of integration and regulation (Forster 2004; Kidder 2006). Data from this study suggest that, for many AA members, the home group became a key primary group whose interactions centered on the meeting:

> If I wasn't part of a group, I wouldn't have gotten sober. I've been to many meetings where I've heard this same thing. There were six or seven men in my home group, all of us were unemployed. We would all go into the woods in the winter and cut wood. It could have been for us or for somebody else. That didn't matter. All that mattered is that we were out in the woods. We'd boil up the kettle, sit around and talk and joke and carried on. Then we would come home, have our suppers and go to a meeting - all together. After the meeting, we would visit somebody's house, play crib until midnight and then go home. We ate, drank and slept AA together. I could not do that on my own. That's why the language in the steps says 'We.' You don't see 'I'.

> I experienced a really healthy group in Ontario this past year. I loved it. It was a group called the Primary Purpose Group (PPG). It was all young people. Average age was 26. There were about 150 people in the group. They talked recovery and lived recovery. They always made me feel welcome. I was asked to do a reading in my first week there. I went Monday, Wednesday and Friday. Friday was called spiritual kindergarten where we all just talked about certain issues of life. Saturday night we might go to a baseball game. Friday we might play football. All of this activity kept me sober. I never had the time to feel sorry for myself and fall into the temptation of drinking as long as I remained involved with this group.

Another respondent described a situation when the home group assembled around him at particularly challenging occasion in his life:

> I fell down a flight of stairs on the job - this was early in my recovery. I fractured my spine in several places and needed three different back surgeries. I was in a body cast for a full year and had to lie flat on a bed for six months. During those

six months, my entire AA group would visit my house once per week to hold their meetings. Just so I could get my meeting in. That's support!

From a macro social perspective, AA and other self-help groups appear to fill gaps in an underfunded, inadequately equipped treatment system for addictions. At the same time, the fellowship meets the deeper social and psychological needs of its members in an age where more traditional social structures (churches, voluntary associations, community organizations) are becoming increasingly fragmented and isolated (Putnam, 2000).

7.6 Conclusion

The promise of Alcoholics Anonymous is that one can find relief from the disease of alcoholism. However, the language of the twelve steps of recovery make it clear that this personal relief is also experienced collectively and tied to the AA home group. As one respondent pointed out to me during an interview, none of the twelve steps contain the word 'I' – they are written with the collective 'We.' This collective 'we' is evident whenever the group springs into action to initiate inclusion rituals and to unfold the drama of recovery. As such, every home group in Alcoholics can be seen as a performance team, some staging better performances than others. Erving Goffman highlighted the fact that within many organizations, members work together to manage impressions, engage in face work, and convey key messages and themes. An AA home group can certainly be considered, in a Goffman sense, as a performance team, with its highly specialized roles such as Greeter, meeting chair, Group Treasurer and General Service Representative .

The conventional sick role offers far fewer, if any, opportunities to dispense advice and actively treat other sick persons. As Parsons (1951) and others (Weitz, 1996;

Crichton et al.; 1997) have pointed out, the physician plays a critical gatekeeper role in the medical establishment to control people who enter the sick role. Conflict perspectives also make the point that power, prestige and profit are often attached to the privileged and restrictive knowledge base of professional groups like doctors. Foucault (1994/1963) suggests that the "clinical gaze" creates a mystique among the public that doctors have special knowledge and hence should be granted special powers. The media also promote this idea that the doctor knows best when it comes to addictions. Popular shows like "Celebrity Rehab" or "Intervention" feature experts like Dr. Drew Pinsky, a licensed psychiatrist who is Board Certified with the American Society of Addiction Medicine. Dr. Drew and the addictions experts like him have acquired some of their legitimacy because they possess valued medical credentials and it is apparent in the program that Dr. Drew has also mastered the clinical gaze as he stages interventions and treats the alcohol and drug dependent Hollywood clientele.

In AA, there are no experts in the rooms who offer diagnoses or prescribed treatment plans. AA is unique in this regard because it encourages one recovering alcoholic to become active in the recovery of other alcoholics. This occurs mainly through the role of sponsor but is also seen in other service roles such as AA Speaker, meeting chair and General Service Representative. Data from this study suggest that the diagnosis of alcoholism in the rooms is not dependent on expert knowledge and objective assessment; nor is it a mostly rational process – 'rational' in medical/scientific terms. Rather, self-identification as an alcoholic is a subjective, largely emotional process involving empathic responses from significant others in the rooms. Within the

fellowship, the most significant other is the sponsor who plays a critical role in this identity work. The more the novice AA member can identify with a sponsor, the more likely it is s/he will maintain the role of recovering alcoholic and the more willing s/he will be to follow the prescribed AA treatment.

Sponsoring and other forms of service are supported by the core belief that in order to maintain sobriety, the recovering alcoholic "must give it away." This is more than a simple call for volunteerism; respondents believe that recovery requires a reduction of selfishness and a "freedom from the bondage of self" – an expression I would hear often in the rooms. Not only does service facilitate this transformation of self but service roles like the sponsor encourage the recovering alcoholic to offer a form of pseudo-counseling and support to those who are perceived as sick. Being a sponsor bestows honour and prestige. It signifies that the member appears to be working a good program and is becoming healthy enough to begin dispensing advice and guidance to sponsees. Just as physicians accrue prestige for having busy practices, having a respectably large number of sponsees is a potential source of prestige within the fellowship.

Within the rooms, the sponsor may potentially displace the key role played by the physician in the treatment of addictions. This relationship has the potential to create tension with the medical establishment. Concerns about maintaining their power base might help to explain the uneasy relationship the medical establishment has had with the self-help movements. Titles such as "Victims All? Recovery, Co-dependency, and the Art of Blaming Somebody Else." (Rieff, 1991) or "Alcoholics Anonymous - Cult or Corrective: A Case Study." (Khantzian,1995) written by authors coming from a medical

perspective, point to the dangers of lay persons engaged in amateur diagnosis and treatment of addiction and alcoholism. While there may certainly be legitimate concerns about the possible harm of lay people diagnosing and treating alcoholism, it may be that much of this criticism stems from a desire of the professional classes to protect their own power bases.

From a dramaturgical perspective, the home group provides the venue for the novice AA member to act out his or her recovery. Thus, meetings which are staged by a home group provide an audience as well as a supporting cast for the theatrical dramatization of recovery. All AA members, from the most senior old-timer, to the meeting chair, to the greeter at the door – must all play their parts appropriately so that the novice AA member can be properly trained and the role of recovering alcoholic can be maintained.

Chapter 8: Conclusion

8.0 Introduction

Alcohol is the most commonly abused drug in Canada, affecting individuals, families, communities and the larger society. Research on alcohol consumption suggests that the people of Newfoundland and Labrador are among the heaviest drinkers in the country (Adlaf et al., 2005). It is against this cultural back drop that I have explored the recovery experiences of members of AA in Newfoundland and Labrador.

There are different approaches to the study of addiction and recovery. Medicine may focus on the brains and bodies of the recovering person, looking for changes in brain chemistry and improvements in the overall physical health of the individual. Psychologists may look to changes in thinking patterns, problem-solving abilities, or changes in personality to indicate recovery. In this thesis, I examine recovery through the theoretical lens of dramaturgical analysis. I argue that recovery can be viewed and understood as a type of performance. AA meetings provide a stage, an audience, props and actors playing roles. The twelve steps provide a social script for getting into the role of recovering alcoholic. On one level, this is a somewhat cynical view of social life, perhaps leaving the reader with a sense that AA members put on a performance, in somewhat of a contrived manner, as they attempt to convince each other that they possess this elusive quality called contented sobriety. It is not my intention to leave the reader with such a negative impression. However, the metaphor of a performance highlights how addiction and recovery are socially constructed by actors within the world of AA.

In this chapter, I will present a summarized account of the factors which help to shape and script the recovery experiences of the men and women who become members of AA. While this dissertation does not offer a comprehensive explanation of recovery, I have been able to identify some of the common themes and structures underlying the narrative accounts of recovery in the rooms of AA. In the first part of this chapter, the major findings of this research are discussed in relation to the theories of interactionism outlined in chapter three. The second part continues with a discussion of how dramaturgical approaches can be applied to the study of recovery. Third, I examine some of the policy implications for the treatment of addictions, given the results of the study. Lastly, I examine some of the implications for future research in the area of addictions and I offer a brief discussion on the suitability of interactionist approaches for studying how men and women recover from alcoholism.

8.1 Making Sense of Recovery from an Interactionist Perspective

This study set out to describe the experience of recovery for the men and women who belong to AA in Newfoundland and Labrador. My aim was to give the reader an insider's view of how AA members conceive of, and make sense of, the so-called disease of alcoholism, as well as the signs and indicators they look for in relation to recovery. In carrying out this study, I hoped to add to the existing knowledge about the AA experience and to expand upon the definition and conceptualization of recovery.

Problems of definition and conceptualization continue to plague notions about addiction and recovery. A case in point is the current controversy surrounding the upcoming publication of the fifth edition of the Diagnostic Statistical Manual of Mental Illnesses set to come out in 2013. Proposed changes for the DSM-5 include merging alcohol dependence and abuse categories into a single diagnosis: substance abuse disorder. Critics of this change argue that the diagnostic criteria proposed to cover a single category will be so broad and expansive that the number of patients diagnosed with substance abuse disorder will artificially increase (Schuckit, 2012). A New York Times article goes so far as to suggest that the DSM-5 could categorize 40 per cent of college students in the U.S.A. with substance abuse because of their binge drinking habits (Urbina, 2012). Changes to definitions are significant because without a good understanding of what addiction and recovery mean, doctors, counselors and researchers have no way of drawing the line between what is considered normal and not normal when it comes to drinking.

In my examination of the research literature on recovery, I pointed out that few studies have tried to understand recovery and addiction from the perspective of the actor who identifies him or herself as a recovering alcoholic. The bulk of the research literature is written from a positivist, rational and scientific perspective, dominated mostly by medical researchers.

In the sociological literature, I noted significant knowledge gaps about how recovery is experienced on a subjective, emotional basis for members of AA. Existing

studies do not offer insights into the factors that shape the emotional experiences of AA members; nor do they reveal the complexities of how actors interpret and make sense of the symbols found in the twelve steps. A significant gap exists in understanding how emotions are displayed as they relate to recovery and in how personal transformations of the actor are achieved by working the steps. Finally, a review of the sociological literature shows a lack of knowledge about the dynamics of the home group and how this mesostructural agency is involved in individual recovery.

I began my study with a historical analysis of Alcoholics Anonymous, pointing out how the men and women who enter the rooms of AA inherit a script for recovery built around the twelve steps and twelve traditions. The principal architects of AA, Dr. Bob and Bill Wilson, were moral entrepreneurs in the sense that they helped to re-cast the suffering alcoholic as a sick person and not necessarily a bad person. AA thus facilitated the medicalization of alcoholism as a disease and planted the seeds for the modern twelve step recovery movement. One of the most important initiatives which helped to legitimize the fledgling organization was the successful alliance AA built with the medical establishment.

The disease concept of alcoholism is framed in the Big Book as an allergy to alcohol. For AA members, the idea that alcoholics are allergic to alcohol provides a pseudo-scientific basis for explaining how and why AA drinkers are different from other non-alcoholic drinkers. The allergy theory also deflects moral judgment away from the individual and posits that it is the genetic make-up or the physiology of the person that

makes him or her sick and not weak-willed or bad. Respondents in this study suggested that the greatest impairment deriving from this allergy is the loss of choice when it comes to drinking. Alcoholics cannot choose to stop drinking on their own, according to those within the fellowship. The cure for their disease involves a total spiritual transformation by finding one's higher power and working the twelve steps.

The appeal of the AA recovery script is that higher power is presented as a flexible, open-ended construct which allows the actor to impose his or her own meaning. In fact, many of the symbols embedded within the language of the twelve steps can be described as polyfunctional and polyvalent – that is, they mean different things to people from diverse backgrounds and in various eras. In the early days of AA, the founders of the fellowship were influenced by the ideas of Carl Jung, Sigmund Freud and William James as well as the religious ideology of the Oxford Group. I suggested that the twelve step program and the organizational structure built by Bill W. and the early founders could thus be viewed as a type of bricolage. Today's AA members may also be considered bricoleurs as they blend ideas from New Age mysticism to create versions of a higher power or as they modify the language of the twelve steps to better suit the needs of women, as I discussed in my review of the feminist literature on recovery.

While there is flexibility in the interpretation of key concepts and symbols in the AA program, there is a common structure guiding the narratives of recovery for AA members. Subjects in this study suggested that their transformations into recovering alcoholics began with the experience of hitting rock bottom. Hitting rock bottom is the

metaphor which subjects use to describe the turning point in their drinking careers. The intense negative emotions and sense of personal crisis at this stage represent epiphanies – those interactional moments that leave a mark on people's lives and have the potential to create transformational experiences for the person. The bottoming out experiences described by respondents in this study corresponds to Denzin's typology of major, cumulative and illuminative epiphanies as described in the sociological literature (Denzin, 1989: 70-71; 1990: 15-18).

The transformation of recovering alcoholics is facilitated by working the twelve steps of AA. In this study, I have suggested that Victor Turner's reformulation of the rites of passage, with its emphasis on personal transformation rather than shifting status, provides a conceptual framework through which the experience of working the steps can be understood as a personal rite of passage. Data from my study reveal that Turner's ideas on liminal experiences and communitas are meaningful in describing the transformational processes involved in becoming a recovering alcoholic. As I discussed in chapter five, the key rite of passage which marks the separation of the person from the role of ordinary drinker is the first time the person admits that "I am an alcoholic." This declaration, when made for the first time before an assembly of AA members, initiates a step one meeting and draws the entire home group into action as a performance team. Thus begins the process of socialization into the fellowship.

Drawing from the sociology of emotions, I suggested that the social processes involved in the construction of an alcoholic identity are not grounded in rationality and

objectivity, but are largely subjective and emotional. Unlike the medical model which relies on experts to rationally determine whether the patient's symptoms align with the criteria for addiction as described in the DSM, the self-diagnosis as an alcoholic is an inter-subjective, emotional process involving the self and significant others. A person entering the rooms looks to other alcoholics to determine if s/he belongs. If the individual identifies with others on an emotional basis, particularly with a sponsor, s/he will assume the identity of recovering alcoholic and learn to play that role. Thus, the decision that "I am an alcoholic" is based more on *feeling* rather than *thinking*. The implication of this finding is that it is entirely possible that a person might identify him or herself as an alcoholic in an AA sense, yet fail to meet the clinical (medical-model) standard for alcohol dependency. It is also possible that a person who enters the rooms might meet the clinical definition of alcohol dependency but fail to identify on an emotional level with the label of 'alcoholic' as it is used within the fellowship of AA. This inability to identify and empathize with the narratives and symbols of the group makes them not qualify as AA penitents and may be a reason for withdrawal from the program.

There are certain emotion display rules for the novice AA member. The penitent, as I have described this social role, is expected to display a narrow range of negative emotional affect which restricts the newcomer to displays of shame, regret, confusion, anger and fear. Such contrite and humble displays are considered the right way for a newcomer to behave. This kind of performance will elicit a warm welcome into the fellowship. On the other hand, if the newcomer acts outside of the penitent role, the home

group will be less receptive, making it more difficult for the newcomer to identify with the role of alcoholic. Thus, emotional displays which portray confidence, joy, peace or serenity, especially at the early stages of recovery, are more likely to elicit a negative evaluation of the novice's performance. A person who is new to the fellowship is not expected to "have his shit together" as respondents so eloquently put it, and those who make this claim risk rejection or isolation from the home group.

My data also point to some important differences in how emotions are displayed for men and women in AA. The male penitent is afforded a greater range of emotional expression, particularly when it comes to displays of anger, aggression and hostility. Female alcoholics, on the other hand, appear to be more restricted to a narrow range of emotional expression. A woman who shows too much anger or resentment may be perceived as "unworthy" according to the rules of "sympathy etiquette" in the mostly male rooms of AA (Clark, 1987: 298).

In chapter six, I described how individuals experience each of the twelve steps of recovery as a personal rite of passage. The first three steps of the AA program, called the surrender steps, require the novice AA member to admit to being an alcoholic and to thus separate him or herself from other drinkers. These steps also involve learning how to relate to one's higher power. As my research illustrates, subjects impose a variety of meanings to higher power but the common theme which emerged from my data is that higher power is depicted as a constructive, life-affirming force which helps to guide the subject in his or her recovery.

Step 4 marks a turning point in the transformation of the recovering alcoholic because the actor is required to look back at the past to carry out a personal inventory. Step 5 continues this process of self-examination and reflection but it goes further by requiring the actor to confess his or her faults to another human being, often the AA sponsor. Evidence from subjects in this study suggest that steps 4 and 5 mark the most difficult and demanding transition in the AA program and is likely the point at which many alcoholics give up and leave the fellowship. Those who successfully complete steps 4 and 5, I argue here, are in the liminal stage of transformation as described by Van Gennep (1960) and Turner (1992). In carrying out these critical steps, the actor attempts to make a break with the past, and is thus "betwixt and between" the former status as an active drinker and the evolving status as a recovering alcoholic.

Steps 6 to 11 continue the liminal stage as members engage in set of exercises designed for personal transformation. These steps involve committing to on-going self-improvement (steps 6 & 7); making amends to others (steps 8 & 9); and practicing prayer, meditation and other spiritual disciplines (10 and 11). Because of the open-ended nature of AA constructs, members are able to interpret the language of the steps in different ways. My data point to considerable variation in how amends to others are made and how spiritual practices like prayer and meditation are carried out.

When the AA member arrives at step 12, there is a more complete reunification into the world of AA and a sense of personal transformation that becomes apparent to the world outside of the rooms. This marks the third transition in Turner's model –

incorporation or aggregation. The language of step 12 reflects this sense of transformation with the words, "Having had a spiritual awakening as the result of these steps." The message inherent in these words is that once the AA member accomplishes the work of the first 11 steps and arrives at step 12, s/he would have had a personal transformation – a spiritual awakening.

Turner's ideas on communitas provide a useful framework for explaining the transformation of the individual in the context of giving back or serving the home group through twelve step work. In communitas, the self is stripped of the structural attributes that define social roles and hierarchical relations. Individuals become disengaged from normal social roles like employer-employee, parent and spouse when they enter the rooms and assume the role of alcoholic. In this new identity, individuals are released from the many degrees of super ordination and subordination that separate them from one another, and they find themselves in a situation of nonidentity which provides the potential for personal change (Turner, 1992).

The experiences of men and women in this study exemplify the intense experience of communitas. Subjects found a temporary release from their ordinary social worlds and entered the rooms of AA to embark on a shared journey of recovery. By participating in the various interaction rituals of the AA meeting, by sharing their stories and listening to the stories of others, and by working the twelve steps, subjects reported finding a sense of community which allowed them to return to society empowered by "...renewed creative

energy, an expanded worldview, and a greater sense of hope..." in the words of Victor Turner (1974: 105).

My data highlight the theme that along with the spiritual awakening that comes from working all twelve steps, there is the realization that one will always have to work the steps. Recovery is thus depicted as a life-long, ongoing process. As illustrated in my research, AA members are encouraged to identify defects of character throughout their lives and to engage in spiritual activities designed to eradicate or, at least, minimize their impact. In this sense, one is always becom*ing* recovered and always working toward an improved and idealized self.

8.2 Dramaturgical Analysis and the Evaluation of Recovery Performances

How do AA members judge whether a person is recovering and actually becoming an improved or more authentic version of his or her self? In this study, I have employed dramaturgical theory to answer this question. Evaluations as to whether someone is getting or not getting the program, whether a person has achieved contented sobriety or is simply a dry drunk, are made as AA members observe each other's performances at AA meetings.

Each and every AA meeting becomes a venue through which recovery is ultimately performed and the work of constructing a new identity as recovering alcoholic is continued. On these *front stages*, respondents pointed to the behavior of AA members during meetings as containing important clues as to whether they are 'getting the

program' and thus experiencing an authentic recovery. Missing meetings, failing to socialize before and after meetings, sharing in gossip about fellow members, not volunteering for AA events were some of the behaviours indicating that a member might not be recovering. Outside of the rooms, members looked for behavioural changes in how members related to significant others (family, friends, others in the community). Thus, an AA member was not only scrutinized on the front stages during meetings and AA social events (dances, speaker meetings, conventions etc.) but the *back stage* domains of work, family and community were also examined for proofs that one was 'living out' their programs of recovery.

One of the main findings of my research, which is not apparent in other studies, is the extent to which recovery is indexed by the principal AA text, *The Big Book*. For the medical establishment, the authoritative text is the DSM IV (TR, 2000), the so-called bible of mental illness, which provides a guide for the diagnosis and treatment of addiction. In AA, the *Big Book* helps to structure and make sense of the recovery experience.

To say that recovery is indexical is to emphasize that the meaning of that expression is tied to a particular context. Indexicality draws attention to the problem of how actors in a context construct a vision of reality in that context. They develop expressions that invoke their common vision about what is real in their situation. Thus, indexicality is at work when an AA actor makes explicit references to the steps and higher power in relation to his or her recovery. Attributing success to one's own efforts

(as opposed to the steps or higher power) become negative indexes – that one is not getting the program. Also, as my data indicated, sharing drunkalogues with no redemptive themes is an index of not being in recovery.

As an example of the indexical nature of recovery, when I asked respondents in my study how they knew they were in recovery, a number of them made reference to the "Twelve Promises." The promises are listed at the end of the Big Book. These are claims and assertions depicting the rewards for following the AA program of recovery:

(1) We are going to know a new freedom and a new happiness.

(2) We will not regret the past nor wish to shut the door on it.

(3) We will comprehend the word serenity and we will know peace.

(4) No matter how far down the scale we have gone, we will see how our experience can benefit others.

(5) That feeling of uselessness and self-pity will disappear.

(6) We will lose interest in selfish things and gain interest in our fellows.

(7) Self-seeking will slip away.

(8) Our whole attitude and outlook upon life will change.

(9) Fear of people and of economic insecurity will leave us.

(10) We will intuitively know how to handle situations which used to baffle us.

(11) We will suddenly realize that God is doing for us what we could not do for ourselves.

(12) Are these extravagant promises? We think not. They are being fulfilled among us—sometimes quickly, sometimes slowly. They will always materialize if we work for them.

The promises suggest that emotional recovery is possible for the one who works a good program. This is contented sobriety, used synonymously in the promises with words like freedom, happiness, serenity, and peace. Recovery also implies the reduction or elimination of such negative emotional states as regret, feelings of uselessness, self-pity, selfishness, self-seeking, fear and confusion (situations which used to baffle us). Respondents pointed to these key passages of the Big Book as describing the benchmarks for recovery.

Further proof that the individual has completed the rites of passage and become incorporated into the fellowship as a recovering alcoholic is found in his or her willingness to perform service work. In chapter seven, I outlined the various social roles within the AA home group. While a number of ethnographies of Alcoholics Anonymous have been carried out, my research is the first to explore these roles in any depth and detail, particularly the role played by sponsors in the socialization of new members. Sponsors are the most important significant other within the AA fellowship for the novice member. Sponsors provide all sorts of practical guidance for newcomers such as how and what to share at a meeting and how to carry out the twelve steps. Sponsors also act as confidantes and pseudo-counselors to their sponsees, sometimes offering advice on marriage and family affairs, relationships, work and finances. There is no formal training in AA to become a sponsor and those who gravitate toward this role become essential mediators and interpreters of the AA program for their sponsees.

Other roles such as the meeting chair, the AA speaker and the General Service Representative are critical to the maintenance of the home group and the larger AA social structure. Performing this type of service work allows the newcomer to develop interpersonal and organizational skills, expand his or her social network within the provincial, national and even international fellowship, and accumulate prestige and honour. Indeed, as my research indicates, involvement in service roles may account for some of the status differences in Alcoholics Anonymous.

8.3 Implications for Social Policy

Unfortunately, very little research has been done concerning people's experiences with seeking and receiving help for drinking problems in this province. The government of Newfoundland and Labrador, through its Department of Addictions Services, does not publish data on the numbers of people suffering from various types of addictions, the types of treatment services being accessed or where they are receiving treatment.[1] Critics argue that the province does not offer a coherent system of health care for those suffering

[1] In Newfoundland and Labrador, the Addictions Services Branch of the Department of Health and Community Services offers a number of services for those suffering from an addictions problem. After an initial consultation with an addictions services counselor, a client or patient might be referred for outpatient counseling at one of its regional offices; undergo a period of detoxification at its St. John's Recovery Centre or receive inpatient care at the Humberwood Centre, its provincial facility in Corner Brook which offers a three-week inpatient treatment services for men and women over the age of 18 years. However, critics of the province's treatment system for addictions point to long waiting lists, lack of resources and a shortage of specialists who are trained in the treatment of more complex forms of addiction.

from addictions, only a patch-work of services, concentrated mostly in the province's urbanized areas. Data from this study shed some light on the experiences of individuals in recovery and has important implications for the treatment of alcohol related problems.

Addiction is now recognized as a public health concern worldwide. According to the Substance Abuse and Mental Health Services Administration of the U.S.A. there are more than 11,000 treatment centres across America. The addiction treatment industry is expected to generate revenues of more than $34 billion by 2014 – an increase of 55% from 2005. The vast majority of that spending – roughly 80% - is underwritten by public funding with the remainder paid by private insurance companies (New, 2011). Services range from hundreds of dollars paid to drug or alcohol specialists up to $2,000 per day of treatment. The exclusive addiction treatment centre Promises, where Britney Spears and Lindsay Lohen have logged stays, can cost up to $100,000 for a month in a beach-view private suite with private physicians. A month-long-in-patient stay at Hazelden, one of the oldest and most prestigious U.S. treatment facilities, costs nearly $30,000 (New, 2011).

Similar to the U.S.A. market, services in Canada offer exclusive, spa-like treatment centers offering gourmet meals, nutritional coaching, full-service gyms, massage, yoga and every imaginable luxury – all provided under the guise of treatment. At the higher end of addiction services are treatment centers like Greenestone Muskoka, which targets executives and their families in need of addiction treatment. Their internet advertisement reads as follows:

> Located in a resort setting in scenic Muskoka, Ontario and equipped with holistic spa services, delicious, nutritious and seasonal menus offered through our Lodge Restaurant, and a full suite of fitness and recreation facilities, GreeneStone Muskoka is a place where you can heal, rest and recover while under the care of a multidisciplinary team of skilled and experienced professionals. Our physicians, psychiatrists, psychologists, therapists, nurses, nutritionists and physical fitness experts work collaboratively to produce the best treatment outcomes for you (http://greenestone.net/).

Canada appears to be following a trend already established in the U.S.A. whereby inpatient care for alcoholics appears to be a luxury afforded only for the well-financed or generously insured addicts. Poorer alcoholics, which include a disproportionate number of ethnic minorities, are left to fend for themselves. Some researchers speculate that many of these less fortunates have no choice but to join AA and other self-help organizations or seek church and charity-based recovery programs (McKellar et al., 2003). Ernest Kurtz, a widely respected AA historian, has stated that his professional mission is to recover the real AA which he feels has been compromised by the erosion of state-funded programs for addicts and alcoholics. Kurtz points out:

> Today, when virtually every hospital, treatment center, court and prison mandates AA referral, the result is that many AA meetings are overrun by a growing assortment of sullen, recalcitrant men and women mandated to attend AA meetings by their employers, judges and probation and parole officers... who outnumber the core members by two or three to one on a given night... I have heard other informal estimates that put the number of what I am calling POW members of AA at more than 70 per cent of the current AA membership (1991: 255).

It is difficult to establish how class and socioeconomic factors might affect treatment choices and options in this province. Certainly, I was not aware of anyone in

my home group who had been mandated to participate in AA. However, as I discussed in chapter six, several respondents in my study were involved in private therapy and treatment in addition to their involvement with AA. These subjects viewed AA as an essential complement for the treatment of their addiction. Two respondents, in particular, cited the enormous benefits of their Employee Assistance Programs.

One might reasonably assume that people who avail of counseling services through a private insurer or an Employee Assistance Program are employed or else they have enough income to afford a counselor's fees. This raises the issue of how factors like employment and income might be related to access to different services and treatment options. It would appear from these cases, at least, that AA is an important supplement to other forms of therapies and that the unemployed or those without employee assistance benefits may not have access to the same range of services outside of AA.

Social class also plays a role when recovering individuals consider some of the newer alternatives to AA. In the United States and in larger Canadian cities, the *Rational Recovery Movement* and the organization *Women for Sobriety* offer some choice for people with drinking problems. People who gravitate toward the former group report that they are attracted to the non-religious, intellectually-oriented philosophy of the program which asserts that "it is pure drivel to think that alcoholics are powerless over their addictions" or that members need some "Higher Power" to find sobriety (Kasl, 1992: 177). Rational Recovery groups recruit more members with higher education than does AA (Galanter, Egelko, & Edwards, 1993). At present, to this researcher's knowledge,

groups like Rational Recovery and Women For Sobriety do not offer recovery programs in Newfoundland and Labrador.

Gender presents another barrier to treatment of alcohol related problems. The proportion of female members in AA is not necessarily related to the number of female heavy drinkers in the population. Studies have shown that women's drinking is more stigmatized than men's, and attitudes more strongly oppose alcohol use and intoxication among women than men (Eisenbach-Stangl, 1986; Schmidt, Klee, & Ames, 1990). It has also been shown that women are less often referred to alcohol treatment than men through social control channels such as physicians, employers, or judicial authorities (Duckert, 1989). Yet, a disproportionate amount of women seek help for their alcohol problems compared to men, consistent with several studies which show that women in general seek help for health and other problems more readily than men (Duckert, 1989; Thom, 1986). One study suggests that AA is particularly attractive to female drinkers because it is free and thus may attract women with limited economic resources (Beckman, 1994).

Even when women join AA, data from this study suggest that they may have unique needs which are not being met if the home group is comprised mostly of men. This is consistent with research findings discussed in chapter three. Women for Sobriety was founded by Dr. Jean Kirkpatrick, a Ph.D. in sociology, who joined AA but was turned off by its apparent chauvinism and its insensitivity to women's needs. According to Kirkpatrick "...AA meetings did not meet my needs...the men were set in their ways and ideas, they dominated the meetings, their stories were often lurid and contained an

ego element of bragging, and their descriptions of women were often very chauvinistic" (Kasl, 1992: 166). In North America, Women for Sobriety seems to attract women in very high social positions with higher occupational status and higher levels of education compared to women who join AA (Kaskutas, 1989).

Age represents another barrier to treatment of alcohol related problems. Membership surveys carried out by AA's own General Service Office in New York indicates that there is no simple relationship between the age of the membership and the age structure of the general population. One clinical study reports that older patients are more likely to attend AA meetings compared to younger patients (Emrick et. al., 1993). However, AA can attract substantial numbers of young members with some studies showing an increase in members under the age of thirty years (Robinson 1989: 27). Findings from this study point to some potential problems that young people experience in identifying with the role of recovering alcoholic since most AA members in this province are over the age of thirty, according to AA's own in-house data. Unlike larger urban centers, it appears that it is much more difficult for a young adult in this province to find a home group comprised of similar age cohorts.

Aside from the social barriers to treatment, sociological research points to changes that must be made at the societal level if the problems associated with addictions are to be reduced or eliminated. For example, social policy changes would address government's own addiction to the profits of alcohol sales or through broader initiatives that target the housing, employment and community factors that might contribute to alcoholic

tendencies. Dr. Gabor Mate, a physician and Medical Director of the Portland Hotel initiative in Vancouver's notorious Downtown Eastside suggests that the healing art of medicine must extend its focus beyond the individual. His project directly targets the type of alcoholic and drug addict who becomes homeless and is often involved in street crimes like drug dealing, theft and prostitution to pay for their addictive lifestyles. Rather than locking them up or processing them through the criminal justice system as part of a continued War on Drugs strategy, Mate calls for more compassionate social policies which foster what he calls an ecology of healing. In his book *In the Realm of Hungry Ghosts* (2008), he offers evidence, based on MRI studies, that the brain chemistry of children living in abusive or neglectful homes is impaired enough that it makes them much more susceptible to developing addictions later in life. To address this problem, Mate advocates high quality prenatal care for mothers and children, care which would extend into the first five years of life. He also suggests that governments target fundamental needs like housing, employment and basic medical care as a way of treating alcohol and drug addictions.

Similar social policy approaches have been advocated by Richard Thatcher, a clinical sociologist in Saskatchewan, with more than 30 years of experience in the field of addictions research and community development among Canada's Aboriginal People. Thatcher, author of *Fighting Firewater Fictions: Moving Beyond the Disease Model of Alcoholism in First Nations* (2004) also advocates initiatives focused on early childhood

education and sustainable community economic development as the primary tools to tackle addictions.

Interestingly, both of these researchers resist the urge to preach simple abstinence of drugs and alcohol. Mate, a medical doctor, advocates decriminalization of drugs and harm reduction strategies using methadone clinics along with a more holistic social policy approach. Thatcher suggests that recovery approaches must be sensitive to the cultural context of particular populations like Native People and must learn to incorporate traditions involving elders and Native spirituality. He also suggests moving beyond simple admonitions that abstinence is the only way to achieve sobriety, arguing that the medical model for too long has bought into this notion promoted by AA and other groups. Thatcher presents evidence that the healthiest segment of the Aboriginal population (those who have high incomes, high levels of education, fewer health problems and higher life satisfaction indicators) are, in fact, moderate alcohol drinkers and not abstainers at all. Surely, he suggests, recovery programs might recognize this possibility - that Aboriginal drinkers are not doomed to alcoholism because of some genetic or physiological predisposition which poisons their minds and bodies - and that learning to drink moderately is a distinct possibility for the Aboriginal population.

8.4 Future Research

Although widely used, the lack of a standard definition for the term *recovery* has hindered research on the phenomenon and possibly prevented better recovery-oriented

interventions for addiction to alcohol. Future research could investigate and attempt to identify some of the core characteristics and measures of recovery from addiction. A clearer conceptualization of recovery has implications for some of the policy initiatives discussed above. For example, if policymakers have standard indicators of recovery, they can better measure the successes or failures of state funded programs and have more information at their disposal to support and extend the recovery process.

The approach taken in this study of recovery is interpretive so I have tried to give the reader a better sense of how actors conceive of recovery from the unique perspective of the AA subculture. The main dimensions of recovery have been described in terms of emotional displays, role behaviors, group performance, and transformational experiences through working the steps. From an AA perspective, recovery manifests itself in different ways at different stages. I have described the appropriate emotional displays of the penitent role, for example, and tried to distinguish this level of recovery from the person who claims to have completed all twelve steps of the AA program. Such individuals report the highest level of subjective well-being, namely contented sobriety.

Other models have attempted to isolate key dimensions of recovery. The prestigious Betty Ford Center, for example, defines sobriety as complete abstinence from alcohol and all other drugs of abuse, delineating early sobriety as between 1-11 months; sustained sobriety as between 1-5 years and stable sobriety as five or more years (Betty Ford Institute, 2007: 221-228). This measure of simple physical sobriety is certainly one of the measures of recovery that AA members look for but as one respondent put it, "you

can be sober in body, but still be a lonely, miserable S.O.B." His comments reflect the more holistic view of the World Health Organization in its definition of health as "... a state of complete physical, mental, and social well-being, not merely the absence of disease" (WHO, 1985: 34).

When we examine the personal stories and narrative accounts of AA members we may be able to use such material to guide the development of codes and help to construct quantifiable categories or dimensions of recovery. Mishler (1986), Riessman (1993), Veroff et al. (1993), Surra (1988), and Weiss (1994) have written extensively on various stages of the gathering, coding, and analysis of personal stories and narrative accounts. These researchers suggest that such approaches can be interpretive and must be planned and executed carefully. Based on my observations and in-depth interviews of AA members, data could be coded and treated within quantifiable categories as they relate to the recovery themes of emotional well-being, service/volunteerism, and a sense of community (Antaki 1988; Veroff et al 1993b). Such work could be used to guide the development of surveys or other quantitative research methods which would be valuable for generalizing to the larger community of recovering persons.

Further research into recovery should also explore the *methods* employed in the recovery process. In AA, the principal method involves working the twelve steps. However, despite a considerable amount of research into AA, there are still a great many unknowns about how the steps are actually experienced and used within the program. One longitudinal study recruited more than 2,000 subjects and used statistical techniques to

evaluate the nature of the correlation between AA membership and sobriety (McKellar et al.: 2003). The analyses indicated that the correlation between sobriety and AA membership was a function of actively engaging in the AA program. The idea that AA's success is really a function of individual characteristics of those who choose to stay in AA (and not what they do in AA) was not supported by the data. In a metanalysis George Vaillant (2005), a renowned expert on alcoholism, concluded that "Alcoholics Anonymous appears equal to or superior to conventional treatments" (2005: 431). Despite such lofty claims about the overall efficacy of AA, such studies hide important information related to the twelve steps.

One of the surprising observations arising from this study is that some AA members do not even attempt the steps, let alone complete all twelve. Future research projects could investigate how many AA members actually work the steps, how long it takes for members to complete them (to get some measure of average duration), and at which step (stage) AA members are most likely to give up. This kind of information may require quantitative research designs that use randomized, representative samples from the AA population. Such information would be useful for researchers who want to know more about how sobriety is maintained within the fellowship and how the AA program is actually used by its members. Research of this type might also help to explain the attrition of individuals from the AA program.

Future research studies might also explore status differences and hierarchies in AA, areas currently not explored in the research literature. If we examine AA as a

potential emotion market we can assume that individuals may have differential access to what Collins refers to as emotional energy. In Collins' model, individuals considering AA as an option for treatment would consider whether they can afford to invest the time, energy, cultural capital, and other resources to participate in the various rituals available to them. Actors exercise rational choice to select those interaction rituals that provide them with maximum *emotional energy*, that is, feelings of pleasure, contentment, excitement and other positive emotions. Presumably then, this would lead some AA members to avoid certain AA meetings, or drop out of the program altogether, if AA interactions are experienced as boring, depressing or emotionally unsatisfying. Such individuals, according to Collins, are likely to be located at the fringes of "social networks" (Collins, 2004: 105). Drawing on Collins' ideas about emotion, future research could investigate the development of typologies, based on levels of attachment and involvement with the fellowship, to better distinguish between the hard-core members of AA who presumably derive greater emotional rewards and the more peripheral member who would seem to be more at risk of dropping out of the program of AA.

The issue of status hierarchies within AA might also be related to the opportunity to provide services and work that is otherwise monopolized by helping professionals like doctors, clergy, psychologists or social workers. AA members who gravitate toward roles like sponsor, chair or speaker are, to a certain extent, offering quasi-professional assistance as they take confession, offer marital advice and claim expertise on matters related to addiction and recovery based solely on personal experience. Thus, the AA member who lacks status and prestige in his occupation outside of the rooms has

opportunities to accumulate prestige and status in the various service roles offered through the fellowship. Future research might probe further into the relationship between service work, status accumulation and the 'professionalization' of the self-help movement.

A focus on status hierarchies and typologies of AA members also points to a need to understand how structural factors like gender, ethnicity, socioeconomic status and age affect the AA experience. There is a growing literature on women's experiences in AA and such studies do reveal some of the unique challenges experienced by women who enter a mostly male-dominated organization. Along these lines, future research might examine the gendered division of labor within AA (by examining such roles as speakers, meeting chairs and sponsors). According to one study of AA in the United States, the higher echelons of the organization are firmly in the hands of men with more men serving on the national service board as well as chairing regional boards (Rosenquvist, 1992). What are the implications of such gender imbalances? Aside from gender, I have also raised the issue of how employment, education and income variables might affect the AA experience, alluding in the previous section to a couple of subjects who were able to avail of Employee Assistance Programs in their programs of recovery. The interplay between variables like socioeconomic status, gender, and ethnicity and involvement in AA groups and other types of addiction services are poorly understood in the research literature and require further investigation.

This study also has implications for applied research and program design in the alcohol and drug addiction field. Data from this study yield important insights into why AA appears to work for certain types of drinkers but it is clear that AA's twelve step approach is not for everyone. Some people who enter the rooms may be turned off by AA spirituality or the over zealousness of AA members. Jim Christopher, the founder of SOS (Secular Organizations for Sobriety), is one well-known AA 'failure' who appreciated the small group setting and mutual support elements of AA but who was turned off by the religious overtones of the organization. Christopher's SOS organization now advertises itself as an alternative to AA or NA for atheists and non-religious people who still want support in a group setting to help them overcome their problems with addiction (www.sossobriety.com). Future research might offer comparisons of the recovery experiences of AA members with the recovery experiences of those who have worked on overcoming alcohol problems through self-help groups like SOS or Women For Sobriety (WFS) or Rational Recovery (RR). Such research might identify specific elements of personal transformation that lead a person to overcome addiction and experience the positive changes associated with recovery. This would provide valuable information for the design of intervention programs in the alcohol and drug addiction field.

Finally, future research might examine the experiences of significant others who are drawn into the recovery performances of AA members. AA members experience recovery as a collective phenomenon in the context of a home group, but they also relate outside of the rooms to spouses, partners, parents, children, friends, neighbours and co-

workers. Family members and significant others are sometimes present at open AA meetings but little research has been conducted to explore the exact nature of their involvement and participation as 'outsiders.' For example, how are family members and significant others perceived and managed when they are present in the rooms of AA? To what extent do significant others become involved as the AA member works the twelve steps? Answers to these questions would help to further flesh out the phenomenon of recovery as it is lived and experienced by AA members.

8.5 Conclusion

This study offers an expanded understanding of the AA experience of recovery. Recovery involves more than just changes in the brains and bodies of the addicted person. It is more than changes in positive affect, mood or personality structure. Recovery is more than the gradual modifications of behaviour associated with learning models. In this dissertation, I present a new and alternative interpretation of recovery by applying insights from the fields of ritual theory and dramaturgy. A qualitative research design, using participant observation and in-depth interviews were used to generate thick descriptions of the social processes involved in recovery. Data generated from these methods have yielded new insights into the 'inner workings' of AA not yet described in the existing sociological literature.

As a theoretical approach, dramaturgical analysis and the conceptual framework of symbolic interactionism as a whole, has been criticized for focusing on the micro-

interactional process of behavior at the expense of macro-organizational influences (Jenkins, 1996; Turner, Beeghley and Powers, 2002; Snow, 2001). Proponents of dramaturgical analysis have argued, however, that organizational and macro social factors can be accommodated within this analytic framework (Denzin, 1990, Brisset and Edgley, 1990). Fine goes so far as to argue that dramaturgical analysis can explain "the interface between macro and micro approaches to the social world" (1993:69).

This study demonstrates that dramaturgy and interactionist theories provide useful tools for the examination of recovery in AA. Drawing on insights from the sociology of emotions, particularly Hochschild's work on emotion management, I have identified the emotion display rules of the AA newcomer through my description of the penitent role. I have also elaborated on the meanings attached to contented sobriety as an important affect goal pursued by AA members (Kemper, 1981; 1987); and how notions of sobriety and recovery are indexed by actors as they relate with significant others within the fellowship. My research has also brought new insights into how actors make sense of the symbols embedded within the twelve steps. Such insights may have applications for studies of the emotional experiences of individuals involved in self-help groups and mutual aid organizations (AA, NA, Overeaters Anonymous etc.). As Putnam points out in his classic study, *Bowling Alone* (2000), such groups remain important exceptions to the overall decline of voluntary associations and organizations.

This research also has important implications for the study of rituals and how these are used to facilitate transformational experiences in AA. As we return to Collins'

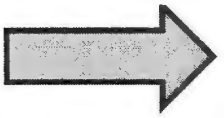
(2005: 48) theoretical work, we can see how social interactions in AA contain all of the prescribed ingredients of interaction rituals: 1) "Group assembly (bodily co presence)"is apparent throughout the meeting process due to the high level of physical and social interaction; 2) "Barriers to outsiders" are enacted through informal mechanisms such as the reading of the requirements to attend a closed meeting which is restricted to alcoholics only and the closing of the door at the start of each meeting; 3) "Mutual focus of attention" occurs as common objects, such as the Big Book, and common activities, such as birthday celebrations and closing ceremonies, promote the mutual awareness of participants in terms of "each other's focus of attention"; 4) A "shared mood" exists as participation encourages a common mood and/or shared emotional experience through activities, shared meeting spaces, and participation in readings and the sharing of personal experiences; (5) a rhythmic coordination and synchronization of conversation and nonverbal gestures; (6) a symbolic representation of this group focus and mood with objects, persons, gestures, words and ideas among interacting individuals; and (7) a sense of moral righteousness about these symbols marking group membership. These ingredients feed on each other to create the positive emotional energy (feelings of peace, serenity, contentment, optimism) that is necessary to draw people back into the rooms. This can produce a process similar to Durkheim's "collective effervescence" with the sharing of beliefs and norms (Durkheim, 1965).

Figure 1 shows a synthesis of the theoretical concepts employed in this study to make sense of the recovery experience. Organized around Turner's rites of passage

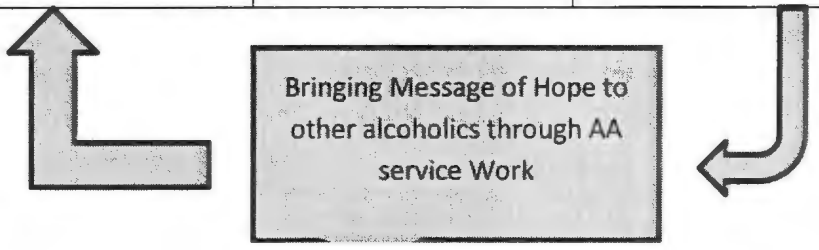
model, the table highlights the appropriate emotional displays and role behaviors as the novice/penitent alcoholic learns how to experience and perform recovery within the unique social world of AA. I present this as 'ideal recovery', recognizing the need for future research as the model does not explain why some individuals remain on the periphery of AA as 'dry drunks' who never immerse themselves in the steps. Nor does the model acknowledge the reasons why some AA members decide the quit the program or seek alternative treatment for their addiction. The lack of knowledge about such individuals who do not follow the ideal recovery path in AA warrants further sociological research.

Future research might build upon my findings around emotion displays, communitas and service work, and the rituals involved in the transformational work of the steps to further flesh out conceptual models of recovery. Insights drawn from this research might help to identify the dimensions of recovery so that conceptual categories can be developed to actually measure this phenomenon. Status hierarchies and inequalities in AA might also be explored through conflict models of interactionism which focus on access and exchanges of emotional energy. Such studies might also expose some of the tensions and barriers experienced by women, ethnic minorities and others who are attempting to find recovery in the rooms.

Figure 1: Ideal Recovery in AA



Rite of Passage	Separation	Liminal	Incorporation
Steps	1,2 & 3 – The Surrender Steps	Steps 4-11	Step 12
Emotional Display	Shame Regret Fear Worry Remorse Anger (males) Sorrow Contrition Humility	Relief of Guilt Cathartic release Hopeful Reflective Determined Acceptance of past Humility	Serenity Peace Contentment Joy Concern for others Humility
Role Behaviors and Major Themes	Focus on Self and pain of illegitimate suffering; Playing the Penitent; Separating from the drinking culture; Surrendering to higher power; Publically admitting to being an alcoholic; Receiving empathy and support from the group; Finding Sponsor	Focus on Self to relieve pain and suffering; Self-examination (personal inventory); Dealing with the past; Committing to self-improvement; Experiencing the present through prayer, meditation and other spiritual disciplines; Rigorous honesty; Working steps with Sponsor	Focus on Others; Immersion in AA subculture; Participate in Service Roles; Concern with group unity and harmony; Become a Sponsor; Demonstrate change outside of the rooms



From a social policy perspective, my findings have implications for the delivery of addiction services for the people of this province. Factors like gender, age and

socioeconomic status affect treatment of alcohol related problems. While there are more heavy drinkers and problem drinkers among males, females may show more of a willingness to look for and receive help for addictions (Adlaf et al., 2005). Individuals with more income can also afford more options when it comes to help for addictions. Private counseling sessions or private rehabilitation centers are options for the rich when it comes to battling addictions but these services are not readily available to the more economically disadvantaged segments of society. Even free services like AA may have invisible barriers which make it difficult for some individuals to access. Clearly, there is a need for further research to obtain a clearer picture of alcoholism in this province and to identify the types of services which aid in recovery.

While this research has contributed to the body of knowledge on recovery in AA, there are limitations to this study. This is partly a consequence of the research questions I posed and the theoretical lens through which I analyzed the experiences of men and women in AA in Newfoundland and Labrador. The questions I raised in this study are 'how' questions – not 'why' questions. Norman Denzin explains the distinction between why and how questions in sociological research when he discusses the epistemological characteristics of symbolic interaction theory with its emphasis on subjective meaning and interaction.

> Interactionists don't believe in asking 'why' questions. They ask, instead, 'how' questions. How, for example, is a given strip of experience structured, lived and given meaning? The likes and dislikes of interactionists mean... they are often criticized for not doing what other people think they should do, like doing macro-

> studies of power structures, or not having clearly defined concepts and terms, or being overly cognitive, or having emergent theories, or being ahistorical and astructural (1994: 44-46).

As a theoretical perspective, interactionism is limited because it must focus on some aspects of reality and ignore or de-emphasize others. Interactionist approaches, more than most theoretical frameworks, appear to be so flexible and elastic that they can respond easily to new topics and subjects of sociological inquiry. For this reason, interactionist approaches remain a useful way to understand the social world, particularly the world inhabited by those who frequent the rooms of Alcoholics Anonymous.

The title of this dissertation portrays recovery as a quest. The term quest brings to mind a pilgrimage or some type of spiritual journey. A quest also requires supreme effort and sacrifice because of the enormous obstacles that need to be overcome. In this study, I have examined the quests of the men and women of Alcoholics Anonymous in Newfoundland and Labrador. The information presented in this study will hopefully shed some light on the obstacles to recovery and illuminate the paths for those on the quest for contented sobriety.

Bibliography

Aaltonen, I. & K. Makela. 1994. "Female and Male Life Stories published in Finnish AA Journals." *The International Journal of Addictions* 29 (4): 485-495.

Adlaf, E., Begin P., Sawka E. (Eds). 2005. Canadian Addiction Survey (CAS): A National Survey of Canadians' Use of Alcohol and Other Drugs: Prevalence of Use and Related Harms. Ottawa: Canadian Center on Substance Abuse.

Alcoholics Anonymous World Services. 1939/2001. Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism, 4th ed. New York: Alcoholics Anonymous World Services Inc.

Alcoholics Anonymous World Services. 1953. Twelve Steps and Twelve Traditions. New York: Alcoholics Anonymous World Services Inc.

Alcoholics Anonymous World Services. 1957. Alcoholics Anonymous Comes of Age. New York: Alcoholics Anonymous World Services Inc.

Antaki, C. 1988. "Explanations, communication and social cognition." In Antaki, C. (Ed.) Analysing everyday explanation: A casebook of methods (pp 1-14). London: Sage.

Atkinson, P. & Hammersley, M. 1994. "Ethnography and Participant Observation." In N.K. Denzin & Y.S. Lincoln (Eds.). Handbook of qualitative Research (pp.248-261). Thousand Oaks, CA: Sage.

Babor, T.F. & Higgins-Biddle, J. & Dauser, D. & Higgins, P. & Burleson, J.A. 2005. "Alcohol Screening and Brief Intervention in Primary Care Settings: Implementation Models and Predictors." *Journal of Studies on Alcohol and Drugs* 66 (3): 361–368.

Barnes, G. E. 1979. "The alcoholic personality: A reanalysis of the literature." *Journal of Studies on Alcohol, 40*, 571-634.

Beckman, Linda. 1994. "Treatment needs of women with alcohol problems." *Alcohol, Health and Research world*. 18 (3): 206-219.

Bennett, L.A and Ames, G. (eds.) 1985. The American Experience With Alcohol: Contrasting Cultural Perspectives. New York. NY: Plenum

Bean, M. 1975. Alcoholics Anonymous. New York: Insight Communications.

Beattie, M. 1990. Co-dependent's guide to the twelve steps. New Jersey: Prentice Hall.

Bogdan, R., & Biklen, S. 1992. Qualitative Research for education (3rd ed.). Boston: Allyn & Bacon.

Borkman, T. 1999. Understanding self-help/mutual aid: Experiential learning in the commons. New Brunswick, NJ: Rutgers University Press.

Brewer, J. 2000. Ethnography. Buckingham: Open University Press.

Brissett, Dennis, and Charles Edgley, Eds. 1990. Life as Theater, 2nd ed. New York: Aldine de Gruyter.

Bebko, C. and J. Krestan. 1991. Codependency: the social reconstruction of female experience. In Feminism and Addiction. Ed. C. Bebko. New York: Hawthorn Press.

Beckman L.J. , 1994. "Alcoholics Anonymous and Gender Issues." In B.S. McCrady and W.R. Miller eds. Research on Alcoholics Anonymous, pp. 233-248. New Brunswick: Rutgers Center of Alcohol Studies.

Benton, Sarah. 2009. Understanding the High-Functioning Alcoholic. Barnes and Noble.

Berenson, D. 1991. "Powerlessness – liberating or enslaving? Responding to the feminist critique of the twelve steps." In Feminism and Addiction. C. Bebko, ed. 67-68. New York: The Hawthorn Press.

Betty Ford Institute Consensus Panel. 2007. "What is recovery? A working definition from the Betty Ford Institute." *Journal of Substance Abuse Treatment* 33: 221–228

Blue , Anthony. 2004. The Complete Book of Spirits: A Guide to Their History, Production and Enjoyment. HarperCollins. New York.

Brown, Stephanie. 1985. Treating the Alcoholic: A Developmental Model of Recovery New York: Wiley.

Canadian Centre on Substance Abuse and Addiction Research Foundation of Ontario. 1995. Canadian Profile: Alcohol, Tobacco and Other Drugs.. Government of Ontario.

Cantril, H. 1963. The Psychology of Social Movements. New York: Wiley.

Charon, Joel. 2007. Symbolic Interactionism: An Introduction, An Interpretation , An Integration. 9th Edition. N.J. Prentice Hall.

Cheever, S. 2004. My name is Bill: Bill Wilson—His life and the creation of Alcoholics Anonymous. New York: Simon & Schuster.

Clark, Candace. 1990. "Emotions and micropolitics in everyday life: Some patterns and paradoxes of place." In Kemper, Theodore D. (Ed). Research agendas in the sociology of emotions. SUNY series in the sociology of emotions.. (pp. 305-333). Albany, NY, US: State University of New York Press.

Clawson, Mary Ann. 1990. Constructing Brotherhood: Class, Gender, and Fraternalism. Princeton University Press. New Jersey.

Cloninger, C. R., Bohman, M. and Sigvardsson, S. 1981. "Inheritance of alcohol abuse." *Archives of General Psychiatry* 38, 861–868.

Collins, Randall. 2005. Interaction Ritual Chains. Princeton University Press.

Community Epidemiology Network on Drug Use (CCENDU). 2006 .Government of Canada.

Conrad, P. and J. Schneider. 1980. Deviance and Medicalization. St. Louis. Mosby.

Coombs, Robert and Pauline Powers. 1975. "Socialization for Death: The Physician's Role." *Urban Life* 4 (3): 250-271.

Crichton, Anne, Ann Robertson, Christine Gordon, and Wendy Farrant. 1997. Health Care: A community concern? Calgary: University of Calgary Press.

D'Aquili, Eugene. 2005. "Human Ceremonial Ritual and the Modulation of Aggression." *Journal of Religion and Science*. Retrieved at http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9744.1985.tb00575.x/abstract 15 Dec. 2005.

Davis, Diane 1997. "Women healing from alcoholism: A qualitative study." *Contemporary Drug Problems*. 24:147-177.

Delamont, S. (2004) "Ethnography and Participant Observation". In C. Seale, G. Gobo, J. Gubrium and D. Silverman (eds.). Qualitative Research Practice. London: Sage. Pp.217-219.

Dennis Cindy-Lee. 2003. "Peer support within a health care context: a concept analysis." *International Journal of Nursing Studies*. 40(3):321–332.

Denzin, Norman
1984 On Understanding Emotion. San Francisco: Jossey-Bass.
1987 The Alcoholic Self. Beverly Hills, CA: Sage.
1989 Interpretive Biography. NewburyPark CA: Sage
1990 Interpretive Interactionism. Newbury Park, CA: Sage.
1990 "Harold and Agnes: A Feminist Narrative Undoing." *Sociological Theory* 8 (2):198-216.
1992 Symbolic Interactionism and Cultural Studies: The Politics of Interpretation. Oxford: Blackwell.
1993 The Alcoholic Society. Newbury Park, CA: Sage
1994 "The Art and Politics of Interpretation." In N. Denzin & Y. Lincoln (eds.), Handbook of Qualitative Research (pp.500-515). Thousand Oaks, CA: Sage.
1995 "Symbolic Interactionism." In J. Smith, R. Harre & L. Langenhove (eds.) Rethinking Psychology (pp.43-58). Newbury Park, CA: Sage.

DSM-IV-TR: 2000. American Psychiatric Association.

Donovan, J.M. 1986. "An etiologic model of alcoholism." American Journal of Psychiatry. 143, 5-6.

Duckert, F. 1989. "The Treatment of Female Problem Drinkers." In E. Haavio-Mannila, ed. Women. Alcohol and Drugs in the Nordic Countries. Helsinki: Nordic Council for Alcohol and Drug Research.

Durkheim, Émile. 1965. The Elementary Forms of the Religious Life. (1912: English translation by Joseph Swain: 1915) The Free Press.

Eisenbach-Stangl, I. 1986. "Alcoholics Anonymous as a Spiritual Community." *Alcoholism: Clinical and Experimental Research* 11 (5): 416-423

Ellis, C., Bochner, A., & Denzin, N. K. 2002. "Symbolic interaction in retrospect: A conversation with Norman Denzin." *Studies in Symbolic Interaction*, 25, 179-198.

Emrick, C.D., 1994. "Alcoholics Anonymous and other twelve-step groups." In M. Galanter & H.D. Kleber, eds. Textbook of Substance Abuse Treatment . pp. 351-358. Washington University Press

Emrick C.D , J.S. Tonigan & H. Montgomery 1993 "Alcoholics Anonymous: What Is Currently Known?" In B.S. McCrady W.R. Miller eds. Research on Alcoholics Anonymous: Opportunities and Alternatives. New Brunswick: Rutgers Center of Alcohol Studies.

Faludi, Susan. 1991. Backlash: the undeclared war against American women. New York: Anchor Books.

Fetterman, D.M. 1998. Ethnography: Step by Step (2nd ed.) Thousand Oaks: CA: Sage

Fine, Gary A.
1987 With the Boys: Little League Baseball and Preadolescent Culture. University of Chicago Press.
1993 "The Sad Demise, Mysterious Disappearance, and Glorious Triumph of Symbolic Interactionism." *Annual Review of Sociology* 19:61-87

Fisher G.& T. Harrison, 1997. Substance Abuse: Information for School Counselors, Social Workers, Therapists and Counselors. Boston: Allyn & Bacon

Foster, Eric. 2004. "Research on Gossip: Taxonomy, Methods, and Future Directions." *Review of General Psychology*. Vol. 8, No. 2, 78–99. Retrieved at http://smg.media.mit.edu/library/Foster.gossipreview.pdf

Foucault, Michel. 1994 [1973]. The Birth of the Clinic: An Archaeology of Medical Perception. London: Vintage.

Galanter, M. 1990. Network Therapy for Alcohol and Drug Abuse. The Guilford Press

Galanter,M., S. Egelko, & H. Edwards, 1993. 'Rational Recovery: Alternative to AA for addiction?" *The American Journal of Drug and Alcohol Abuse* 19 (4): 499-510.

Garfinkel, Harold.
1956 "Conditions of Successful Degradation Ceremonies." American Journal of Sociology 61: 420-24.
1967 Studies in Ethnomethodology. Northwestern University Press.
2002 Ethnomethodology's Program. New York: Rowman and Littlefield.

Gerlach, Luther and Virginia Hine. 1968. "Five factors crucial to the growth and spread of modern religious movement." *Journal for the Scientific Study of Religion*.7:23-40

Geertz, C. 1973. The Interpretation of Cultures. London: Fontana.

Goffman, Erving
1959 Presentation of Self in Everyday Life. Garden City, N.Y.: Anchor
1959 Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Garden City, N.Y.: Anchor
1961 Encounters: Two Studies in the Sociology of Interaction. Indianapolis: Bobbs-Merrill.
1963 Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs. N.J. Prentice-Hall.
1971 Relations in Public. New York: Basic Books.
1974 Frame-Analysis: An Essay on the Organization of Experience. New York: Harper Colophon.
1979 Gender Advertisements. New York: Harper and Row
1988 "Entretien avec Erving Goffman." In Yves Winkin, Ed. And trans., Les moments et Leurs Hommes. Pp.231-38. Paris: Seuil/Minuit.

Gomme, I. 2004. The Shadow Line: Crime and Deviance in Canada. Thomson Nelson Press.

Gold, R. 1958. "Roles in sociological field observation." *Social Forces*. 36, 217-213.

Greenestone Muskoka. Retrieved from greenestone.net September 12, 2011.

Griffin, Kevin. 2004. One Breath at a Time: Buddhism and the Twelve Steps. Rodale Press.

Gross, J. J. 1998. "The emerging field of emotion regulation: An integrative review." *Review-of-General-Psychology*. 2, 271–299.

Gusfield, Joseph R. 1996. Contested Meanings: the Construction of Alcohol Problems. The University of Wisconsin Press.

Halberstadt, Amy and Martha Saitta. 1987. "Gender, Nonverbal Behavior, and Perceived Dominance: A Test of the Theory." *Journal of Personality and Social Psychology* 53:257-272

Halliwell, Ed. 2009 "AA: Addicted to Addiction." *The Guardian*. Tuesday, 28 April. Retrieved at http://www.guardian.co.uk/commentisfree/belief/2009/apr/28/alcoholics-anonymous-12-step-religion.

Harrison H., Carver J., and Prochaska.O. 2005. Handbook of Alcoholism Treatment Approaches (3rd edition). Boston: Allyn & Bacon.

Harvey J.H., Orbuch T.L, Weber A.L. 1990a. Interpersonal Accounts. Oxford: Blackwell.

Harvey J.H., Orbuch T.L., Weber A.L. 1990b. "A social psychological model of account-making in response to severe stress." *Journal of Language and Social Psychology* 9 (3): 191-207

Hezler, J., A. Burnham, and L. McEvoy. 1991. "Alcohol abuse and dependence." In Psychiatric disorders in America: the epidemiological catchment area study. L. Robins and D. Regier, eds. Pp.81-115. New York: The Free Press.

Hill, S. 1984. "Vulnerability to the biochemical consequences of alcoholism and alcohol-related problems among women." In Alcohol problems in women: Antecedents, consequences, and intervention. S. Wilsnack and L. Beckman, eds. Pp.121-154. New York: Guilford Press.

Hobsbawm, Eric & Terence Ranger, eds. 1983. The Invention of Tradition. Cambridge University Press

Hochschild, Arlie. 1983. The Managed Heart: The Commercialization of Human Feeling. Berkeley: The University of California Press.

Huss, M. 1849. Alcoholismus chronicus. Chronisk alkoloisjukdom: Ett bidrag till dyskrasiarnas känndom. Stockholm: Bonner/Norstedt.

Jenkins, Richard. 1996. Social Identity. London: Routledge.

Jensen, George H. 2000. Storytelling in Alcoholics Anonymous: A Rhetorical Analysis. Southern Illinois University Press.

Johnson, Paul 1978. A Shopkeeper's Millenium: Society and Revivals in Rochester, New York, 1815-1837. New York: Hill and Wang.

Johnson, H. C. 1987. Alcoholics Anonymous in the 1980s: Variations on a theme. University of California Press.

Judge M.G., 1994. "Recovery's Next Step." *Common Boundary, 12 (3): 16-24.*

Kaskutas, L. 1989. "What do Women Get Out of Self-Help?" *Journal of Substance Abuse Treatment* 18 (3): 299-314.

Kasl, C.D. 1992. Many Roads: One Journey: Moving Beyond the 12 Steps. New York. Harper Perennial.

Katz, Jack. 1999. How Emotions Work. University of Chicago Press.

Keller, M. 1976. "The Disease Concept of Alcoholism Revisited." *Journal of Studies on Alcohol*, 11, 1701

Kemper TD.
1978 A Social Interactional Theory of Emotions. New York: Wiley
1990 Research Agendas in the Sociology of Emotions. New York: SUNY Press

Kemper, Theodore and Randall Collins. 1990. "Dimensions of Microinteraction." *The American Journal of Sociology*. 96:32-68.

Kenney, J. Scott and Ailsa Craig. 2012. "Illegitimate Pain: Introducing a Concept and a Research Agenda." In Emotions Matter: a Relational Approach to Emotions. Edited by Dale Spencer, Kevin Walby and Alan Hunt. University of Toronto Press.

Khantzian E. 1995. "Alcoholics Anonymous - cult or corrective: A case study." *Journal of Substance Abuse Treatment*. 12(3): 157-165

Kidder, Jeffrey. L. 2006. "Bike Messengers and the Really Real: Effervescence, Reflexivity, and Postmodern Identity." *Symbolic Interaction* 29: 349-371.

Kirkpatrick, Jean.
1977 Turnabout: New Help For the Woman Alcoholic. New York: Bantam Books.
1986 Good Bye Hangovers, Hello Life: Self-Help for Women. New York: Atheneum.

Kosut, Mary. 2006. "Mad Artists and Tattooed Perverts: Deviant Discourse and the Social Construction of Cultural Categories." *Deviant Behavior*. 27.1 (2006): 73-95. Retrieved at:
http://web.ebscohost.com

Kurtz, E. 1991. Not God: A History of Alcoholics Anonymous. Center City, Minnesota. Hazelden.

Kyvig, David E. 1985. Law, Alcohol, and Order: Perspectives on National Prohibition. Greenwood Press.

Langeland, W., and C. Hangers. 1998. "Child sexual and physical abuse and alcoholism." *Journal of Studies on Alcohol*. 59: 336-350.

Leach, Barry and John Norris. 1977. "Factors in the Development of Alcoholics Anonymous." Pp.441-553. In The Biology of Alcoholism, edited by B. Kissen and H. Begleiter. New York: Pergamon.

LeCompte, M.D., & Schensul, J.J. 1999. Designing and Conducting Ethnographic Research. Walnut Creek, CA: AltaMira.

Lee, R. 1997. "Journal Keeping as an aid to research. Some ideas." The Weaver: A Forum for New Ideas in Education.

Lender, M. E., & Martin, J. K. 1987 [orig. 1982]. Drinking in America: A History. New York: Free Press.

Ledermann S. 1956. "Alcool et Alcoolisme." In Drinking and the Distribution of Alcohol Consumption. Ole-Jorgen Skog Rutgers Center of Alcohol Studies. 1991

Lemanski M.J. 2001. "The Tenacity of Error in the Treatment of Addiction." *The Humanist* 57 (3): 18-24

Lender, M.E. and Martin, J.K.1982. Drinking in America: A History. New York: Free Press.

Levi, A. 1996. Feminist reconstructions of identity in a self-help program: a study of two social movement organizations for incest survivors. Ohio State University Press.

Levine, H. 1978. "The Discovery of Addiction: Changing Conceptions of Habitual Drunkeness in America." *Journal of Studies on Alcohol* 39 (1): 143-174.

Levine H. 1988. "An Overview of Intervention Issues from a Historical Perspective." In Society, Culture and Drinking Patterns Reexamined. D.Pittman & Helene White (eds). Rutgers Center of Alcohol Studies. New Jersey.

MacAndrew, C. 1986. 'Toward the psychometric detection of substance misuse in young men: The SAP scale." *Journal of Studies on Alcohol*, 47, 161-166

Madsen W. 1980. The American Alcoholic. Springfield, Illinois: Charles Thomas

Manning, Philip. 1992. Erving Goffman and Modern Sociology. Stanford University Press.

Mate, Gabor. 2008. In the Realm of Hungry Ghosts: Close Encounters with Addiction. Knopf Canada.

Maxwell, M. 1984. Alcoholics Anonymous: A Close-Up View for Professionals. New Jersey, Wiley Press.

McCarthy, R. 1958. Alcoholism: Attitudes and Attacks. 1775-1935. Chicago - University of Chicago Press.

McClelland, David. 1972. The Drinking Man. New York: Free Press.

McHugh, M., Beckman, L. & Frieze, I.H.1979. "Analyzing Alcoholism." In I.H. Frieze, D. Bar-Tal, & J.S. Carroll (eds), New Approaches to Social Problems (pp.168-208). San Francisco: Jossey-Bass.

McKellar, J., E. Stewart and K. Humphreys. 2003. "Alcoholics Anonymous involvement and positive alcohol-related outcomes: Cause, consequence or just a correlate?" *Journal of Consulting and Clinical Psychology*. 71 ,302-308.

Miller, Geri. 2005. Learning the Language of Addiction Counseling. Second Edition. New Jersey. Wiley Press.

Miller, W. R. & Hester, R. K. 1989. "Treating alcohol problems: Toward an informed eclecticism." In R. K. Hester & W. R. Miller (Eds.), Handbook of alcoholism treatment approaches: Effective alternatives (pp. 3-13). Elmsford, NY: Pergamon Press.

Mintz, Sidney and Christine Dubois. 2002. "The Anthropology of Food and Eating." *Annual Review of Anthropology* Vol. 31: 99-119. Retrieved at http://www.annualreviews.org/doi/abs/10.1146/annurev.anthro.32.032702.131011?journalCode=anthro

Mishler, Elliot G. 1986. Research Interviewing: Context and Narrative. Cambridge, MA: Harvard University Press.

Moore, M. and Gerstein, D. Eds. 1981. Alcohol and Public Policy: Beyond the Shadow of Prohibition. Washington, D.C. National Academy Press.

Murphy, W., E. Coleman, E. Hoon, and C. Scott. 1980. "Sexual Dysfunction and treatment in alcoholic women." *Sexuality and Disability*. 3: 240-255.

New, Catherine. 2011. "The Real Tab for Rehab: Inside the Addiction Treatment Biz." Retrieved from http://www.dailyfinance.com/2011/06/03/

Nixon, S.J. 1994. "Cognitive deficits in alcoholic women." *Alcohol Health & Research World* 18(3):228–232.

Noaks, L., and Wincup, E. 2004. Criminological Research: Understanding Qualitative Methods. London: Sage.

O'Dwyer, P. 1993. Alcoholism Treatment Facilities. New York: Guilford Press.

Ogborne A. C. 1989. "Some limitations of Alcoholics Anonymous." In M. Galanter (Ed.). Recent developments in alcoholism: Treatment research. New York: Plenum

O'Halloran, Sean.
2009 The Discourse of Alcoholics Anonymous. Cambria Press.
2003 "Participant Observation of Alcoholics Anonymous: Contrasting Roles of the Ethnographer and Ethnomethodologist." *The Qualitative Report*, (8) 1 March edition.

Orbuch, Terri L. 1997. "People's Accounts Count: The Sociology of Accounts." Annual Review of Sociology Vol. 23: 455-478. Retrieved at http://www.annualreviews.org/doi/full/10.1146/annurev.soc.23.1.455

Parsons, Talcott. 1951. The Social System. Glencoe, Ill.: Free Press.

Pattison, E. M. 1982. Selection of treatment for alcoholics. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Peele, Stanton 1999. Diseasing of America: How We Allowed Recovery Zealots and the Treatment Industry to Convince Us We Are Out of Control. New York: Harper

Peterson, J.H. 1992. "The International Origins of Alcoholics Anonymous." *Contemporary Drug Problems* 19 (1): 53-74.

Pittman, B. 1988. AA: The Way it Began. Seattle: Glen Abbey

Putnam, Robert. 2000. Bowling Alone: The Collapse and Revival of American Community. New York: Simon & Schuster.

Rapping, Elaine. 1996. The culture of recovery: making sense of the self-help culture. Boston: Beacon Press.

Rehm, J. 1993. "Don't Drink: Believe and Act! The Derivation from philosophical pragmatism of the principles of Alcoholics Anonymous." *Addiction Research* 1:109-118.

Rieff, David. 1991. "Victims All? Recovery, Co-dependency, and the art of blaming somebody else." Harper's Magazine. October, 1991.

Riessman, C.K. 1993. Narrative Analysis: Qualitative Research Methods Series, No. 30. Newbury Park, CA: Sage.

Robertson N., 1988. Getting Better: Inside Alcoholics Anonymous. New York, Morrow.

Robinson D. 1989. Talking Out of Alcoholism: The self-help process of Alcoholics Anonymous. London. Croom-Helm.

Roebuck MC. JD Ketcham. C Lucarelli. EJ Miravete. 2010. "Sinking. swimming. or learning to swim in Medicare." *American Economic Review* 21 (4): 301-315.

Room, R.
1989. "Alcoholism and Alcoholics Anonymous in U.S. Films, 1945-1962: The party ends for the Wet Generations." Journal of Studies on Alcohol.50:368-383.
1993 "Alcoholics Anonymous as a social movement." pp. 167-187 In: Barbara S. McCrady and William R. Miller, eds., Research on Alcoholics Anonymous: Opportunities and Alternatives. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Rorabaugh, W.J. 1979. The Alcoholic Republic: An American Tradition. New York - Oxford University Press.

Rosenhan. D.L. 2002. "On Being Sane In Insane Places". Pp.. 222-237 In: Brent Slife (ed.), Taking Sides: Clashing Views on Controversial Psychological Issues. NY: McGraw-Hill.

Rosenquvist. P. 1992. "From the Rib of AA." *Contemporary Drug Problems* 19 (4): 605-629.

Rudy. David R. 1986. Becoming Alcoholic: Alcoholics Anonymous and the Reality of Alcoholism. Southern Illinois University Press.

Sagarin E. 1969. Odd Man In: Societies of Deviants in America. Chicago: Quadrangle Books.

Sanders. Jolene. 2009. Women in Alcoholics Anonymous. First Forum Press.

Schaef. Anne. 1987. When Society Becomes an Addict. CA: Harper and Row.

Schaler. Jeffrey. ed. 2004. Szasz Under Fire: A Psychiatric Abolitionist Faces His Critics. Open Court Publishing

Scheff. Thomas. 1999. Being Mentally Ill 3rd Edition. Hawthorne. NY: Aldine de Gruyter.

Schmidt.C. L. Klee. & G. Ames. 1990. Review and Analysis of Literature on Indicators of women's Drinking Problems. British Journal of Addiction 85:179-182.

Schneider, J. 1978. "Deviant Drinking as Disease: Alcoholism as a Social Accomplishment." *Social Problems* 25:361-72.

Schuckit, Marc. 2012. "Changes To Criteria For Substance Use Disorders In Next Diagnostic and Statistical Manual of Mental Disorders (DSM-V)." Retrieved from http://www.quantumday.com/2012/06/changes-to-criteria-for-substance-use.html June 6, 2012

Scott, C. K., Foss, M. A., & Dennis, M. L. 2005. "Pathways in the relapse treatment-recovery
cycle over 3 years." *Journal of Substance Abuse Treatment*, 28, S63–S72.

Silkworth. History of Alcoholics Anonymous. Retrieved at www.silkworth.net/aahistory/historyaa.html

Smith, A. R. 1993. "The Social construction of Group Dependency in Alcoholics Anonymous." *The Journal of Drug Issues* 23 (4): 689-704.

Sournia, Jean-Charles 1990. A History of Alcoholism. B.Blackwell Publishers.

Snow, David
2001 "Extending and Broadening Blumer's Conceptualization of Symbolic Interactionism." *Symbolic Interaction* 24:367-377
2007. "Frame." In George Ritzer (ed.). The Blackwell Encyclopedia of Sociology. Oxford: Blackwell.

Spear, L.P. 2000. "Adolescent period: Biological basis of vulnerability to develop alcoholism and other ethanol–mediated behaviors." In Noronha, A.; Eckardt, M.; and Warren, K.; eds. Review of NIAAA's Neuroscience and Behavioral Research Portfolio. National Institute on Alcohol Abuse and Alcoholism (NIAAA) Research Monograph No. 34. Bethesda, MD: NIAAA, 2000*a*.

Stake, R. 1995. The Art of Case Research. Thousand Oaks, CA: Sage.

Stokes, Randall and John P. Hewitt. 1976. "Aligning Actions." American Sociological Review, vol. 41 (October): 838-849. Retrieved at http://www.jstor.org/discover/10.2307/2094730?uid=3739424&uid=2&uid=3737720&uid=4&sid=21101297851427

Storr, Anthony. 1989. Freud. Oxford University Press.

Student Drug Use Survey. 2007. Government of Newfoundland and Labrador. Department of Health and Community Services.

Surra CA. 1988. Turning point coding manual. University of Texas. Austin.

Sutro. L. D. 1989. "Alcoholics Anonymous in a Mexican peasant-Indian village." *Human Organization* 48 (2): 180-186

Szasz, T. 1974. The Myth of Mental Illness. New York: Harper and Row.

Tallen, Bette. 1995. "Codependence: a feminist critique." In Challenging codependency: feminist critiques. M. Babcock and C. McKay. eds. Pp.169-176. University of Toronto Press.

Tajfel, H. 1982. Social identity and intergroup behavior. Cambridge, England: Cambridge University Press.

Temperance Orders. Retrieved September 1, 2011 at www.phoenixmasonry.org/masonicmuseum/fraternalism/temperance_orders.htm

Thatcher, Richard. 2004. Fighting Firewater Fictions. Moving Beyond the Disease Model of Alcoholism in First Nations. University of Toronto Press. Scholarly Publishing Division.

Thatcher, D.L., and Clark, D.B. 2004. "Alcohol misuse in adolescents: Epidemiology, clinical characteristics, diagnosis, and treatment." In: Preedy, V., and Watson, R., eds. Comprehensive Handbook of Alcohol Related Pathology Vol. 1. London: Elsevier. pp. 195–215.

Thio, Alex 2001. Deviant Behavior. Seventh Edition. Pearson Education.

Thom B. 1986. "Sex Differences in Help-Seeking for Alcohol Problems." *British Journal of Addiction* 81:777-788.

Trice. H. and Paul Roman. 1970. "Delabeling, relabeling and Alcoholics Anonymous." *Social Problems* 17: 38-58.

Turner. Jonathan H., Beeghley, Leonard. & Powers. Charles H. 2002. The emergence of sociological theory (5th ed.). Belmont. CA: Wadsworth Thomson Learning.

Turner. Terence S. 1977. "Transformation, hierarchy and transcendence: A reformulation of Van Gennep's model of the structure of rites of passage." In S.F. Moore & B. G. Myerhoff (Eds.). Secular Ritual (pp. 53-70). Amsterdam. The Netherlands: Van Gorcum.

Turner. Jonathan. 2002. Handbook of Social Theory. New York: Plenum Publishers.

Turner. Victor W.
1969. The ritual process: structure and anti-structure. Chicago: Aldine Publishing.
1973. "The Center Out There: Pilgrim's Goal". *History of Religions*, 12: 191-230.
1985. On the edge of the bush: anthropology of experience. Tucson: University of Arizona Press.
1992. Blazing the trail: Way marks in the exploration of symbols. Tucson: University of Arizona Press.

Trice H.and P. Roman, 1970. "Delabeling, Relabeling, and Alcoholics Anonymous." *Social Problems* 17 (4): 538-546.

Tsekeris, Charalambos and Nicos Katrivesis. 2008. "Reflexivity in Sociological Theory and Social Action." *Philosophy, Sociology, Psychology and History* Vol. 7, No1, 2008, pp. 1 – 12. Retrieved at http://facta.junis.ni.ac.rs/pas/pas2008/pas2008-01.pdf

Ulrichsen J, Nielsen MK, Ulrichsen M. 2010-12, "Antabuse in Severe Alcoholism: An Open Controlled Study." *Nord J Psychiatry*. 64(6):356-62. Epub 2010 Mar 18.

Urbina. Ian. 2012. "Addiction Diagnoses May Rise Under Guideline Changes." New York Times. May 11, 2012. Retrieved from http://www.nytimes.com/2012/05/12/

Vaillant. G.E. 2005. "Alcoholics Anonymous: Cult or Cure?" *Australian and New Zealand Journal of Psychiatry*, 39, 431-436.

Van Den Bergh, Nan. 1991. "Having bitten the apple: a feminist perspective on addictions." In Feminist perspectives on addiction. Nan N. Van Den Bergh. ed. Pp.3-20. New York: Springer Publishing.

Van Gennep. Arnold.1960{1909]. The Rites of Passage. Chicago. Illinois. University of Chicago Press.

Van Maanen. J. 1988. Tales of the Field: On writing ethnography. Chicago: University of Chicago Press.

Veroff J. Sutherland L. Chadiha L. Ortega RM. 1993. "Newlyweds tell their stories: A narrative method for assessing marital experiences." *Journal of Comparative Family Studies*. 10:437–457.

Vourakis. Christine. 1989. The process of recovery of women in Alcoholics Anonymous: seeking groups like me.University of California Press. Berkeley. San Francisco.

W. Bill. 1969. Testimony Before the Special Subcommittee on Alcoholism and Narcotics of the U.S. Senate Committee on Labor and Public Welfare. July 24. 1969.

W. Bill. 1989. The Language of the Heart: Bill W.'s Grapevine Writings. New York: Alcoholics Anonymous.

W. Bill. 1967. As Bill Sees It. New York: Alcoholics Anonymous.

Weiss, Robert S. 1994. Learning from strangers: The arts and method of qualitative interview studies. New York: Free Press.

Weitz, Rose. 1996. The Sociology of Health, Illness and health care: A critical approach. Belmont, Calif.: Wadsworth.

West SL, Garbutt JC, Carey TS, Lux LJ, Jackman AM, Tolleson-Rinehart S, et al. 1999. Pharmacotherapy for alcohol dependence. Rockville, Md.: U.S. Department of Health and Human Services; Public Health Service; Agency for Health Care Policy and Research.

Wilkerson. A. 1996. A History of the Concept of alcoholism as a Disease. University of Pennsylvania Press.

Wilsnack. R., S. Wilsnack and S. Hiller-Sturmhofel. 1994. "How women drink: epidemiology of women's drinking and problem drinking." *Alcohol, Health and Research World.* 18 (3): 173-181.

Wilson, John. 1978. Religion in American Society: the Effective Presence. Englewood Cliffs, N.J.: Prentice Hall.

Wolcott. S. 1990. Writing Up Qualitative Research. Newbury Park. CA: Sage.

Wood. Julia. 1999. Gendered Lives: Communication. Gender and Culture 3rd Edition. Belmont, CA: Wadsworth.

Woolverton. J.F. 1983. "Evangelical Protestantism and Alcoholism 1933-1962: Episcopalian Samuel Shoemaker. the Oxford Group and Alcoholics Anonymous." Retrieved at www.silkworth.net. September 10. 2011.

World Health Organization. 2003. World health Report 2003. New York: World Health Organization. Retrieved September 12. 2011 at http://www.who.int/about/definition/en/print.html

Wuthnow, Robert. 1990. The Restructuring of American Religion: Society and Faith Since World War II. Princeton University Press

Appendix 1:

Letter of Introduction: Members of Alcoholics Anonymous Needed for Research Project:

My name is Terry Murphy. I am a doctoral student with the Department of Sociology at Memorial University of Newfoundland. I am interested in hearing the experiences of AA members, particularly with regard to how they experience the AA program of recovery. I would like to hear how you make sense of the twelve steps, the twelve traditions and how you experience recovery within the fellowship of AA.

For example, how do you feel your "Higher Power" helps you to recover? How have you experienced each of the twelve steps? What are your personal views on recovery? What does it take to recover from the disease of alcoholism?

If you volunteer for this study, I will be asking you to describe, in your own terms, your experiences and opinions about such matters. I have a list of open-ended questions which encourage you to express your experiences and opinions on these topics in your own words. With your written permission, interviews will be audio taped on standard cassettes, and later transcribed for use in this study. Interviews will be conducted in person at a location of your choice. The whole process should take you no more than an hour or two to complete.

No harm will come to you as a result of participating in this research. Your participation in this study is entirely voluntary, and you can rest assured that any comments you personally make to me is entirely confidential. What you say will not be shared with other members of AA, other researchers or anyone else in the area. In addition, you must feel free to decline any questions that may upset you, and, if you choose, must feel free to stop at any time and be assured that all your comments will be deleted at your request.

Confidentiality will be assured in the following manner. First, I urge you not to use your real name or the names of others, referring instead to people by their roles (e.g. the "Meeting Chair" or "my sponsor"). Second, you can rest assured that any actual names or inappropriate details inadvertently given will be deleted, replaced in the above manner, and never used in any publication. Indeed, you will only be referred to by a number, in addition to your age and gender. Third, any details that may call attention to your identity will either be left out, or when necessary, discussed at such a broad level of generality that no clear identification can be made.

In addition, all tape recordings, transcripted data, and computer disks will be stored in a locked drawer in a secure room when not being used in this research. Following completion and publication of this study, all consent forms, tape recordings, surveys, computer diskettes, and transcripts will be destroyed.

Ultimately, if you choose to participate in this research, you will have the opportunity to provide input for a study that may contribute to the body of knowledge on alcoholism and the recovery process. For, if we can find what out how members use the AA program of recovery to achieve sobriety, we may find solutions to the serious social problems posed by alcoholism, particularly in the province of Newfoundland and Labrador. At your request, a copy of the research findings will be made available to you upon completion of this study through the Provincial Archivist of Alcoholics Anonymous in Newfoundland and Labrador.

If you are interested in participating in this study, please contact the GSR who will then put youin contact with me at the addresses below. Thank you.

Terry Murphy PhD Candidate
Department of Sociology, Memorial University of Newfoundland
Email: Terry.Murphy@cna.nl.ca
Telephone: St. John's 709-737-7443
Carbonear 709-596-8917 or home 709-786-1158.

Appendix 2: Consent Form for Interviews

Please read the following carefully before deciding whether or not to proceed with this interview.

I am a Ph.D student with the Department of Sociology at Memorial University. I am inviting you to participate in my research study. The purpose of this project is to explore the little-studied experiences of AA members as they become acquainted with the AA program of recovery and learn to make sense of the Twelve Steps, Twelve Traditions and the roles associated with becoming a member of Alcoholics Anonymous. If you choose to participate, your role will involve participating in an interview.

You will be asked to describe, in your own terms, your experiences and opinions about the AA program in your life. I have prepared a list of open-ended questions which encourage you to express your experiences and opinions on these topics in your own words. Your participation is completely voluntary. You may withdraw from this study at any time without penalty. With your written permission, sessions will be audio taped on standard cassettes, and later be transcribed for use in this study. The interview should take you no more than an hour or two to complete.

You can rest assured that any comments you personally make to me are entirely confidential. In addition, please feel free to decline any questions that may upset you and, if you choose, feel free to stop at any time and be assured that all your comments will be deleted at your request. All information obtained in this study will be kept strictly confidential and anonymous. I will keep all information and observations in the strictest confidence, whether in terms of data collection, storage, reporting or publication. No real names will be used in data collection, and I urge you to refer to people in terms of their roles (i.e. My sponsor, the Meeting Chair). Aside from observable demographic details (i.e. age and gender), I will record information using only the official role that the specific parties occupy in the AA organization (Chair, GSR, AA delegate). Subjects' real names / identifying information will appear nowhere except on these consent forms, which will be securely locked away in sealed envelopes. All other data will be separately stored in a locked office accessible only to myself. Once it is no longer reasonably necessary to refer to these data, all consent forms, coded data, and computer files will be securely stored.

Ultimately, if you choose to participate in this research, you will have the opportunity to provide input that will not only contribute to academic understanding, but likely contribute important insights into the experiences of recovering alcoholics.

Please feel free to ask any questions about the research or the interview process. If you have concerns that cannot be answered by me, you may contact my PhD supervisors, Dr. Peter Sinclair, Dr. Robert Hill or Dr. Scott Kenney at the Department of Sociology, Memorial University at 709-737-7443.

Please keep one copy of this form for your own records. Thank you very much for agreeing to participate in this important research. If you would like to review a summary of the research findings upon completion of this study, please write your mailing address and other contact information on the back of this form and I will notify you when I submit a copy of my findings to the provincial AA Archivist.

If you feel distressed in any way as a result of participating in this research, information on local counsellors may be obtained by calling the Association of Newfoundland Psychologists for an appropriate referral: (1) (709-739-5405).

Thank you in advance for your assistance in this project.

Terry Murphy, Ph.D Candidate
Department of Sociology
Memorial University
St. John's NL

1. I agree to be interviewed.

Signature_____ Date:_____

2. I agree/disagree that the interview will be audio-taped.

Signature_____Date:_____

3. I agree/disagree that the interview transcript may be deposited in a public archive for five years after the research has been completed.

Signature_____

Appendix 3: Interview Schedule

Questions for Topical Life History

Early Experiences with Alcohol

When did you realize that you had a problem with drinking?

Please tell me how you came to realize that you were an alcoholic.

Who do you reveal this identity to and who do you conceal it from? Why?

Entry Into AA

Please describe how you became involved with AA.
Please describe your initial impressions and experiences with AA. What else attracted you to AA?

Probes:
(Probe:What was your first meeting like?)
How did you find out about the organization? How did you make first contact - i.e. did you call a service office? Receive a visit from an AA member (12 step call), attend an open/closed meeting?

Interpretation of Disease

AA suggests that alcoholism is a disease but there is some discussion that it's more of a morality issue or it's more of a personal choice? What are your thoughts on alcoholism as disease?

Experience with Steps

Note: Hand out the 12 Steps:

The first step of the program says that you "admitted powerlessness over alcohol." How do you interpret the idea of powerlessness?

The second step talks about turning to a "Higher Power" for assistance.
What does this step mean to you?
What does the term "Higher Power" mean to you?
Did your conception of "Higher Power" change as a result of your involvement with AA? If so, how?
Please describe how your Higher Power helps you in your recovery - provide examples.
How has your sense of spirituality affected your recovery - please give examples.

Please tell me about your experience of doing a "moral inventory." How did this help your recovery?

Step Five suggests that you should admit to another human being the exact nature of your wrongs. Could you tell me how you carried out this step and what it meant to you?
What is significant to you about step 6 (having God remove defects of character) and step 7 (asking God to remove our shortcomings)?

Please tell me about your experiences of naming persons you harmed (step 8) and making amends (step 9). How did you go about doing this? Why did you feel this was necessary?

Step 10 talks about taking a personal inventory and admitting wrongs. Please tell me about your experiences with this step.

Step 11 encourages prayer and meditation to understand God's will. How do you incorporate this step into your recovery?

Step 12 talks about carrying the message of AA to other alcoholics. Why do you think this is important to your recovery? Please provide some examples.

Using Literature

AA provides a great deal of literature on alcoholism and recovery.
Has any of this literature been significant in your recovery?
How did you use the literature? Please provide examples.

Service Work: Giving Help to Significant Others & Receiving Help from Significant Others

Have you ever performed any service work for AA? If so, could you describe this work? Probe for experience as sponsor, GSR, district officer, AA delegate, 12 step caller.

In your opinion, is service related to recovery? If so, how? Could you describe how your service activities have affected your own recovery or of others in the fellowship?

Sponsorship:
Have you been a sponsor to anyone?
What are the primary responsibilities of being a sponsor?
What are the most important tasks and responsibilities of a sponsor?
What do you like about being a sponsor - what's the most satisfying?
What is the most difficult thing about being a sponsor?

Have you personally had a sponsor in the AA program? Please tell me about your relationship

with your sponsor - how you met, your early experiences?

How did your sponsor help you in your recovery? Did s/he help you to come to terms with your identity as an alcoholic?

The Group:

The role of the AA group. How is the group involved in your recovery? Why is group unity so important to you? Why is the welfare of the group important to you?

Tell me what a healthy AA group looks like? What about an unhealthy one?

Emotional Experiences

Could you describe your emotional state when you first got involved with AA?

How would you describe the emotional changes of your recovery? Probes: how did you deal with (guilt, remorse, shame, etc.).

How did your sponsor or others help you to deal with these feelings?

How did you feel when you first admitted to being an alcoholic at an AA meeting?

AA speaks of "finding inner peace" and "serenity". How would you describe this "peace" in emotional terms? Have you achieved this "peace" ? If so, how?

Probes: How did you express your emotions prior to your involvement in AA - i.e. did you find it difficult or easy to express how you were feeling?

Conceptions of Recovery

AA suggests that members never fully recover from the disease of alcoholism - that they will always be "in recovery." Do you agree with this interpretation?

What does "being in recovery" mean for you - i.e. what are the signs or indicators of recovery? How can you tell if somebody is not recovering or simply "going through the motions"?

Please complete this sentence: Recovery means _____.

Conclusion:
Is there anything else that you would like to add? Is there anything about your experiences with AA that you would like to share?