A lifetime of living sober: An exploration of how people with an alcohol use disorder use self-help groups in pursuance of a lifetime of sobriety, using Alcoholics Anonymous as an exemplar

Brendan Murphy

MSc Counselling and Therapeutic Communication Faculty of Life and Health Sciences

School of Nursing Ulster University

A thesis submitted for the degree of Doctor of Philosophy

Dedication

I dedicate this thesis to the following people:

Participant "Denise", who passed away just as I was finishing writing up this thesis. In her 40 years plus of sobriety, she was the "poster girl" for Alcoholics Anonymous (AA) through how she applied its program in every circumstance – even in her last few days.

"You are not gone until no one mentions your name anymore."

and

My neighbour and friend, Jennifer Harvey, who gently persuaded me to “have another go” at “doing” a PhD while I was still bitter and resentful in the relatively early years of remission from the second form of cancer I live with.

Acknowledgements

I wish to acknowledge the unfailing guidance and support of my supervisors – Dr Anne Moorhead with her infectious enthusiasm and Dr Maggie Long for her insightful comments – especially during the early changes enforced by the SARS- CoV-2/Covid-19 pandemic.

I am also indebted to all the participants, whose identities must remain anonymous. Without their openness and honesty about their personal recovery journeys, freely and willingly given, I could not have undertaken this study or been able to gain such insights into how they lived sober through some of the horrific traumas their lives entailed. Having heard of my work, many other members who were not part of the interviewing process added to my understanding of how AA works by providing helpful comments and insights into their beliefs of "*How it works"*.

Often overlooked are two ladies who played vital roles in starting AA in the U.S. and Ireland. The first is Henrietta Seiberling, who introduced Bill Wilson to Bob Smith in 1935, and set the ball rolling for what was to become the initiating meeting of this now worldwide philanthropic organization. The second is Eva Jennings who was instrumental in getting Conor F. to meet with Richard P. and start the first ever meeting of AA in Ireland in 1946. Without their interventions, countless lives would have been unnecessarily wasted.

Declarations

I hereby declare that with effect from the date on which the thesis is deposited in the Research Office of the University of Ulster, I permit

1. The Librarian of the University to allow the thesis to be copied in whole or in part without reference to me on the understanding that such authority applies to the provision of single copies made for study purposes or inclusion within the stock of another library. This specifically excludes the full interview transcripts as they contain sensitive and personal data.

2. The thesis to be made available through the Ulster Institutional Repository and/or EThOS under the terms of the Ulster eThesis Deposit Agreement, which I have signed.

It is a condition of use of this thesis that anyone who consults it must recognize that the copyright rests with the author and that no quotation from the thesis and no information derived from it may be published unless the source is appropriately acknowledged.

I confirm that the word count of this thesis, excluding Abstract, References, Appendices, Indices and Tables, is less than 100,000 words

Abstract

Background: Alcohol use disorder (AUD) is an- increasing global issue and this study addresses an existing gap in addiction research by exploring how self-help groups support members in achieving a lifetime of recovery.

Aim: To increase the understanding of how people with alcohol use disorder (AUD) use 12 step self-help groups to achieve a lifetime of sobriety,

Methodology: This research was based on qualitative methodology drawing on interpretative phenomenological analytic principles. In total, 23 purposively selected members of AA from five different countries across five different decades of sobriety were interviewed. The 5 groups had six participants with 10 years of unbroken sobriety, five with 20 years, five with 30 years, 5 with 40 years and two with more than fifty years.

Findings: Four main findings emerged

(i) An overarching theme, *"moving from alcohol dependence to living happy, joyous and free"*, was identified, deriving from eight recurrent themes.

(ii) Cognitive impairments affect recovery for many months; with true stabilization taking many years.

(iii) There are, in fact, core elements to Alcoholics Anonymous group's undefined "message" and

(iv) AA's "12 promises" come true in line with the recovery process.

Discussion and Recommendations: While self-help groups can succeed, interventions at an early education level have an excellent potential to address addiction precursors. Accepting severe dependence as lifelong conditions facilitates a "remission" rather than a "cure" approach. Rehabilitation organizations need to be more cognizant of the findings that cognitive impairments impair client's ability to absorb rational thoughts, cognitive processing, sobriety-based knowledge and new practices for many months and that early admission to such therapeutic facilities are unlikely to produce very low successful outcomes.

Conclusion: Experiences of a self-help group for people with AUD can provide the context of mutual support necessary for the realization of an enriched abstinent life in recovery; this process may translate to treatment of other dependency behaviors.

Keywords: Alcohol Use Disorder (AUD); Lifetime recovery; self-help groups; Sobriety; Messages for Recovery; Alcoholics Anonymous.

Table of Contents

2. Literature Review

4. FINDINGS

6. CONCLUSION

LIST OF TABLES

List of Figures

Indices:

APPENDICES

Abbreviations:

(i) General abbreviations

AA Alcoholics Anonymous

AAI Adult Attachment Interview

APA American Psychiatric Association AUD Alcohol Use Disorder

DSM Diagnostic and Statistical Manual

ICD International Classification of Diseases

NA Narcotics Anonymous

WHO World Health Organization

(ii) Abbreviations used by participants

"Twelve-step" and "12-stepping" are terms deriving from the twelfth step of Alcoholics Anonymous (and other similar programmes) that states, "*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"* (AA, World Services, 2001, p.60). Details of how this may be done are set out in Chapter 7 of that book (pp. 89-103). It is the process whereby a person who is actively drinking/using may be approached and told there is a solution to their problem with alcohol/substance use through the programme; the member tells them how they did it themselves. The chapter starts with *"Practical experience shows that nothing will so much insure our immunity from drinking as intensive work with other alcoholics."* (AA, World Services, 2001, p .89).

"Big Book" is the name members use for the principal textbook "Alcoholics Anonymous" (2001).

"Doing service" or "service" is an integral part of the 12-step ethos. It can mean anything from preparing a room for a meeting, arranging a meeting, acting as Treasurer or Secretary, to representing a group at an Intergroup meeting (which coordinates groups within an area so that they do not send out mixed messages).

"Doing the steps" means going through each of the 12 steps sequentially with a sponsor in detail in the format laid out on pp. 65-6 of the book "Alcoholics Anonymous" (AA, World

Services, 2001). The sponsee is supposed to write a detailed account before the discussion with the sponsor.

"Group Of Drunks", "God" and "Good Order and Direction" are used interchangeably in AA.

“Front-line group” refers to a group that is singular in the way it approaches its meetings. There are many differing bases for this label e.g., the type of attendees (‘beginners’ or ‘old-timers’). Mainly, however, it means a group that remains focused on a particular Step, Tradition or AA topic - allowing only slight variation, and usually a speaker is time-constrained to a few minutes.

“Geographicals/geographics” is a term used to describe moving to a different place or country to get away from life problems. When used, it is to point out that the problems remain with the individual – no matter where they go – until they deal with them.

“Group sponsorship” is where a small number of members get together to discuss an individual problem and how they could deal with it.

“ISMs” is a term used by 12-step groups to describe the behaviours attached to alcohol dependence deriving from splitting the word *alcohol* and *ism*. Members believe they can still manifest themselves, even when not actively drinking or in recovery. It covers a diverse range of negative behaviours, such as ways of thinking, selfishness and self-centeredness. There are several colloquialisms for what it means, such as “I Sabotage Me”. This colloquialism is often used in association with the term “dry drunk”. It also draws on the WHO’s ICD-10 classification of diseases 1993 definition of addiction as cited by Crilly (2002, p.119):

“*A state of periodic or chronic intoxication detrimental to the individual or society, produced by the repeated consumption of a drug, characterized by an overpowering desire or need (compulsion) to continue taking the drug, because of either psychological or physical dependence on the effects of the drug, and a tendency to increase the dose or frequency of use.*”

“Prison service” is seen as a vital role in carrying the message of AA/NA that alcohol/drug abuse is the reason why many people are in prison. Prisoners, per se, could not set up a group in prison without a prison guard being present – breaching the twelfth tradition *“Anonymity is the spiritual foundation of all our traditions – ever reminding us to place*

principles before personalities" (AA World Services Inc., 2012, p. 188). However, when an AA/NA member from outside a prison approaches a prison governor hoping to set up a meeting within the prison, they are usually allowed to while in sight of, but not the hearing of, a prison officer. Many new members are recruited this way and go on to lead everyday decent lives when they are released.

"Sponsors" are members with several years of experience from whom a member may seek guidance or help. They are available 24 hours a day, seven days a week, but usually meet weekly at pre-determined times.

"Step meetings" are meetings that address a specific step of the 12 steps. The group usually addresses a step and then moves on to the next step at each subsequent meeting, week or month until all 12 are visited, and then they repeat the process. The focus is on how each of the steps works and impacts members. Generally, the discussion follows the subject as set out in the AA publication "*Twelve Steps and Twelve Traditions"* (AA World Services Inc., 2012).

"Open meetings" are meetings where non-members are allowed to attend, and the speakers usually include 1-3 active members, a member of Al-Anon and an addiction professional. Each speaker gives their perspective on alcoholism and recovery, and there is a question-and-answer session towards the end.

"War stories" are lengthy monologues given by alcohol-dependent people at a meeting describing, in detail, their drinking behaviour and careers. They are usually given by relative newcomers who are in the early stages of their recovery. "Long-termers" tend to find them repetitive and boring as they very rarely hear anything they have not heard before.

1. INTRODUCTION

In 2021a, the World Health Organization (WHO) estimated that the number of Covid-19 related deaths lay somewhere between 1.8 and 3 million. That pandemic has wholly changed and affected the way people now live their lives throughout the world. On the other hand, for many years now WHO has been reporting more than 3 million deaths annually directly related to alcohol abuse, and a multiple of that number by 40 times in disability-adjusted life years lost. However, no major upheaval in day-to-day living has been imposed or is appreciable in addressing or highlighting this problem. There is a vast amount of literature on many aspects of Alcohol Use Disorder (AUD), but little has been done to stop the unnecessary waste of life. In the absence of any effective intervention at a governmental or international level, those affected are making efforts "on the ground" to address the problem themselves through self- help groups, societies and other non-governmental organizations.

1.1 Introduction

The World Health Organization's *Global Status Report on Alcohol and Health 2018* (WHO, 2018a) highlights many aspects of alcohol misuse problems. Although the World Health Organization has produced many subsequent documents, this is the most recent comprehensive report covering all aspects of alcohol-related problems. Worldwide, over 3 million deaths in 2016 (approximately 5.3% of all deaths) were due to harmful alcohol use, rising to 7.7% for males compared to 2.6% for females. The report also pointed out that alcohol consumption causes death and disability relatively early in life. In the age group 20–39 years, approximately 13.5% of total deaths are alcohol-attributable. Alcohol was also responsible for causing 132.6 million disability-adjusted life years (DALYs). The proportions of all fatalities and DALYs caused by alcohol consumption were highest in the European region, where 10.1% of all deaths and 10.8% of all DALYs were attributable to alcohol consumption – 4.1% higher than their nearest comparator, America (WHO, 2018, p. 65). They point out that the European region is also the region with the highest prevalence of alcohol use disorders in the population (WHO, 2021b) Further, an estimated 237 million men and 46 million women have alcohol use disorders, with the highest prevalence among men and women in the European region – 14.8% and 3.5% respectively

(WHO, 2018, p. xvi).

Alcohol consumption can lead to dependence and an increased risk of developing more than 230 diseases including liver cirrhosis, HIV/AIDS, and some cancers. The World Health Organization classifies the abuse or misuse of alcohol as a disease in its International Classification of Diseases (ICD-10), (WHO, 2018b) Chapter 5, F10.0-6; sub-clause 02, F10 deals with dependence. The report highlights that harmful alcohol use can also have severe third-party social and economic consequences for individuals and society. Those affected may be the spouse or partner, child, relative, friend, neighbor, co-worker, or strangers (e.g., in road traffic accidents). Hope et al. (2018) show that 51% of those affected are strangers and a survey of specific harms to others carried out in New Zealand found the prevalence of such damage to be higher than the majority of injuries from one's own drinking – 18% versus 12% (Connor & Casswell, 2012).

Despite warnings in previous reports, and indeed the evidence "on the ground", only 80 of the WHO's 194 member states had written national alcohol policies by 2018. However, a further 73 did have national awareness-raising activities. The report also points out:

> *"In general, the greater the economic wealth of a country, the more alcohol is consumed and the smaller the number of abstainers."* (WHO, 2018a, p. 78).

Although the ICD-10 was the official document used in the United States to classify diseases since 1999 (updated and superseded by ICD-11 from 1 Jan 2022), in far greater usage is the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA). The WHO drew heavily on the proponents of the then DSM-IV in drawing up their International Classification of Diseases,

"…which ensured effective and productive consultation between groups working on ICD-10 and those working on the fourth revision of the American Psychiatric Association's Diagnostic Statistical Manual (DSM-IV) classification." (WHO, 1993)

The DSM (now in version V) does not enjoy universal acceptance, however. It has been labelled as *"the billing bible of psychiatry"* (Breggin, 1994, p. 193). Paul McHugh, Chairman of Psychiatry at Johns Hopkins University, is quoted as saying the following while speaking at the APA's 2004 annual convention symposium held on the topic *"DSM-V Classification of Personality Disorders: The White Paper and Beyond"*

> *"…the Diagnostic and Statistical Manual"* has *"permitted groups of 'experts' with a bias to propose the existence of conditions without anything more than a definition and a checklist of symptoms. This is just how witches used to be identified."*

Regarding the increasing costs in terms of life, society and social well-being, in 2010 the WHO's General Assembly on the Prevention and Control of Non-Communicable Diseases set the voluntary target of a 10% relative reduction in harmful use of alcohol by 2025, measured against a 2010 baseline. While the 2018a report may indicate macro moves by governmental agencies towards that objective through control mechanisms, it is not clear how this may be filtering down to an individual personal psyche – wherein both the origin and the terminus of the problem lie.

Despite the WHO (2018a) taking an interest in the subject, as defined by their ICD-10, AUD is not a cross-cultural phenomenon. Room et al. (1996) undertook studies in nine societies chosen for their cultural and language differences and found substantial differences in applying the concept on a cross-cultural basis.

1.2 Constructing the disease concept of alcohol dependence

Three academic papers between them give a representative account of the origins and time frame of the construction of the concept of alcohol addiction as a disease – *The Discovery of Addiction* (Levine, 1978); *The Cultural Framing of Addiction* (Room, 2004), and *Addiction as an Accomplishment* (Reinerman, 2005). Levine (1978) points to the transformations in society at the Industrial Revolution in the late eighteenth century, when there was a shift to powered special-purpose machinery, factories and mass production, and mobility. Room (2004) suggested that these led to seismic changes in family dynamics and traditional community support networks. Economies, and the economic functioning of families, required more self- control. He suggested that it was in this historical and cultural context that the concept of the nuclear family was to emerge, attuned to the clock (where time is viewed as a commodity or spent rather than experienced), allowing the notion that a substance might "cause" one to "lose" self-control to become thinkable. Reinerman (2005) points out that not all drinkers become alcoholics, and it follows that the pharmacological properties of the psychoactive substance are not the cause of the addiction-as-disease. The other option is that it is a person-specific disease, but any

biological basis remains unproven to any substantial extent after decades of research. Reinerman also refers to the conceptual acrobatics needed, reflected in the continual redrawing of definitional boundaries – the essential elasticity of addiction-as-disease – to keep it within a workable framework. According to Levine (1978), the idea that AUD is a progressive disease is about 175-200 years old, but no older. Levine (1978) suggested that we are now entering the era of "post-addiction" where the question of the nature of alcohol problems lies within the relationship between the individual and society, not the individual and the drug, and refers to the growing success of self-help groups. Levine (1978) is not alone with this *"blasphemy of doubt"* (Reinerman, 2005). Zinberg's (1984) study of heroin usage among returning Vietnam veterans and the rates at which they voluntarily quit, on returning home, added further doubt about established outcomes such as an inevitable "loss of control". Many other experts joined this argument, such as Seeley (1962), Hanson, B. (1985), Fingarette (1989), Peele (1989) and Cohen (2000). Schneider (1978) showed that Alcoholics Anonymous, Dr E.M. Jellinek, The Yale Centre for Alcohol Studies and The National Council on AUD provided the institutional basis to construct the disease concept – paving the way to give that conception an official imprimatur and a substantial funding base.

West (2001) carried out a relatively straightforward literature search and highlighted 138 different addiction theories to various substances. Since then, there have been many more, such as his own *Outline of a Synthetic Theory of Addiction* (West, 2006); Orford's (2001) *Addiction as an Excessive Appetite,* and Flores' (2004) *Addiction as an Attachment Disorder.* The simple enduring fact is that alcohol is an inanimate substance, not vital to human physical existence, that is harmless to humans unless they ingest it. The title of Shaffer's paper (1997) summed up the position succinctly: *"The Most Important Unresolved Issue in the Addictions: Conceptual Chaos".* Although there is still no clear consensus on the nature of addiction or dependence as a disease, the treatment industry's focus has now turned its attention to attempting to define recovery. No actual "recovery" figures are available because only a few Alcohol Use Disordered people seek treatment, and many resolve their problem through their own devices, methods, or volition. However, Mekonen et al. (2021), in a systematic review and meta-analysis, concluded *"Globally, approximately one in six people with AUDs receives treatment. Treatment rates for AUDs are generally low, with even lower rates in low and lower-middle-income countries"* (p. 2617). Attempting to carry out comprehensive follow-ups by treatment

centers has always presented significant operational difficulties, since those who left early or relapsed become almost impossible to trace or declined contact.

Severe alcohol dependency was only acknowledged since the 1600's (Reinerman, 2014), and has had many different formal curative approaches applied to its remediation, starting with the Washingtonians in 1850. Before *time* itself became a 'commodity' (Room, 2004, p. 226), alcohol did not appear to have been a significant problem. Ironically, the role of alcoholism is not given much attention by one of the most outstanding social commentators of the time (Shakespeare 1565-1616). Many different therapeutic approaches have been attempted in more recent times, since originated in 1905 by Pratt for tuberculosis (Kaklauskas and Greene, 2019) such as the biopsychosocial model of Prochaska & DiClemente (1984), Cognitive Behavior Therapy (Beck 1960), Rational Emotional Behavioral Therapy (Ellis 1950's) and many more. There are no significant differences in the outcomes (American Addiction Centers, 2022) between group and individual approaches. A Psychodynamic approach such as Khantzian, E.J.& Mack, J.E. (1989) and Motivational Interviewing (Miller & Rollnick, 1983) are also part of a broader approach to addressing substance or behavioral dependence, which have been successfully trialed. Although Alcoholics Anonymous (AA) became the 'public face' of alcoholism treatment, it was only one part of many different approaches.

Project Match (1993) was the most extensive and expensive research project in the US into approaches to AUD remediation and lasted three years. Conducted years after the infamous 'Dodo Bird effect' (an analogy derived from 'Alice in Wonderland'), which showed that all therapeutic approaches have similar outcomes – described initially by Rosenzweig (1937) confirmed by Eysenck (1952/62) and re-confirmed by Luborsky (2002), Project Match demonstrated that this effect was still applicable when Twelve Step Fellowships (TSFs), Motivational Interviewing and Cognitive Behaviour Therapy were compared under carefully controlled matching circumstances, and furthermore that matching clients to specific types of treatments made no difference. Kelly et al.'s (2020) Systematic Review, came out in favor of TSF's stating that they lead to less interventions and produced similar benefits to other treatments on all drinking related outcomes except for continuous abstinence and remission, where AA or TSF's are superior (p. 641). AA/TSF's also reduce healthcare costs. A total of 27 studies (21 RCTs, quasi-experiments, 5 nonrandomized and 1 purely economic study) containing 10,565 participants were included.

AA/TSF interventions performed at least as well as established active comparison treatments (e.g., CBT p, 641) on all outcomes except for abstinence where it often outperformed other treatments. It is plausible, for example that other AUD recovery-supportive, mutual-help organizations, such as Self-Management and Recovery Training (SMART), LifeRing, and Women for Sobriety, may confer similar benefits (Kelly *et al.*, 2009; Kelly and White, 2012). Although these organizations may espouse different theoretical orientations and variations in their approaches to help people attain and maintain recovery from AUD, there may be more similarity than differences in the therapeutic dynamics operating within these groups (Kelly *et al.*, 2009; Kelly, 2017).

Moreover, attrition rates in the treatment of AUD are a significant issue reported in much research. The dropout rate from treatment worldwide is in the range of 80% (e.g., Kluwer et al., 2017; Moos & Moos, 1998). Emrick and Beresford (2016) reported similar figures when they refer to initial dropout rates from all therapeutic approaches as being approximately 78-80%. However, they point out that many who relapse return to treatment again, leading to a much higher but indeterminable rate of permanent success and are calculated at 48 months as 42%. These findings show the imperative need to develop approaches that address the issues impacting on initial drop-out rates.

In this author's experience while working in one rehabilitation centre over two years, the high drop out rate is directly associated with genuine abstinence 'lifting the fog' on the enormity of damage, neglect and irrational behavior that had being going on for years. This is replaced by a misplaced sense of panic that they must leave immediately to fix or address some of the more compelling resultant problems or another. It is only after a few weeks (and usually a relapse) that they realize that their 'dropping out' was a serious error of judgement on their part. Regarding dropping out of AA meetings, there is the additional effect of decreasing the person's perception of self-worth and they are often too embarrassed to return and admit further failure.

Morgan (1994) suggested that more studies on extended lengths of sobriety (10 years or more) "*...the exception outcome rather than the rule...*" (p.60) may give some guidance about the changes that have taken place and contributed to the recovery success. He cited Vaillant and Milofsky's (1982) work on understanding the "natural healing processes" as

vital to the guidance and design of more effective treatment interventions. Ojesjö et al. (2000) described outcomes for treated alcoholics under the 40-year follow-up Lundby Study in Sweden, and this demonstrated the subjects' reasons for change as social stabilization, treatment, family and peer pressure, and medical complications.

Pattison et al. (1977) broadened the base of exploring "recovery" by suggesting there were circumstances where "*...recovery from alcohol dependence bears no necessary relation to abstinence although such a concurrence was frequently the case"* (pp. 4-5) (see also Helm, 2019). His view led to new treatment approaches, such as motivational interviewing and cognitive behavioural therapy. White (2007a) also suggested a shifting from the pathology and intervention paradigms to a solution-focused one, evidenced by the international growth of addiction recovery mutual aid societies (Humphreys, 2004; White, 2004), a new recovery advocacy movement (White, 2007b), and a shift in the design of addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management.

1.3 Self-help and mutual help groups' involvement in addressing excess alcohol consumption

The excessive use of alcohol fell under the general term of gluttony from time immemorial and was regarded as a "moral failing". Alcoholics and other deviants were grouped with others who had demonstrated "moral failings." In the years leading up to Prohibition, many US states began passing laws that mandated the sterilization of those they considered "defectives" – the mentally ill, developmentally disabled, alcoholics and addicts (Mann et al., 2000). During Prohibition (1920-33), AUD was generally seen from a social rather than a medical perspective. Alcoholics were relegated to city "drunk tanks," "cells" in "foul wards" of public hospitals, and the "rear wards" of ageing insane asylums. They did not get the help they needed. In the Second World War, alcoholics, under the Nazi regime, met the same fate as other deviants – extermination.

The temperance/puritanical movement approach from the 1800's had transferred the view that what was once "*the good creature of God"* was now the "*demon destroyer*" (Reinerman, 2005, p. 311). While that view may have been appropriate to a particular

time, it fell out of favor with the abolition of Prohibition in the United States. However, the personal ownership of AUD has not lost its foothold in the public mind. Flacks (2012) points out that although "*'addiction', or the preferred term, 'substance dependence' is classified as a disability for international systems of disease classification,"* it is excluded from provisions prohibiting discrimination against disabled people. In criminal matters, it usually constitutes an exacerbating factor.

As this opprobrium against excessive drinkers gained a foothold, a growing number of self-help or mutual help groups emerged. Mutual help groups (MHGs) – often described as self- help groups (SHGs) – are groups of two or more people who come together and share an experience or common problem to provide problem-specific help and support to each other (Humphreys, 2004). The terms are used interchangeably in the literature (Katz, 1993; Katz & Bender, 1976). These non-professional groups are run by their members, who attend as they wish for as long as they like. They do so without any official approval or divulgence of personal identification. In contrast to professional intervention, help is available whenever it is most needed, whether that time is out of office hours, weekends or not – they are highly adaptive to the undulating risk of relapse (Kelly & Yeterian, 2011). However, in some communist or totalitarian regimes they are regarded as being subversive.

Sagarin (1969) suggested a fundamental difference between the two types of self-help groups in their approach to the "*management of deviance".* One system seeks to disavow the related stigma attached to the group and its members by public adherence to the society's normative order by reforming or giving up the aberrant behaviour. In contrast, other groups take the approach of changing the attitudes of others in society. Use is made of the first part of Katz and Bender's (1976) five-fold typology of self-help groups, *"Groups that are primarily focused on self-fulfillment or personal growth"* (i.e., therapeutic groups) in the following review of the literature relating to alcohol dependence treatment approaches. By far the best-known and most written-about self-help group for AUDs is Alcoholics Anonymous (AA); hence the preponderance of the review is based around AA literature.

The founders of AA in 1937 were able to draw on the failings of past efforts (White, 2010), and for this reason they realized they needed (a) a programme to stop their members from killing themselves and (b) a set of 12 "traditions" to prevent members from

killing one another – imploding or destroying the new fellowship. Bufe (1991) described AA as carrying into practice the organizational ideals of classical anarchist thought. Room's (1998) international outline described how MHGs flourish in other countries – Sweden (Links movement); France (Vie Libre, Croix d'Or and Croix Bleu); Italy (Clubs for Alcoholics in Treatment – CATS); Croatia, Poland, and Denmark. Chenhall and Oka (2006) describe Danshukai (also known as The All- Nippon Society), a Japanese self-help organization for alcoholics. Room (1998) also explained how each of these organizations is influenced to a greater or lesser degree by AA. Parkman et al.'s scoping review of SHGs for AUDs (2015) claimed to be an *"...international review of SHGs in recovery..."* (p.102), but no references to these organizations appear within it.

The "dry" status of the US (Room & Mäkelä, 2000) – particularly post-Prohibition and economic depression – led to severe alcohol abuse and dependence problems, leaving it open to exploitation by the newly formed AA self-help group. Its simplicity, against the background of elitism and commercialization of the Oxford Group and others, and general moral disapproval of inebriates, led to its rapid expansion, popularity and survival, which has continued long after the deaths of founders Bob Smith (dec. 1950) and Bill Wilson (dec. 1971). In 1955, Wilson transferred the assets of AA were to an independent board of trustees – thus beginning AA's "corporate vow of poverty" – possibly one of the reasons it has endured, by putting "...principles before personalities" (AA World Services Inc., 2012, tradition 12).

Alcoholics Anonymous World Services, Inc. (2021) currently estimates that the organization has 2.1 million members worldwide in 118,000 groups spanning 180 countries.

The first 164 pages of AA's handbook (*Alcoholics Anonymous,* 4th Ed. 2001) have remained unchanged since first published in 1939. Throughout, it emphasizes that it is a suggested recovery programme only and makes no attempt to define how to conceptualize recovery in the way Witkiewitz et al. (2020a) and others seek to. Indeed, Williams (2021), in addressing the problem of AA's timeless wisdom but outdated language states,*" While constructive criticisms of AA can be beneficial to the organization, other criticisms have merely served as rhetorical devices intent on discrediting the 12-step approach"* and concedes that *"Findings reveal tenuous statements in the AA literature that appear*

contradictory and thereby invite a misreading." (p. 1079), leading it to being an 'open target' for critiquing and taking from its actual beneficial content. For this thesis, "alcoholism" accords with the Diagnostic and Statistical Manual V (2013). While that Manual describes three levels for the condition – mild, moderate and severe alcohol use disorder – the latter is most germane to this research.

1.4 Research question, aim and objectives

Although there is a large volume of literature on alcohol addiction, no study has, as yet, explored how members of a 12-step group can stay in remission over a lifetime. This study aims to address this knowledge gap by exploring how members of one particular alcohol dependence self-help group, AA, have done and are doing so.

Research question

How do people with alcohol use disorder (AUD) use self-help groups to achieve a lifetime of sobriety?

Aim

To explore the experiences of people with alcohol use disorder (AUD) using self-help groups to achieve a lifetime of sobriety, using Alcoholics Anonymous (AA) as an exemplar.

Objectives

1. To explore the experiences of people with AUD at the first meeting of their self-help group, on which their current sobriety is based.
2. To understand the core elements of the message from the self-help group for people with AUD in developing a lifetime of sobriety.
3. To understand how people with AUD interpret and develop the core elements of the message underpinning their recovery at 10 years, 20 years, 30 years, 40 years, and 50 years.
4. To understand the challenges of incorporating the core elements of the message from a self-help group into a lifetime of recovery from AUD.
5. To provide recommendations for self-help groups on supporting people with AUD in maintaining a lifetime of sobriety.
6. To provide recommendations for spin-off organizations, educational and

preventative services, and other professionals interested in alcohol or substance use disorder in the wider community to address AUD.

1.5 Outline of the thesis

Chapter 1 sets out the prevalence of current problems with severe alcohol abuse disorders, the ambiguities that arise with understanding its origins, and the doubts about whether it is a medical problem or a social one. Bypassing the 134 theories about its nature, self-help groups have been getting on with addressing the problem – the most prominent organization being Alcoholics Anonymous (AA). The research question is then stated, followed by the aim and objectives of the study, together with an outline of the thesis chapters.

Chapter 2 sets out a review of relevant literature, generally at first, then focusing on AA's practices and procedures and its strengths and weaknesses, leading to the theoretical backdrop and rationale for this study's research question, aim and objectives.

Chapter 3 sets out the evolved interpretative analytic methodology adopted and the rationale for that choice. It then describes the individual stages and the logic of participant selection and

numbers; recruitment methods; obtaining participant informed consent; how anonymity, data protection and safety measures were incorporated; and how research integrity was assured through the project's approval by Ulster University Research Ethics Committee. Data gathering and the underlying epistemological and theoretical foundation are also described. The chapter concludes with a statement of the researcher's reflexive interest.

Chapter 4 illuminates the findings of participants' idiographic sense-making of "where they were at" in terms of recovery and how they had got there. This chapter is divided into sections of increasing decades of recovery, and, for each decade, superordinate themes, themes and sub- themes are identified. Each section's summary includes the researcher's sense-making of the participant's sense-making. When all decades from years 10 to 50 (inclusive) have been explored in detail, and together, an overarching theme and themes common to all groups emerges for scrutiny.

Chapter 5 contextualizes the findings in Chapter 4 within extant literature and the theories

of Bowlby (1973) on attachment and Maslow's (2014) psychology of being. It discusses the critical processes of severe alcohol use disorder recovery without professional intervention – save for issues outside the remit of the 12-step ethos such as residual childhood abuse traumatology. This discussion chapter has two parts – "From Insanity to seeking Normality" and "From Normality to Generativity/Transcendence".

Chapter 6 concludes the thesis by describing how the research aim was met through the findings, acknowledges its limitations, and illuminates how the research can have real practical value if the stated recommendations are implemented. It also sets out three substantial contributions to the already large body of literature that have hitherto been overlooked.

2. LITERATURE REVIEW

2 (i) Introduction

This chapter explores existing literature that reviews how self-help groups (SHGs) function, communicate and perpetuate their messages. Because of the wide breadth of literature and a diverse range of methodologies about SHGs, a narrative review was selected as the most effective tool to map the field of information most germane to this thesis.

The nature of the research did not lend itself to a systematic review, which is a precise and detailed format designed to answer a specific question. A narrative review was selected as the most appropriate format for this thesis because it facilitated identifying what was already known, allowing for consolidation, and building on previous work and identifying omissions or gaps (Grant & Booth, 2009, p. 97). However, there are weaknesses to this approach, including the lack of explicit intent to maximize the scope of the analysis of data collected, risk of bias, and the omission or lack of scrutiny of the validity of statements made. Further, there is the risk that the researcher may only select literature supporting their particular world view, leading to undue credence in a preferred hypothesis (Grant & Booth, 2009, p. 97). Nonetheless, a narrative review, strengthened using systematic approaches, was deemed most suitable for the topic under scrutiny. This literature review aimed to critically review previous research in the area of self-help groups for alcohol recovery.

2 (ii) Search Strategy

A systematic approach was used to inform this narrative review and locate relevant research studies. The specific literature of interest to this review contained empirical studies that (a) explored the impact of SHGs on participants suffering from AUD or alcohol dependence, including studies that used comparison or control groups; (b) considered interventions whether by 12-step groups or fellowships, non-12-step groups or SHGs or Mutual Help Groups (MHGs), or social groups that had no professional connection or association either with treatment facilities, counsellors or ongoing monitoring or residential homes such as Oxford Houses; (c) were restricted to measuring outcomes with abstinence-only recovery from alcohol as their primary focus; (d) were limited to participants over the age of 18 regardless of location or ethnicity who were

attending one of the SHG or MHGs, and (e) were in the English language only. Specific studies excluded from the review were those (a) that did not record the length of sobriety of participants; (b) that related to any online groups or SHGs; (c) whose outcome did not focus on examining abstinence-only results such as returns to controlled drinking. Policy papers, theoretical papers, commentaries, dissertations and theses were outside the review's scope.

Figure 1: Literature inclusion and exclusion criteria

Inclusion criteria:	Exclusion criteria:
Study type: Empirical work that explored the impact of SHG's for people suffering from alcohol dependence, including where comparison groups are used. Intervention type: 12-step, SHG, MHG, peer groups, 12-step fellowships, or social group led by recovering alcoholics and no professional connection or association with facilities such as residential houses. The latter avoids cross-fertilization of outcomes. Outcomes: Only studies that investigated abstinence from alcohol as their primary focus. Recipients: Aged 18 and upwards, regardless of location or ethnicity, attending SHGs Language: Only English language studiesx`	Study type: Any study that did not record the length of sobriety of participants. Studies relating to any online groups. Outcome: Any study that did not assess abstinence as their primary outcome (to exclude those that also considered returns to controlled drinking etc.) Nature of reference: Policy papers, theoretical papers, commentaries, dissertations and theses.

This literature review needed to be transparent in identifying the highest possible amount of relevant material (Centre for Reviews and Dissemination, 2001). A four-stage modified approach to the searching was adopted in line with Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines (Moher et al., 2009), and each stage was documented to make it replicable by others – ensuring its methodological rigour (Mays et al., 2001; Arksey & O'Malley, 2005). The steps were: (a) searching electronic databases, (b) searching the reference lists of located material, (c) hand-searching selected journals, and (d) Internet searching.

2 (iii) Databases Searched

The following databases were searched: Ovid Medline; PsychINFO; Embase; CINAHL Plus; Web of Science; Cochrane Database of Systematic Reviews; Social Services Abstracts; ASSIA; Social Care Online. Internet searching carried out through Google

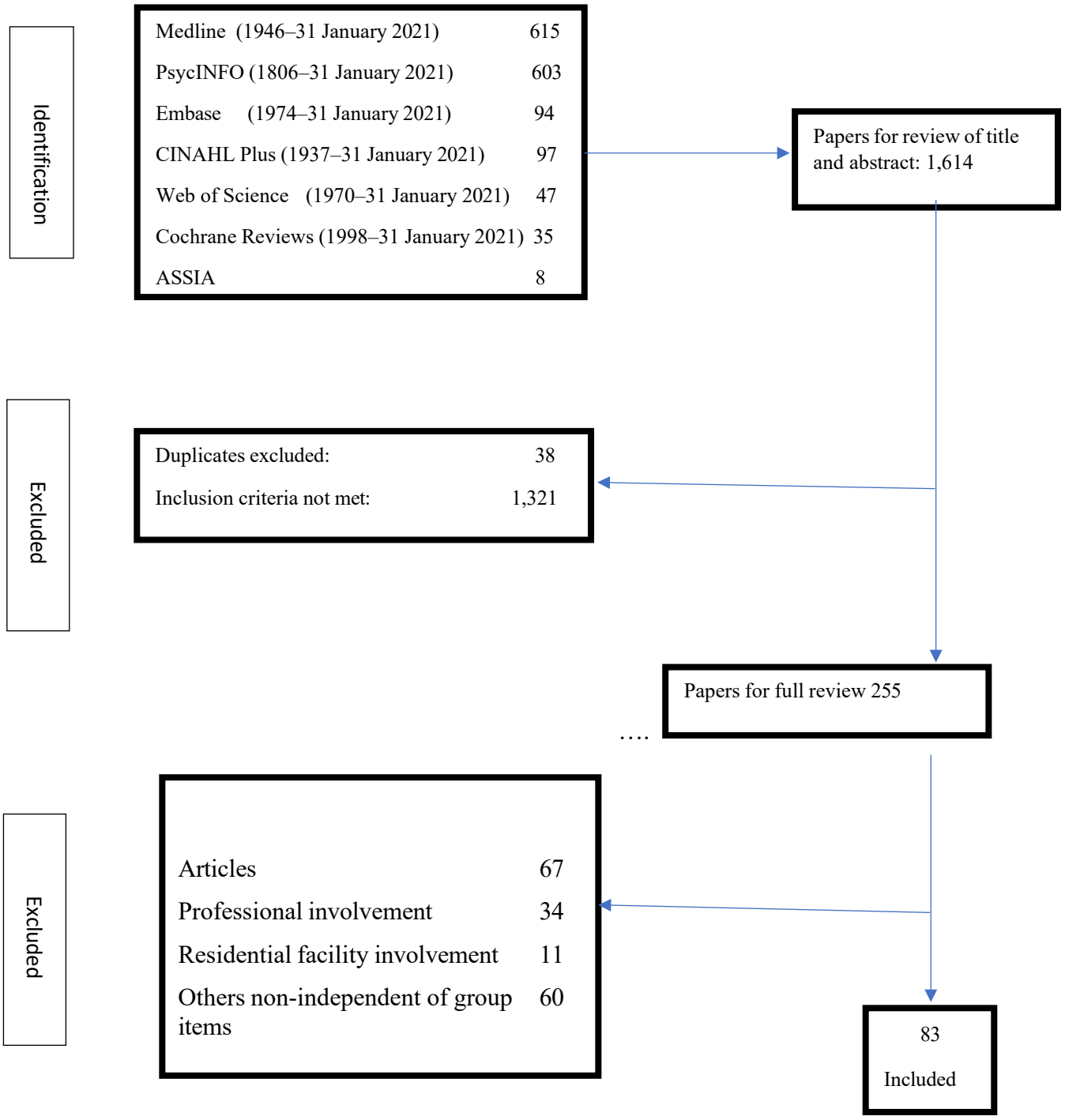
Scholar was limited to the first 15 pages per search item retrieved. The following journals were searched manually: *Drug and Alcohol Review* (1980-2021), *Alcohol Research: Current Reviews* (1990-2021), and *Alcohol Treatment Quarterly* (1997-2021).

2 (iv) Search Strings Used

Before the database search initiation, a comprehensive list of search terms sufficiently inclusive to cover any papers relevant to the current topic was compiled (the search terms/strings selected are listed in Figure 2). The search strategy output report followed PRISMA guidelines (Moher et al., 2009). Search strings used were amended/varied to comply with different database or journal formats.

Terms used were "alcohol*"; "alcohol AND depend*"; "alcohol use disorder*"; alcohol OR alcoholism"; "abuse"; "dependence"; "dependent"; "addict*"; "Alcoholics Anonymous"; "mutual AND help AND group*"; "mutual help group*"; "self-help AND group*"; "12 step group*"; "12-step fellowship*"; "12 step fellowship*"; "12 step"; "twelve step"; "twelve-step"; "fellowship*"; "peer-group"; peer group"; "recover*"; "recover* group"; "recover AND group"; abstinent"; abstinence"; "longterm OR long-term OR "long term"; "group*"; "psychological AND construct* AND of"; "emotional AND construct* AND of"; "spiritual AND construct AND of"; "social cognitive theor*"; "social learning theor*"; "social"; "stigma*"; and "gender"

Figure 2: PRISMA Diagram



2 (v) Search result sections

Due to the wide breadth of material encountered, a thematic analysis of the findings was carried out (Braun & Clarke, 2006) to identify sections significant to the current thesis. The areas identified were:

1. AUD and related mental and or psychological issues
2. Non-professionally assisted recovery from alcohol dependence
3. Mutual help groups for alcohol dependence – non-12-step groups
4. Mutual help groups for alcohol dependence – 12-step groups.

The initial literature search was from the initiation of the particular electronic databases being searched. Since this search commenced in 2017, there have been many changes in the commercial functioning of journal databases – multiple cross-database searching is now possible, and the narrative literature search is now validated up to the end of August 2021.

Furthermore, literature databases also began carrying out automated daily checks and sending reports by email when they located any material matching the initial search. This facility was utilized wherever possible. Figure 3 shows a copy of one such daily report from 'Web of Science'.

Figure 3: Sample daily automated literature check received on February 6th, 2022

"Greetings! You have a saved search alert.

Your search, **TOPIC:** (. ("mutual help group$" or "peer-group$" or "peer group$" or "non 12- step" or "non twelve step" or (sob$ and (group$ or Fellowship$ or societ$)) or "12-step fellowship$" or "twelve-step fellowship$" or "alcoholics anonymous")) *AND* **TOPIC:** ((alcohol* or alcoholism or alcohol use disorder*) and (depend* or addict*)) *AND* **TOPIC:** ((long-term or longterm or long term) and (recover$ or abstinent or abstinence)) has 0 new records since Feb 6th 2022"

2.1 Alcoholism and its related mental and or psychological problems

Before the functioning of self-help groups for Alcohol Use Disorder (AUD) recovery could be considered in detail, it was necessary to identify existing cognitive, emotional and psychological factors that may impact that process. The question of spiritual matters is explored later in this review.

(i) Alcohol dependence and attachment

According to attachment theory, the inability to form meaningful relationships originates in insecure attachments established in early life. “Attachment” has been defined by John Bowlby (1973) as "*any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, usually conceived as stronger and/or wiser*" (p. 292). Finn et al. (1987) suggested that alcohol consumption relieves, changes or defers those uncomfortable feelings related to insecure attachment style without judgment or approval. Flores (2004) (citing Lewis et al., 2000) stated, "'*Attachment theory holds the position that it is impossible for individuals to completely regulate their affective states alone' (Lewis et al., 2000, p .3)".* Flores (2004) suggested that it follows, therefore, that until people with substance abuse disorders are able to adapt their insecure attachment styles and develop the capacity for healthy interpersonal affect regulation (secure attachment and mutuality), they will remain vulnerable to substituting one obsessive behaviour for another (Flores, 2004, p. 3). This topic is developed in greater detail later in this thesis.

(ii) Cognitive malfunctioning and memory impairment in alcoholism

AUD has been linked with the experience of multiple cognitive deficits. *"Chronic excessive alcohol consumption is associated with structural and functional brain abnormalities leading to mild to moderate cognitive impairment, particularly in attention, executive functions, memory, visuospatial and motor skills, as well as in metacognitive abilities"* (Le Berre, 2019; Le Berre et al., 2017). Nixon and Lewis (2020) also summarize the neurobehavioral, neurophysiological, structural, and neurochemical aberrations and or deficits encountered in alcohol- dependent people and how they improve with recovery. They confirm two items: "*...improvements in neurobiological functions occur during the first 4 to 8 weeks of abstinence, followed by more modest mid-term (i.e., approximately one year) gains"* (p. 4) and *"*...long-term *recovery in social cognition is limited and has yielded mixed results"* (p. 5)*,* citing Le Berre et al. (2019). They also suggest (p. 13) "... *long-term studies remain understudied".* Rupp (2021) also reaffirms that no natural recovery of social cognitive impairments occurs in the intermediate to long term, especially in the first two months – the usual treatment duration. This finding confirms earlier literature that "*Attention, working memory, speed of processing, visuospatial abilities, executive functioning impulsivity, learning, memory, and verbal fluency have all been shown to be impaired in AUD"* (Stavro et al., 2013, citing Beatty et al., 2000; Davies et al., 2005; Noël

et al., 2007; Pitel et al., 2009). Another study by Powell et al. (2021), trialing a new device ('the brain gauge') in assessing cognitive recovery, also indicated similar short-term and long term meta-cognitive deficits.

In chronic AUD these impairments may develop, through thiamine deficiency, into Wernicke's encephalopathy, having a 10-15% mortality rate (Akhouri et al. 2021). This condition is amenable to treatment if treated as a medical emergency and a high level of recovery is achievable. However, in the absence of treatment the condition progresses into Korsakoff's syndrome (>80% permanent severe memory impairment requiring supervised living) or alcohol-related dementia. Saxton et al. (2000) suggest that 29% of dementia cases are alcohol- related. While chronic alcoholics demonstrate memory dysfunction and significant cognitive decline, there was a lack of agreement on which functions were most severely affected by AUD (Uekermann et al., 2003; Ratti et al., 2002; Rourke & Grant, 1999). Further, there was no consensus on rates of cognitive recovery during varying periods of abstinence. Rupp (2021) also confirmed that social cognitive impairment endures for months after cessation of alcohol usage. Nor is the situation helped by drug and alcohol treatment centres "mixing their metaphors" by intermingling the "Disease Model of Addiction" or the "Brain Disease Model of Addiction" with other concepts (Barnett et al., 2018).

Stavro et al.'s (2013) meta-analysis of the literature examining cognition in AUD determined how the duration of abstinence affects cognitive recovery – retrieving 62 studies (n=5,032). Inclusions were limited to people with AUD only and no confounding problems (such as co- morbid psychoactive substance abuse). The cognitive domains of IQ, verbal fluency/language, speed of processing, working memory, attention, problem solving/executive functions, inhibition/impulsivity, verbal learning, verbal memory, visual learning, visual memory, and visuospatiality were measured at >1 month, 2 months to 1 year, and <1 year. Stavro et al. (2013) found that apart from IQ, which remained relatively stable at all intervals, there was moderate impairment across 11 domains for the short-term abstinent and across 10 domains for the intermediate-term abstinent In the short-term abstinent group, attention was the most affected, followed by the visual memory domain. With the long-term abstinent group, only small effect sizes were noted. The study showed significant cognitive impairment might linger long after cessation of drinking and it takes up to one year before normality is returned – except for visuospatial acuity, which remains

impaired for longer.

In an earlier study, Reed et al. (1992) examined whether non-Korsakoff alcoholics had subtle defects of memory. They used 31 recently detoxified participants, 28 intermediate-term abstinent participants, 32 long-term abstinent participants, and 37 non-alcoholic controls. Their objective was to see if there was a gradient of recovery over time. The subjects were tested under six main headings (verbal learning, verbal recall, visual learning, visual recall, paired associate learning, verbal-verbal paired associate learning), and also under seven standard neuropsychological tasks (category test, tactual performance test, trail making part B, WAIS digit symbol, block design, and digit span subtests; the WAIS vocabulary subtest was also included to estimate premorbid intelligence). They concluded that whether it was memory ability or other cognitive areas, neuropsychological impairment did show principally in the first months of abstinence, but that with long-term abstinence, mnestic skills were indistinguishable from non-alcoholic controls. Further, memory disturbance demonstrable in recently detoxified alcoholics in their early weeks is not evident in demographically matched long-term alcoholics with similar drinking histories. These findings are significant and are discussed under the appropriate headings of emotional functioning and stigmatization of the alcohol-dependent person below.

(iii) Emotional functioning and alcohol dependency

The inability to recognize, process and regulate emotions (alexithymia) and its relationship with AUD was the subject of a critical review by Thorberg et al. (2009). They suggested there was little evidence to support the contention that alexithymia is a risk factor in developing a dependency. They concluded, *"...there is some, albeit weak, evidence that alexithymia and alcohol dependence are related, and scarce evidence on the relationship between alexithymia and other psychological drinking related constructs"* (p. 243). However, as alexithymia has a prevalence rate of between 45% and 67% in alcohol-use-disordered people, this weak linkage does not appear sustainable and may interfere with treatment outcomes (Thorberg et al., 2009, p. 239). An earlier study by Cleland et al. (2005) found a significant positive association between difficulties identifying and describing feelings and the severity of AUD before and after treatment. Another study by Finn et al. (1987) found that alcohol helped alleviate stressful situations and enhance interpersonal functioning in those with alexithymia.

Thorberg et al.'s (2009) review failed to reference one of the catalysts between alexithymia and AUD – the role of emotions of loneliness in alcohol dependency. Other studies have revealed that individuals who suffer from AUD experience more intense feelings of loneliness than those who are not alcohol use dependent (Akerlind & Hornquist, 1992; Medora & Woodward, 1991; Weissbach et al., 1976). Alcoholics can bear a form of loneliness so severe it can result in the "erosion of one's self-esteem" (Loos, 2002, p. 200). Loos (2002) refers to this contingency as "*depraved loneliness*" (p. 201), suggesting that it allows alcoholics to feel so empty and hopeless they can only find solace in alcohol. *Alcoholics Anonymous* (AA World Services Inc., 2001) adverts directly to this ("depraved") loneliness. While only referring to it as loneliness, their stark description exceeds the ordinary definition – *"Then he will know loneliness such as few do. He will be at the jumping-off place. He will wish for the end"* (AA World Services Inc., 2001, p.152).

In this context, psychoanalysts have argued that "self-medication" underlies addictions (Khantzian, 1980 &1987; Wurmser, 1978). Wurmser (1980) said that a dependency might arise in counteracting negative emotions; people develop different addictions for the various reliefs they require.

> *"The choice of drugs shows some fairly typical correlations with otherwise unmanageable affects – narcotics and hypnotics are deployed against rage, shame, jealousy, and particularly the anxiety related to these feelings; stimulants against depression and weakness; psychedelics against boredom and disillusionment; alcohol against guilt, loneliness, and related anxiety"* (Wurmser, 1980, p. 71).

Ingram et al. (2020) suggested that loneliness among substance-use-disordered people could be addressed through *"Groups for Belonging"* – a six-session group-based intervention – but the trial only met with a 50% rate of success. Ingram et al. (2020) carried out a systematic review of literature on loneliness and found that only a single loneliness intervention had been trialed and was ineffective in reducing loneliness for people with substance use problems. They concluded that loneliness is prevalent among substance-using populations, and future longitudinal research is merited.

From a medical perspective, Sullivan (2020) suggested,

> *"Rather, neuroadaptation to life without alcohol takes time and is complicated*

by the nature of alcohol dependence as a multisystem disorder. Accordingly, recovery trajectories of affected neural systems differ, and as a consequence, recovery trajectories of the associated affected behaviours are not in lockstep." (p. 1022)

(iv) Stigmatization of the alcohol-dependent person

AUD is classified as a disease by the WHO under its ICD-10. Notwithstanding this, public reaction stigmatizes and ostracizes the individuals concerned. For the alcohol use disordered, their self-perception and motivation to enter treatment or resolve their difficulty are reduced by this reaction.

Room's (2005, p. 147) working definition suggests that:

"'*Stigma' means disqualification from social acceptance, derogation, marginalization and ostracism encountered by … persons who abuse alcohol or other drugs as the result of societal negative attitudes, feelings, perceptions, representations and acts of discrimination."*

According to Klingemann (2001), the adverse effects of AUD are not limited to physical health but also impact social behaviour and environmental interactions. Stigmatization may contribute to social exclusion for those who need acceptance (Room, 2005). Rundle et al.'s (2021) cross- national study on the implications of addiction diagnosis and addiction beliefs reaffirmed that public stigma ratings were significantly higher in the alcohol use disorder condition compared to other conditions. Burns (2021) describes the paradoxical stigma she faced within the academic community on the question of her own 'self-disclosure' of alcohol dependence and recovery. This general population's stigmatic perception is exacerbated by private and public health insurance's reaction by imposing more stringent coverage limits than somatic illnesses. Between 1988 and 1993, mental health and substance use coverage became more restrictive, leading to a decline from 27% to 14% of insured employees. Similarly in the public sector, treatment also became significantly more restrictive. More significant limitations on covered inpatient days and outpatient visits were imposed, higher cost-sharing requirements were applied, and higher ceilings on out-of-pocket expenditures (or none at all) were set (Hanson, 1998). AA itself states, *"The less people tolerated us, the more we withdrew from society, from life itself"* (AA World Services Inc., 2001, p. 151).

In 2011(b), Schomerus et al. reviewed international population studies on the stigma of alcohol dependence compared with other mental disorders and outlined some noteworthy results under different headings. Of 33 studies in 17 population studies, depression and schizophrenia were selected as comparison subjects, and the review follows that pattern. The results were categorizable in two ways: individual adverse reactions and structural discrimination to alcohol-dependent people. Adverse reactions to alcohol-dependent individuals fell mainly within the following categories: AUD as a mental illness; blame; stereotyping of being a danger and unpredictable; emotional responses to alcoholics; desire for distance – rejection. In the USA, 88% of those surveyed classified schizophrenia as a mental illness compared with 49% for AUD (Link et al., 1999). In New Zealand, 95% classified schizophrenia as an illness, but only 32% rated AUD the same way (Ng et al., 1995). Comparable results were found in Canada by the Canadian Medical Association (2008).

Across all studies, Schomerus et al. (2011a) found that alcoholics were held much more responsible for their condition than schizophrenia or depression. In two studies in the UK, 60% and 54% respectively thought they were to blame themselves (Crisp et al., 2000; 2005). In Germany, 85% blamed the alcoholic themselves compared with 8-18% for other conditions (Schomerus et al., 2006). In a study by Angermyer et al. (1992), three-quarters of those surveyed ascribed the problem to a lack of willpower. Pescosolido et al.'s (2010) review of the McArthur Mental Health Study – a sub-set of the 1996 National Opinion Research Centre, General Social Survey, (GSS96) -was replicated in 2006 and suggested the perception that "bad character" was responsible for AUD was 49% and 65% – the higher figure being 10 years after the first, showing the enduring underlying theme of addiction as a moral failing.

In a UK survey (Squire & Zouzounis, 1988), alcoholics were ranked equal to or worse than people with schizophrenia – 65% as a danger to others and 71% as unpredictable. In two surveys, five years apart, Crisp et al. (2000; 2005) showed no noticeable change in public perceptions. The GSS96 survey was cited by Schomerus et al. (2011) as reporting that 71% of respondents considered that alcoholics were likely to hurt others. No appreciable difference was noted when surveyed 10 years later, then at 69% by Pescosolido et al. (2010). In Brazil, the rate was 81% (Peluso & Blay, 2008a). In Germany, two-thirds of those surveyed rated people with AUD as unpredictable and one-third

dangerous. Schomerus et al. (2010) reached the overall conclusion that in the public mind, there are clusters of hazardous and unpredictable conditions, i.e., AUD, addiction and schizophrenia, that are more of a problem than depression and anxiety disorders or dementia.

Only two studies researched emotional reactions to people with AUD, and there were marked differences in the outcomes. In Germany, alcoholics evoked more irritation, anger and repulsion than people with schizophrenia or depression, and less empathy, pity, understanding or desire to help (Angermeyer et al., 1992). In the second study in Brazil, alcoholics provoked more fear, irritation and indifference than schizophrenia, depression or Alzheimer's disease, and less friendliness and warmth. However, emotional responses such as desire to help, warmth and pity were felt towards the alcoholic (Blay & Peluso, 2010; Peluso & Blay, 2008a; 2008b). Regarding the desire for distance from or rejection of the alcoholic, similar results were found in six studies examining willingness to have an alcoholic as a neighbor. Rejection rates were 60% in Germany (Beck et al., 2003) and the USA (Link et al., 1999). In a follow-up study in 2006 in the USA, the figure remained unchanged (Pescosolido et al., 2010). A 1970 survey (Blizard, 1970) reflected a similar reaction to those with AUD and schizophrenia. When repeated 30 years later by Marie and Miles (2008), the only change noted concerned attitudes towards people suffering from depression. In The European Values Study (2020; EVS) covering 32 European countries, the percentage of rejection again averaged 60% – lowest in Luxembourg at 32% and highest in Hungary at 91%. The review concluded that people suffering from substance dependencies were rejected far more strongly than other mental disorders, medical disorders, or members of minority communities. Schomerus et al. (2010) note that this rejection may be a cultural-based phenomenon as AUD is lower down the list of unacceptable conditions in some countries. Their review does not advert to the situation in Japan where stigmatization of the alcoholic is severe, affecting all aspects of the alcoholic's life from almost permanent unemployability to social congregation, despite a strong drinking culture in the country (Chenhall & Oka, 2006).

Schomerus et al. (2010) also identified structural forms of discrimination against alcohol-dependent people in a study carried out in Germany. Alcoholism was selected by 78% as being the medical condition from which financial means for treatment could be saved or not spent at all. (Beck et al., 2003, p. 603). These findings were unchanged when the study

was replicated by Matschinger & Angermeyer (2004).

Schomerus et al. (2010) also reviewed studies covering compulsory treatment and found that 39% favored compulsory outpatient treatment, 25% endorsed compulsory medication, and 41% favored compulsory inpatient treatment (Pescosolido et al., 1999). Ten years later, this support for compulsory treatment remained unchanged (Schnnitker, 2008). In the United Kingdom, institutional support for discrimination was explored in Flacks' (2012) article on the exclusion of drugs and alcohol addiction from the Equality Act 2010.

The negative effect of stigmatization and exclusion were explained by Keyes et al. (2010) as causing alcoholics to be less likely to seek treatment. For those in recovery, stigmatization can lead to a self-fulfilling prophecy of returning to drinking with the lowering of personal confidence and capacity to resist (Schomerus et al., 2011b). Potter-Efron (2002) and Scherer et al. (2011) discussed the cyclical impact of shame, guilt and low self-esteem and how that, in turn, can lead to continual relapsing. An Interpretative Phenomenological Analysis (IPA) phone-based study (due to Covid-19) by Sawyer et al. (2020) found *"...that management of shame was an important component of recovery programmes for alcohol dependence"* (p. 79) with AUD participants on average 30 years abstinence.

Interestingly, Schomerus' work was replicated by Kilian et al. (2021), and no significant change in attitudes of stigmatization and allied adverse reactions were noted (Schomerus co- authored the article.) Despite the negative connotation associated with stigmatization, Room (2005) pointed out that some literature discusses the value of stigma in discouraging excessive drinking. Pescosolido et al. (2021) repeated their two previous studies (in 1996 and 2006) in 2018 and found that, apart from depression, stigma levels had stagnated or disimproved for all other disorders (including alcohol dependence) and there were increasing public perceptions of likely violence among persons with schizophrenia. Surprisingly, Corrigan et al. (2017) showed that some stigmatizations are culturally sanctioned where "(a) discrimination against people with addictions is often legal; (b) public health communications frequently use stigma to promote prevention; (c) some programmes, such as '12 steps' promote self-stigma." (p. 180).

Summary

Currently, commercial rehabilitation facilities restrict their programmes to four weeks,

including detoxification, because this is the limit that health insurance companies will recompense. If the meta-analysis and research findings in the literature referenced earlier are accurate, dried-out alcoholics still suffer significant cognitive and memory impairment despite being physically sober when released. Even those who extend their rehabilitation programme to three months are still releasing patients under the misguided impression that they have been returned to ordinary thinking and acting ways. Indeed, with the indeterminacy of residual visuospatial limitation unresolved (Fein et al., 2006), it is questionable whether a treated alcoholic should be allowed to drive a car for at least a year post-detoxification, and only then subject to a medical examination. The systematic review by Domínguez-Salas et al. (2016) also raised concerns about evidence linking limited cognitive-executive resources and treatment outcomes in the context of a lower ability to benefit from talk therapies. Regarding the issues of emotions, loneliness, the absence of meaningful relationships, and stigmatization, these matters are revisited later in this thesis when considering the recovery role of self-help groups and whether they fulfil these needs by providing beneficial supportive social networks.

Further, Stavro et al.'s (2013) meta-analysis and later research also raise whether Minnesota- based treatment centres, and many others, serve any purpose regarding cognitive and memory deficiencies uncovered. A complete review of residential rehabilitation may be needed to consider whether alcoholics should undergo a rehabilitation programme until three to six months after a person is detoxified.

2.2 Non-professionally assisted recovery from alcohol dependence

Many people categorized as alcohol or substance dependent, or addicts recover from their addictions without intervention, assistance, treatment or attendance at SHG meetings (Rayburn, 2015; Cloud & Granfield, 2001). One of the earliest writings about this phenomenon was Rush in 1785 (cited by Lewis, 1991). There is substantial literature on the subject, and Cloud and Granfield (2001, p. 84) cite several empirical studies starting with Winick (1962). Others have expanded the term "natural recovery" (Waldorf, 1983; Biernacki, 1986) to include "maturing out" (Winick, 1962; Maddux & Desmond, 1980), auto remission (Klingeman, 1992), spontaneous remission (Saunders & Kershaw 1979; Stall & Biernacki, 1986), unassisted change (McMurran, 1994) and self-resolution (Finfgeld, 1999).

According to two surveys in the US (Dawson, 1996) and Canada (Sobell et al., 1996), between 75% and 78% of people who recovered from alcohol use disorder did so without receiving any treatment. More recently, Tucker et al. (2020), in exploring the epidemiology of recovery from AUD, suggested that a lower rate that is "Approximately 70% of persons with AUD and alcohol problems improve without interventions (natural recovery)". However, a 16-year follow-up study by Moos and Moos (2006) noted that those achieving "natural recovery" without professional treatment or mutual aid support experienced one or more relapses in 60% of cases. Emrick and Beresford (2016) arrive at similar figures when they refer to initial drop- out rates from all therapeutic approaches as being approximately 78-80%. However, they go on to say that many lapsers return to treatment again with a much higher rate of permanent success.

The original non-punitive assistance with detoxification and or alleviation of AUD through mutual aid societies or religious missions dating back to the 1850s faded into oblivion for diverse reasons. White (2001) suggested that many imploded from being too closed and isolated due to their cult-like characteristics. Further, such organizations were prone to co-opting or takeover by more powerful organizations within their general remit if, or when, they became too involved in outside interactions and concerns.

The founding of Alcoholics Anonymous (AA) in 1935 and its subsequent structuring through its "Twelve Traditions" (AA World Services Inc., 2001, pp. 563-6) distanced itself from potential internecine difficulties previously experienced by such organizations. It views AUD as having physical, mental and spiritual dimensions (AA World Services Inc., 2001, p. 64), and based its conception of AUD and recovery programme on these three dimensions. However, there was more to their programme of recovery – it promoted well-being, improving quality of life and the development of spirituality: *"We claim spiritual growth rather than spiritual perfection"* (AA World Services Inc., 2001, p.60). Chapter 9 of the same book describes how to deal with and reintegrate with *"The Family Afterward"* (pp. 122-35). That Chapter goes on to say,

> *"We are sure God wants us to be happy, joyous, and free. We cannot subscribe to the belief that this life is a vale of tears, though it once was just that for many of us."* (p. 133)

White (2007b) summarized several of the growing perceptions concerning the actual nature

of recovery. There was a shift towards a recovery paradigm (Humphreys, 2004; White, 2004) and a desire to shift the design of addiction treatment from a model of acute biopsychosocial stabilization to one of sustained recovery management (e.g. Dennis et al., 2003; Flaherty, 2006; McKay, 2005). This shift in emphasis occurred in the absence of a clear-cut recovery definition, leading to significant variability in reported treatments (Maddux and Desmond, 1986). Seeking to redress the anomalies, the Betty Ford Institute drew together a panel of experts who came up with the consensus definition:

> *"Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship"* (Betty Ford Institute Consensus Panel, 2007, p. 222).

Laudet (2008) revisited the subject based on the research outcome she had reported in 2007 (Laudet, 2007). In that earlier research, through the Pathways Project (n=289), participants were asked what recovery meant to the person involved in the process. Total abstinence was endorsed by 86.5%.

Having regard to the impact of 12-step ideology in the USA (McElrath, 1997) and the outcome of Laudet's et al.'s (2002) USA based quantitive research, Laudet and Storey (2006) repeated the USA recovery research project in Australia. 73.5% of Australian participants endorsed total abstinence from drugs and alcohol as their definition of recovery. However, in Laudet's 2007 USA study, participants had identified other items as part of recovery: recovery as a new life, well-being, a process of working on themselves, living life on life's terms, self-improvement, learning to live drug-free, recognizing the problem, and getting help. Elms et al. (2018) analyzed the Australian research outcome in detail and found that people may experience high recovery well-being irrespective of the pathway they take, but social factors may influence the particular pathways people take.
Laudet (2008) cited the following:

> *"Typically, the immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety—i.e,. recovery"* (McLellan et al., 2005, p. 448).

This conceptualized clinical outcome is consistent with the WHO's conceptualization of health as "*a state of complete physical, mental, and social wellbeing, not merely the absence of disease*" (WHO, 2013).

While treatment providers effectively reduce substance use and improve functioning (e.g.,

Magura et al., 1999; Teesson et al., 2006), such treatments do not last long after the programme has been completed. Gains are short-lived, and relapse rates are high (Gossop et al., 2002; Laudet et al., 2007). Therefore, evidence was needed that identified non-treatment factors that impact the sustainability of the recovery. Laudet (2008) pointed out that treatment facilities may provide clients with three possible interventions:

(i) Cognitive-behavioral skills for change and adaptive coping strategies (Rounsaville and Carroll, 1993)

(ii) Twelve-step "Minnesota Model" treatment (i.e. an AA-based programme) (McElrath, 1997) to treat the chronic lifelong condition

(iii) Motivational interviewing to reduce ambivalence about using drugs (Miller & Rollnick, 2002).

However, Laudet (2008) asserted that the skills acquired during treatment do not always endure, and the participants may revert to old ways of behaving, socializing, and using. Furthermore, in the course of "stepping down" (McKay et al., 1998), Alcoholics Anonymous and other SHGs are particularly well suited to providing a form of aftercare – as well as being widely available and virtually free of charge.

Considerable research supports the effectiveness of 12-step participation in encouraging reductions in alcohol and illicit drug use (Etheridge et al., 1999; Fiorentine, 1999; Gossop et al., 2003; Humphreys & Moos, 2001; Laudet et al., 2000; Moos & Moos, 2007; Morgenstern et al., 2003; Project MATCH Research Group, 1997). The support that 12-step participation offers is significant after treatment ends. Twelve-step meeting attendance after formal treatment (that is, as aftercare) is a strong predictor of abstinence in both short- and long-term studies (Kaskutas et al., 2005; Kelly et al., 2006; Laudet et al., 2007; Morgenstern et al., 2003). Further, the effectiveness of 12-step participation rises in tandem with addiction severity (Tonigan et al., 1996). As with formal treatment, a higher level of 12-step meeting attendance – especially weekly or more frequent attendance (Fiorentine, 1999) – and longer duration of participation, are associated with better outcomes (Moos et al., 2006). Twelve-step attendance early in the recovery process is crucial to consolidate treatment gains (Humphreys et al., 1997).

The benefits of 12-step participation extend beyond cessation of substance use (Humphreys et al., 2004). Other benefits include (a) psychosocial functioning and enhanced self-

efficacy to resist temptations to use drugs or alcohol and motivation for abstinence (Kelly et al., 2000; Morgenstern et al., 1997); (b) improved coping strategies (e.g. Morgenstern et al., 1997; Timko et al., 2000); (c) enhanced social support, and particularly social support for recovery (Humphreys and Noke, 1997; Humphreys et al., 1999); (d) reduced psychological problems (Gossop et al., 2003); (e) lower stress (Laudet & White, 2008); (f) higher quality of life (Gossop et al., 2003) and (g) higher levels of life-meaning and purpose (White & Laudet, 2006). Meeting attendance and fellowship with other recovering people at 12-step meetings is one of the cornerstones of the 12-step recovery programme, cited as a critical support source by remitting individuals (Laudet et al., 2002; Margolis et al., 2000). However, the 12-step programme of recovery does suggest that participation in the fellowship extends beyond meeting attendance. Enhanced stabilization may flow from other recommended practices such as having a sponsor, working the 12 steps, having a home group, reading 12-step recovery literature, and doing "service" (Caldwell & Cutter, 1998). Meeting attendance alone is associated with high attrition and consequent loss of the potential benefits of 12-step participation (Walsh et al., 1991). Moreover, 12-step affiliation may be more predictive of remission outcomes than meeting attendance alone (Timko and DeBenedetti, 2007; Weiss et al., 2005).

In 2012 El-Guebaly carried out a systematic review of the recovery paradigm in "addiction" and its implications. El-Guebaly determined that the concept of recovery is growing in tandem with recovery from other chronic disorders, and the features of addiction, as a chronic disorder, require continuing care like other mainstream chronic illnesses. He made a further point that therapeutic communities have now moved away from the concept of being totally "drug-free" to adopting biopsychosocial approaches, accommodating patients with mental disorders that require medication (Perfas & Spross, 2007). He also referred to the fact that "there is no such thing as a graduation" within the current view of a chronic condition (McLellan et al., 2000; Laudet, 2007) – drawing on Finney and Moos' (1991) contention that resolving addiction often takes multiple attempts and treatment episodes. Prochaska and DiClemente (1984) and Prochaska et al. (1992) described the cycle of change and its stages in their transtheoretical model of how people change. They developed the view of the process of addiction recovery as being helical, with five main points – the first being pre-contemplation. The second is going through vague, ill-defined, but unsettling concerns (contemplation), that may include attempts to cease or reduce substance abuse and develop the desire or intention to change very shortly.

Determination or preparation is followed by doing something about their problem – implementing the strategies considered in contemplation (action) and then retaining their substance-free lifestyle (*maintenance/exit*). In this model, relapsing may be addressed from different stages rather than a "back to square one" attitude adopted by treatment centers. However, while Kim et al. (2021) provides some substantiation, this modelling has not been free from criticisms such as being *"at best descriptive rather than explanatory"* (Davidson, 1998, p. 32), being *"a security blanket for researchers and clinicians"* (West, 2005) and lacking sufficient precision to be considered as incomplete (Manoj & Ashutosh, 2006).

El-Guebaly (2012) also found that abstinence alone is insufficient to achieve recovery – that recovery development was as crucial as recovery initiation. Peabody (1933, p.133), cited by White (2007a), stated that *"A man who is on the wagon may be sober physically, but mentally he may be almost as alcohol-minded as if he were drunk"*. One of the founders of AA, Wilson (1958), made similar comments on the concepts of the "dry drunk" versus physical, emotional sobriety and serenity. El-Gueblay (2012) concluded his review that, while there may be growing consensus on what is involved, the conceptualization remains complex; there is a movement towards ushering in addiction management with initial treatment as a stepping-stone towards that end. Helm (2019) cogently describes the difference between sobriety and abstinence.

Laudet (2013) developed her earlier work through a subsequent study with Faces and Voices of America following her research in 2007, commentaries by others, and the systematic review by El-Geubaly in 2012. The study's purpose was to document the experiences of those in recovery nationally, to inform policymakers and other interested parties of the benefits of policies that promote rather than hinder recovery, to advance research on how people get well, and to reduce stigma and discrimination. The survey utilized Survey Monkey taking 10-15 minutes to complete (n=3,218). The results showed that the average age of entry into recovery was 36. Sixty-seven per cent claimed to be in stable recovery (i.e., more than five years), 95% had attended AA, and 22% had participated in non-12-step fellowship meetings (such as Life Ring, SMART RECOVERY or Rational Recovery). The survey's main finding was, "*Life keeps getting better as recovery progresses"* (Laudet, 2013, p.2). The detailed report shows that this statement covers all aspects of the participants' lives, including financial, family, social, criminality,

legal problems, a dramatic decrease in health and safety risks, and increased employment and work. There were, however, numerous differences on gender grounds. Limitations to the study included the possibility of self-selection by participants, the veracity of responses, issues concerning computer literacy and literacy – i.e. exclusion on these grounds – and that the survey was Internet-based.

In the year following the Faces and Voices of Recovery survey, Kaskutas et al. (2014) ran a USA countrywide survey. The intent was to move the substance disorder field beyond the broad definitions of recovery by empirically identifying specific recovery domains and elements as experientially perceived. The survey drew on the WHO's Quality of Life Groups reports in drawing up the survey questionnaire. The survey was Internet-based, and the selection of participants was from a broad base (n= 9,341; 54% female). Four domains and 35 recovery elements emerged from the results. The domains were: abstinence in recovery, essentials in

recovery, enriched recovery, and the spiritual element of recovery. As a result of this survey, The National Council on Alcoholism and Drug Dependence Inc. (NCADD; 2018) came up with another definition of recovery:

> *"Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life."*
>
> [web resource, accessed 16/11/21]

Following the Faces and Voices Survey, Turning Point – a major Australian organization – replicated the study under the title "*Life in Recovery Australia*" (Turning Point, 2015). The survey was both Internet- and paper-based (n=573). The results reported an average age on entry to recovery of 34.8, with a more extended recovery period than to last use of alcohol or drugs, and >70% were in stable recovery. Longer time in recovery equated with better physical and psychological health and quality of life. Fifty-two per cent were receiving help for mental health issues and scored lower in terms of quality of life than those who were not. There were some ambiguities in the results. For instance, reported emotional and mental health problems decreased from 86.1% in the first three years to 58% for those with 3-10 years of recovery, and 33.5% with >10 years of recovery. It is unclear whether this was due to maturation out of difficulty, length of sobriety, or not maintaining their recovery. Significantly, 79.8% described themselves as "in recovery" and viewed recovery

as an ongoing event.

Best et al. (2015) replicated the USA and Australian surveys in the UK. Their objective was to measure the emotional cost to family, friends and partners of those suffering from addiction. These costs remained stubbornly hard to measure, as were the financial and intangible benefits of a stable and lasting recovery. This report attempted to quantify some of those gains. They employed an adapted version of the USA survey form, again using Survey Monkey (n=802). Results showed that 79% had never received treatment for an emotional or mental health problem, but 74.3% had experience with alcohol. Almost two-thirds stated they were in recovery. Of those, 57.3% were in long-term recovery (> five years), 29.4% were in sustained recovery (three years), and 13.3% were in early recovery. Seventy per cent had attended 12- step meetings; 13% had attended SMART recovery. At the time of the survey 41.3% were regularly attending meetings. Fifteen per cent used online support, which 10% of those found highly unhelpful. Consistent with the other similar surveys, financial and family circumstances improved. There was a substantial increase in community involvement at 79.4% – which was considerably higher than the general public at 42%. Healthcare improvement led to a significant decrease in calls on emergency services. Criminality dropped from 60% involvement to 2.9%. Applicants for furthering their education or training increased from 32.5% in active addiction to 80% in recovery. Coupled with the reduction in costs to the health service and criminal justice system, Best et al. (2015) suggested that these findings represented further evidence of the significant life transition that recovery entails, with consequent impacts on personal growth and development, and contribution to society generally – specifically through taxation.

A similar survey by Murphy (2011b) of 28 recidivistic "serious" criminals (i.e., who served terms longer than six years in prison) showed that their crime rate dropped while they were engaged in a Community Employment Scheme from 100% to 0%.

In 2017, Canada replicated the Life in Recovery surveys (with modifications), already carried out in the USA, UK and Australia (McQuaid et al., 2017). The purpose was to consider what those in recovery believed recovery meant. Although online, the researchers used non- probability snowball sampling for recruitment purposes (n=855). Key findings were that alcohol was considered to be the active constituent of addiction by 93.3%; more than half of respondents claimed to have achieved stable recovery without a single relapse (51.2%); 91.8% attended 12-step mutual help groups; participants with stable housing

constituted 95.9%; family life improvement was reported by 90%; and 79% were now in steady employment. The community involvement level was 66.8% (compared with 14.4% while in active addiction), and planning for the future was carried out by 88.8%.

Summary

Alcoholics Anonymous (AA World Services Inc., 2001) intended the programme to be a turning point regarding what recovering from AUD entailed – that it was no longer simply a life of abstinence (Kelly et al., 2009). While there are differences between the definition suggested by the Betty Ford Institute Consensus Panel (2007), the NCADD, and the outcomes from the USA, UK, Australian and Canadian Surveys, there is a growing consensus that recovery encompasses physical, mental, psychological, spiritual and social issues. Kaskutas et al. (2020) list eight current recovery definitions in addition to their new one - "*...as a dynamic process of change characterized by improvements in health and social functioning, as well as increases in well-being and purpose in life"*

However, NCADD is the only survey adverting to religiosity/spiritual awareness. Other issues arise with the information obtained from the surveys:

1. The surveys were cross-sectional.
2. Reliability and representability – there may have been a pool of prospective respondents who are neither literate nor computer literate.
3. Stigmatization may have prevented participation.
4. It is unclear whether the studies included ethnic minorities.

2.3 Mutual help groups for alcohol dependence – non-12-step groups

Although many non-12-step self-help or mutual help groups exist to assist with alcohol-related and or addiction problems, there is little in the form of research or other formal literature on their functioning. Notwithstanding that, according to Kessler et al. (1997), Americans make more visits to self-help groups for substance abuse or psychiatric problems than they do to all mental health professionals combined. To determine the efficacy of such groups by comparison with 12-step groups, Zemore et al. (2018) carried out a large national study. They selected four active abstinence-focused groups - Women for Sobriety, Secular Organizations for Sobriety (now LifeRing), Soberitas Online Community, and SMART Recovery. For the research, participants were selected and surveyed via the Internet (n=651). Recruitment was effected through contact with online meetings, emailing meeting convenors and attendees, and social media announcements.

Participants logged on to an online survey site (subject to their earlier preliminary suitability screening) and completed the survey. Results showed that, compared with 12-step groups, members of the alternatives were less religious and generally better educated and financially secure. Women for Sobriety and LifeRing members were older, more likely to be married, and scored lower on lifetime drug and or psychiatric severity. LifeRing and SMART members were less likely to favor total abstinence as a target. Despite lower attendance, members of the alternatives showed greater satisfaction and cohesion than 12-step group members and had an active involvement equivalence.

2.3.1 Women for Sobriety (WFS)

In this organization, set up in 1975, there is a fundamental tenet – that women alcoholics have unique needs in recovery, relating to the particular feelings of guilt experienced only by women alcoholics. Subsequent literature identifies more precisely the logic for such a group (Holzhauer et al., 2020; Glanton & Cucciare, 2020). Lockheed and Hall (1976) identified that women and men tend to behave differently in mixed-sex groups – men are more likely to be proactive in participation, while women spend their time agreeing or praising others. Further, women also deferred to men, especially when more men were in the group (McLachlan et al., 1979).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) believes that part of the *"philosophical base for the advocacy of separate women's treatment programs*" is the need for role models and for insiders' sensitivity to women's problems (Downing, 1991; NIAAA, 1983, p.9), which can only occur in all-women settings. Support groups where men are not present seem necessary for women who drink, for reasons associated with sexuality and gender roles, including the following:

1. Drinking to get along on dates (Fillmore et al., 1979).
2. In response to family problems (Gomberg & Lisansky, 1984).
3. Because of frigidity (Lindbeck, 1972; Sandmaier, 1977).
4. Drinking to feel more womanly, or out of doubts about one's adequacy as a woman (Wilsnack, 1973).
5. Having suffered sexual or physical abuse at the hands of a man (Beckman, 1994).
6. Feeling one cannot have sex without drinking (Wallen, 1990).
7. Other alcohol-related issues of sexuality and sexual dysfunction (Beckman, 1979; Wilsnack et al., 1991) that are *"difficult for women to discuss in the mixed-sex*

groups that characterize most treatment facilities" (Wallen, 1990, p.107).

8. The increased sensitivity to alcohol's physical effects during the premenstrual phase (Blume, 1982).
9. The association between alcohol consumption and other reproduction-related issues (Beckman & Amaro, 1984; Beckman, 1979).

All the factors above support the need for a women-only forum for alcohol treatment.

The WFS affirmations have four themes (Kaskutas, 1989; 1994). Those four themes are no drinking, positive thinking, believing in one's competency, and growing spiritually and emotionally. WFS and AA meetings differ in structure, format and programme philosophy (Kaskutas, 1989; 1992a; 1992b) but have total abstinence as a goal in common. While an AA meeting is organized by a secretary and consists of members sharing their experiences, strengths and hopes, WFS meetings, led by a certified moderator, do not encourage drinking stories and emphasize positive thinking (affirmations). However, this may be the subject of some controversy as it promotes the suppression of true feelings.

Kaskutas (1994) reviewed the results of a 1991 survey of the total membership of Women for Sobriety (n=600), representing a response rate of 73%. In summary, the findings were that women attended because of the need for support and nurturance (54%); for a safe environment (26%); for sharing about women's issues (42%); and because of its positive emphasis (38%) and focus on self-esteem (39%). Members also attended AA as insurance against relapse (28%); for AA's wide availability (25%); for sharing (31%) and support (27%). Women who did not attend AA felt that they never fitted in at AA (20%); found AA too negative (18%); disliked the drunkalogues (14%); their focus on the past (14%); and that AA tended to focus on men's needs (15%).

A significant limitation of this study was that its representivity is questionable. Humphreys et al. (2004) point out that membership is almost entirely Caucasian and middle class. Surprisingly, the study did not identify the issue of how safe or unsafe AA can be for women – they may be subject to a behaviour known, euphemistically, as "thirteenth stepping" (Bogart & Pearce, 2003). "Thirteenth stepping" is a colloquial term used by AA (and other 12-step fellowship) members that refers to the practice by experienced members of targeting new, more vulnerable members for dates or sex. Section 2.4.9 (iv) below explores this subject in more detail.

Further research is emerging into the role that gender differences play in developing

dependency neurobiologically through its impact on the brain and developing alcohol use disorder (Flores-Bonilla & Richardson, 2020). Evidence is also emerging that the ratio of men to women with AUD decreases for two reasons: men drink less and women more (White, 2020). While it was not a focus of the Kaskutas (1994) study, the last alcohol use figure for five years in WFS was lower than AAs by 5.6%.

AA, following the tenets of their Preamble (AA Grapevine Inc., 2017) have no view on the matter. However, a Public Information Officer pointed out two salient matters. The first was their Tradition 3, *"The only requirement for membership is a desire to stop drinking",* and secondly, their Tradition 4, *"Each group should be autonomous except in matters affecting other groups or AA as a whole".* She explained there was no exclusion of "women only" groups – that would be their choice, and there are already many LGBT and other specific meetings working harmoniously.

2.3.2 Secular Organizations for Sobriety (SOS) – now LifeRing

This organization, founded in 1986, was in response to an aversion by people desiring to stop drinking to the religiosity/God concepts of Alcoholics Anonymous (Connors & Dermen, 1996). By then, in 1996, the organization had a membership of approximately 20,000 worldwide. The groups are autonomous. Sessions have a threefold purpose: (a) to provide peer support for people seeking to achieve and maintain sobriety; (2) to provide a forum for participants to express thoughts and feelings about their recovery; and (3) to provide a non- religious atmosphere. The format of meetings is at the discretion of each group. There are approximately 350 meeting convenors, widely geographically spread across the USA. Connors and Dermen (1996) sought to determine the characteristics of SOS members. They recruited convenors by way of random selection (n=200). The researchers then mailed packets of surveys. Anonymity was assured. Connors and Dermen explored five domains: background, involvement, AA involvement, drinking history, and drug use history. There were 158 responses from 22 states, but they could not be guaranteed to represent the membership for several reasons. As with WFS, members were white, well-educated and employed. A quarter were women. Thirty-seven per cent described themselves as atheists, 33% as agnostic and 22% as spiritual but non-churchgoers (Connors & Dermen, 1996). Seventy per cent claimed abstinence for an average of 6.3 years. Abstinence was the goal of 86%. While 30% also attended AA, 96% had participated in at least one AA meeting, with over half attending >100 AA meetings.

Nineteen per cent reported that they found AA harmful. Generally, the organization met the needs of those who rejected the AA "higher power"/God fundamental.

SOS has become almost defunct as LifeRing has effectively taken it over. LifeRing has 163 meetings across 17 states in the USA and has a presence in Canada, the UK and Ireland. The format remains much the same. They have approximately 10 members per meeting and are peer-led. Their recovery goal remains abstinence.

2.3.3 Soberitas Online Community

This online facility was set up in 2013 by Lucy Rocca as *a "social network site for people who are trying to resolve their problematic drinking patterns."* (Sinclair et al. 2017) It attempts to circumvent the problem of perceived stigmatization attached to alcohol use disorders than that can lead to lower levels of disclosure about alcohol use, and it also removes a barrier to treatment, especially for the treatment-naive who may be shy or uncertain how to perceive their problem (Jones et al., 2015; Probst et al., 2015). Another perceived benefit is that those unwilling or unable to go to in-person services can access support (Vernon, 2010; Hester et al., 2013). Sinclair et al. (2017) carried out a Soberitas Online Community study to determine whether the "processes of change" may be different online and to consider potential mechanisms of action for future research. Recruitment was by way of advertisement on the Soberitas website (n=438). Ninety-four per cent of respondents were women, of whom 50% lived with their children. A quarter reported that their last drink was <24 hours previously, while 17.8% said >1 year. AA had been tried by 28.9%, while 46.5% had tried nothing. Anonymity, the ability to be honest, being a source of trusted information, and ongoing support were reasons for continued membership.

The study concluded that Soberitas does offer a form of mutual aid, primarily used by women, who have often not engaged with other treatment or support. Sinclair et al.'s (2017) preliminary study suggests that the online, flexible platform may afford members an accessible and anonymous community to address their difficulties and encourage developing a positive "alcohol-free" identity. Limitations to this research are there is no reference to the level of fees for fee-paying members – a separate class of members – or the constraints of service to those not paying; the sample size is small; the study was cross-sectional in nature; and the inability to validate the veracity of responses. Generally, like all other online Internet-based self-help groups, it carries dangers from stalkers, disgruntled partners and the like.

2.3.4 Self-Management and Recovery Training (SMART Recovery)

In 1994, SMART Recovery became a model recommended alongside 12-step clinical guidelines for addiction and dual diagnosis (Mills et al., 2010). SMART Recovery is a not-for- profit organization that provides mutual aid in group and online formats (Horvath & Yeterian, 2012). SMART Recovery focuses on self-empowerment and adopts key principles (e.g., self- efficacy) and therapeutic approaches (e.g. motivational interviewing and cognitive-behavioural therapy) that have been shown to be effective in promoting recovery from addiction. Unlike 12-step approaches that offer addiction-specific support groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous), SMART Recovery offers support for a range of addictive behaviours (Horvath & Yeterian, 2012) – and much more, such as decreasing stress and enhancing resilience amongst breast cancer survivors (Loprinzi et al., 2011). Beck et al.(2017) carried out a systematic review of Smart Recovery's outcomes and process variables. Twelve studies met the required criteria. Alcohol-related outcomes were the primary focus. Standardized assessment of non-alcohol substance use was infrequent. The criticisms contained within the review speak for themselves about determining SMART Recovery efficacy:

> *"Functional outcomes were rarely reported. Feasibility was largely indexed by attendance. Economic analysis has not been undertaken. Little is known about the variables that may influence treatment outcome, but attendance represents a potential candidate. Assessment and reporting of mental health status was poor. Although positive effects were found, the modest sample and diversity of methods prevent us from making conclusive remarks about efficacy."*
>
> (Beck et al., 2017, p.1)

As a consequence of SARS-CoV-2/Covid-19, SMART Recovery and many SHG's had to stop meeting and go online. Kelly et al. (2021) consulted SMART Regional Offices in 5 countries and identified this change as an opportunity to critically evaluate the online delivery of mutual support groups, how to understand the mechanisms through which they work, and how people may continue to access the groups post-pandemic or in greater numbers.

Summary

By their nature, accurate and detailed research into non-12-step SHG processes and outcomes is virtually impossible (Zemore et al., 2017). Groups tend to be independent, autonomous, self- financing, and with poor record-keeping of results. Apart from the usual "glossy" annual report produced by such bodies to satisfy funders or local authorities about their activities, little information is available that could be of any scientific use. Further specific limitations are that they may be unrepresentative – members tend to be middle-class, white and well-educated. Two critical points noted were: (1) that in Women for Sobriety, the figure for five years sobriety was appreciably lower than the equivalent figure for AA (Kaskutas, 1989), and (2) members of these other organizations also attend AA.

Although most literature on self-help and 12-step groups has originated in the United States, Martinelli et al. (2020) explored whether members of mutual aid groups were better equipped for addiction recovery in Europe using participants from the UK, Netherlands and Belgium n=367). Their results showed marked equivalences with the earlier findings of their US counterparts.

2.4 Mutual help groups for alcohol dependence – 12 step groups

While studies have been carried out into the efficacy of 12-step fellowships (TSFs) generally, they have focused primarily on Alcoholics Anonymous (AA) due to its size, longevity, impact and global nature.

2.4.1 The 'message' of the Alcoholics Anonymous 12-step fellowship

The title of Butler's (2010) book, *Benign Anarchy,* is an apt description of how AA is organized or autonomized. The title originated in correspondence between Wilson (AA founder) and an Irish founding member, O'Connor-Mallins (Butler, 2010, p.xi), and describes how the organization runs from the bottom up and is entirely decentralized in its organization. So too are the messages of all the 12-step fellowships – obliquely and indirectly stated. Notwithstanding that the 12-step programme can be somewhat directive at times, its final page says, *"Our book is meant to be suggestive only. We realize we know only a little"* (AA, 1976, p. 164). There *are* key messages contained within the overall text. However, no literature has explored what exactly is the message that AA passes on – although transmission is an integral part of their programme under Step 12.

2.4.2 A review of AA's suitability for a particular cohort of alcohol-dependent clients

To determine whether matching specific clients with particular treatment approaches would result in better outcomes, a study entitled Project MATCH was conducted in 1995. It was the largest ever project to consider the benefit of matching AUD treatments with client heterogeneity. Three therapeutic approaches were selected – Twelve-Step Facilitation (TSF – a 12-step, AA based approach), Cognitive Behavioural Therapy (CBT), and Motivational Enhancement Therapy. Allen et al. (1997) found that there was little difference in outcomes by type of treatment. In the outpatient study, clients low in psychiatric severity had more abstinent days after TSF treatment than CBT. Aside from psychiatric severity, providers need not take client characteristics into account when triaging clients to one or the other therapeutic approach. Problems possibly affecting the study results were that "therapist allegiance" was disregarded, nor was there any control group.

Allen et al. (1998) carried out a Project MATCH follow-up review of three-year drinking outcomes. This study's objective was to review the matching effects found in the first year of follow-up, testing for other emerging divergences, and determine whether any client matching attributes might serve as predictors of long-term outcomes. As in the one-year follow-up, there were few differences among the three treatments, although TSF continued to show a possible slight advantage. The study reaffirmed the findings in the original research about client and treatment matching. Regarding overall outcomes, the reductions in drinking observed in the first year after treatment endured over the three-year follow-up period – almost 30% of the subjects were abstinent in months 37 to 39. Interestingly, anger, as an issue, responded better to Motivational Enhancement Therapy.

The reviewed literature suggests that using abstinence alone as an outcome led to a situation where nothing could be categorically proven or disproven to be efficacious, just as Rosenzweig (1936) postulated about psychotherapy generally.

2.4.3 Alcoholics Anonymous efficacy

Although over two million people "vote with their feet" favoring Alcoholics Anonymous (AA World Services Inc., 2019), the organization's efficacy remains controversial among researchers. Bebbington's (1976) three-decade review of the literature concluded that "*the methodological quality of the studies was so poor that it does not add to the knowledge concerning AA which we possess from clinical experience"* (Bebbington, 1976, p.572).

Miller and Hester (1986) concluded that AA completely lacked experimental support for its efficacy and was no better or worse than alternative treatments.

Kownacki and Shadish (1999) carried out a meta-analysis of controlled experiments to again address the question of whether Alcoholics Anonymous works. A review of 403 studies concluded that attending conventional AA meetings was worse than no treatment or alternative treatment, and that AA-modelled treatments performed no better or worse than alternatives. However, selection bias was an endemic confounding issue. These findings were slightly more direct than those of Tonigan et al. (1995), who concluded that while better-designed studies were likely to report positive psychosocial outcomes related to AA attendance in general, AA studies lacked sufficient statistical power to detect relationships of interest.

A further study by Harris et al. (2010) explored whether baseline abstinence was moderating intervention effects. Using a large sample size (n=3,181) demonstrated the effect of not considering the heterogeneity of abstinence levels at baseline on research outcomes. The result was that failure to separately examine individuals who are or are not abstinent at baseline overestimates the "treatment effect" on those abstinent at baseline and underestimates the effect on non-abstinence at baseline.

As self-selection, selection bias and coercion have undermined the merit of many studies on the efficacy of TSFs (Kownacki & Shadish, 1999), Humphreys et al. (2014) sought to overcome this difficulty by using an instrumental variable modelling approach to control for these confounders. When such biases were removed, and the outcome measure was the number of days sober, they concluded that AA attendance leads to significantly greater short- and long- term decreases in alcohol consumption than alternative treatments, which cannot be attributed to self-selection. However, for those who already had a high level of pre-existing AA involvement, further increasing AA attendance had little impact.

Emrick and Beresford (2016) considered the "success rate" of AA and, while acceding to the equivalence of early drop-out rates (approximately 80%) within the first year of all therapeutic approaches, suggested that these early dropouts are more to do with how individuals with addiction disorders relate to their addiction intervention. Surprisingly, they did not advert to the potential impact of Stavro et al.'s (2013) findings regarding enduring cognitive impairment in year one, or Brorson et al.'s (2013) equivalent findings.

Emerick and Beresford (2016) suggested it would better serve to demonstrate AA's efficacy by assessing those who have had an adequate "dose" of the programme. They opined that treating all dropouts and one-time attendees as failures led to a gross underestimation of AA's effectiveness. Drawing correctly on figures produced by Harris et al. (2003) and Fiorentine (1999) – as opposed to the inaccurate interpretations published by Dodes and Dodes (2014) – Emrick and Beresford suggested that the actual rates for those who are regularly involved in 12-step groups through the period 18 to 24 months is 77.7% for drugs and 74.8% for alcohol. Secondly, 42% of people with alcohol dependence regularly involved in 12-step programmes were abstinent through their fourth year.

2.4.4 Alcoholics Anonymous effectiveness

Emerick et al.'s (1993) meta-analysis showed positive correlations between AA participation and desired drinking outcomes. However, this result was correlational and, while promising, did not establish causation.

Ferri et al. (2006) assessed the effectiveness of AA or TSF programmes compared to other psychosocial interventions in reducing alcohol intake, achieving abstinence, maintaining abstinence, improving the quality of life of affected people and their families, and reducing alcohol-associated accidents and health problems. Eight trials (n=3,417) were included. Those studies did not allow a conclusive assessment of the effect of TSF in promoting complete abstinence. "*No experimental studies unequivocally demonstrated the effectiveness of AA or TSF approaches for reducing alcohol dependence or problems compared with other treatments"* (Ferri et al., 2006, p.2).

Valliant (2012) examined the first 50 years of a study of alcoholic men from both a college group and an inner-city group (n=768) and concluded that those who remained stably abstinent attended approximately 20 times more AA meetings than those that did not. However, Valliant's (2012) findings, similar to Emerick et al.'s (1993), were taxed with the issue of self- selection bias. While correlational, they are significant in having regard to the period involved. Kaskutas (2009) provided a focused review of the literature on AA's effectiveness, according to six criteria required for establishing causation: (1) magnitude of effect; (2) dose-response effect; (3) consistent effect; (4) temporally accurate effects; (5) specific effects; (6) plausibility. However, the literature search extended beyond AA to include Narcotics Anonymous, Cocaine Anonymous, 12-step group, and 12-step

facilitation in the title or used as a keyword. The evidence for criteria 1, 2, 3, 4 and 6 is robust: Rates of abstinence are about twice as high among those who attend AA (criteria 1, magnitude); higher levels of attendance are related to higher rates of abstinence (criteria 2, dose-response); these relationships were applicable for different samples and follow-up periods (criteria 3, consistency); prior AA attendance is predictive of subsequent abstinence (criteria 4, temporal); and mechanisms of action predicted by theories of behaviour change are present in AA (criteria 6, plausibility). However, rigorous experimental evidence establishing the specificity of an effect for AA or TSF (criterion 5) was mixed. The author claimed that this is not a thorough review of the literature on AA effectiveness – she was presenting representative studies that address AA effectiveness according to six accepted criteria for establishing scientific causation.

Large-scale surveys, already referred to earlier, have moved on to try and empirically establish the components of enduring recovery. The surveys were by Laudet (2013), Kaskutas (2014), Best et al. (2015), and McQuaid et al. (2017). They were cross-sectional surveys, taking place over some months, and were not confined to alcohol consumption only. More recently et al. (2020b), in a systematic review, concluded that AA provided the most effective approach, stating that

> *"AA/TSF interventions produce similar benefits to other treatments on all drinking-related outcomes except for continuous abstinence and remission, where AA/TSF is superior. AA/TSF also reduces healthcare costs."* (p.641)

As stated at the beginning of this section, over 2 million people "vote with their feet" and attend AA meetings despite the somewhat lukewarm research findings discussed earlier in this section. Apart from AA, spin-off groups such as Narcotics Anonymous and others have an estimated 6 million members. That would suggest that some vital stages in 12-step group processes remain unexplored and or unexplained.

2.4.5 The mechanisms of change in AA

The identified mechanisms of change in earlier AA literature mentioned above were change behaviour, spiritual growth, spirituality, the 12 promises of AA, and reduced impulsivity.

(i) Change Behaviour

Kelly et al. (2009) carried out a systematic review of the research on the mechanisms of change behaviour of people recovering from alcohol dependence through AA

participation. A more in-depth elucidation of those mechanisms could inform the understanding of addiction recovery and alcohol-related interventions' timing and content. The results suggested that AA helps individuals recover through common process mechanisms that enhance self-efficacy, coping skills and motivation, and facilitates adaptive social network changes. This systematic search did not support AA's practices or spiritual practices. Instead, it suggested that AA's effectiveness may not be due to its specific content or process. However, its chief strength may lie in its ability to provide free, long-term, easy access and exposure to recovery-related common therapeutic elements, the dose of which can be adaptively self-regulated according to perceived need.

(ii) Spiritual growth

Despite the finding by Kelly et al. (2009), Tonigan et al. (2013) investigated spiritual growth as a change mechanism in 12-step programmes (n=130). Their baseline interview lasted two hours, comprising three semi-structured interviews and a toxicology check. The follow-up checks at three, six, and nine months were slightly shorter in duration than the initial one. As reflected in religious behaviour, spiritual change was found predictive of increased abstinence and decreased drinking intensity, and this effect varied across different levels of spiritual practices.

(iii) Spirituality

Tusa and Burgholzer (2013) reviewed the evidence from 1992-2012 regarding spirituality as a behavioural change mechanism within AA. Of the 24 papers reviewed, four showed no correlational link, whereas the others did to some extent or other. While strong associations were noted, most had persistent problems ranging from sample size through self-selection to construct validity. Ironically, and as pointed out by Tusa and Burgholzer (2013), AA identifies its primary mechanism of change as *"deep and effective spiritual experiences which have revolutionized our whole attitude toward life, toward our fellows and toward God's universe"* (AA World Services Inc., 2001, p.25). Galanter et al. (2013) interviewed physicians in long- term recovery who were members of AA, because the experience of those long-term members could help them to better understand the role of spirituality in AA membership and how that spirituality may help stabilize abstinence (n=144). Participants were all physicians with a mean period of sobriety of 140 months. The survey took place at an AA conference, and anonymity was guaranteed. The key finding was that participants scored higher on scales for depression and anxiety than

normative populations but were more adherent to AA's spiritual character than a formally religious orientation**.** They concluded that the experience of long-term AA members might be characterized in terms of abstinence, spirituality and alcohol craving. While the survey showed that alcohol problems are not confined to the uneducated, lower-income, socioeconomic grouping, it did not examine the effect of coercive or mandated attendance by the physicians in treatment. Kelly and Greene's (2014) literature review suggests five possible mechanisms of how AA's spirituality may aid recovery and suggests that further qualitative research into them may help explain spirituality's role in facilitating sobriety and recovery.

(iv) The 12 promises of Alcoholics Anonymous

Kelly and Greene (2013) considered the 12 promises of AA (AA World Services Inc., 2001, pp. 83-4) and suggested that they are one of the few documented explications of the cognitive, affective and behavioural benefits that may accrue to members who follow the AA programme. Their study investigated the psychometric properties of a measure of the 12 promises and examined whether it mediated the effect of 12-step participation on abstinence. Participants (n=302) were predominantly young, male and white. They considered the central proposed mechanism of recovery from alcohol addiction, which according to AA is through a *"psychic change"* (AA World Services Inc., 2001 p. xxvi) or "*a spiritual experience or spiritual awakening"* (AA World Services Inc., 2001, p. 567). This "spiritual awakening" may occur through the completion of the 12-step programme. (AA World Services Inc., 2001, p. 58-60). Having had such a spiritual awakening due to those steps, members then try to carry the message to other alcoholics and practice the principles outlined in the steps in all their affairs. Kelly and Greene (2013) noted that although AA states this "awakening" can take the form of a sudden and sometimes dramatic shift in belief and perspective, it can also result as a gradual transformation of an educational variety that leads to *". . . a profound alteration in [his] reaction to life"* (AA World Services Inc., 2001, p. 567).

After considerable consultation with other clinicians, the authors constructed a Twelve-Promise Scale (TPS), giving a 26-item self-reporting measure designed to capture the essentials of AA's original 12 promises. Participants took part in an interview at intake and three-, six- and nine-month intervals. Only two factors were positively affected – "psychological wellbeing" and "freedom from craving." However, the authors concluded

that the TPS showed potential as a conceptually relevant and psychometrically sound measure that may help understand the 12 promises' importance.

(v) Reduced Impulsivity

Blonigen et al. (2011) considered whether reduced impulsivity was a plausible mechanism of change associated with salutary effects of AA. Participants (n=628) were recruited as people who had not been previously treated for alcohol use disorders. They were initially assessed under the Differential Personality Scale (Jackson & Messick, 1971), legal problems, drinking outcomes, and psychosocial outcomes. They were reviewed at years 1, 8 and 16 with only 507 participating in the last review. The result was that there were significant mean-level decreases in impulsivity, and longer AA duration was associated with reductions in impulsivity. Decreases in impulsivity from baseline to year 1 were associated with fewer legal problems, better drinking and psychosocial outcomes at year 1, and better psychosocial functioning at year 8. A limitation of this study was that issues outside of the AA sphere were considered and may have confounded outcomes. AA may be a mechanism of change but not just for alcohol- related behaviours – impulsivity is a multifaceted construct inclusive of several tendencies, including risk-taking and poor emotional regulation. For example, Estévez et al. (2017) found that emotion regulation was predictive of all addictive behaviors assessed in their study (n=472; alcohol and drug abuse, gambling disorder, video game addiction, and problematic Internet use), while attachment predicted non-substance-related addictions (gambling disorder, video game addictions).

2.4.6 AA - Religiosity and spirituality

This section considers literature on Jung's influence on Wilson's thinking when formulating AA's approach to spirituality, religiosity's role, empirical findings on spiritual awakenings in AA, the role of 12-step-related spirituality in addiction recovery, and whether AA is religious, spiritual, or neither.

2.4.6 (i) Carl Jung and AA

Carl Jung's work, indirectly, proved to be highly influential in the development of AA – deriving from a comment Jung made to a former alcohol-dependent patient Rowland Hazard. Jung told him that the only hope was for him to have a life-changing "vital spiritual experience" that he had observed in others – an experience that he regarded as a phenomenon. *"You have the mind of a chronic alcoholic, and I've never seen one single*

case recover where that state of mind existed to the extent that it does in you" (cited in AA World Services Inc., 2001, p. 26). Jung also added that simply affiliating with a church did not provide the necessary "vital" experience. This prognosis so shook Rowland that he sought out the Oxford Group, an Evangelical Christian group he had heard about dedicated to what its members termed "the Four Absolutes" – "self-survey, confession, restitution and the giving of oneself in service of others" (Kurtz, 1991, p.9). It worked for Rowland, and he passed this message on to a friend Ebby T., who passed it to Bill Wilson. While hospitalized after yet more drinking, Wilson underwent such a "spiritual awakening" (as earlier described to him, third hand, by his friend Ebby). Wilson remained reticent in speaking about that actual event until 20 years later. He gave a fuller account of how he had cried out, *"'If there is a God, let Him show Himself! I am ready to do anything, anything.' When, suddenly, the room was lit up by a bright light. I was caught up into an ecstasy which there are no words to describe"* (Kurtz, 1991. pp. 19- 20). However, there is an unresolved question as to the extent that the drug belladonna played in that event (McCabe, 2015, p. 25).Through the written work of William James in *The Variety of Religious Experiences,* Wilson also learned that many spiritual experiences are of the educational variety (Appendix 15) but that the key to succeeding was the having of "*...complete hopelessness and deflation at depth"*(Wilson, B., cited in Kurtz, 1991, p. 21).

Over the following years, Wilson communicated with Jung via Margarita Luttichau (a student of Jung and a protégé of Wilson) until 23rd January 1961 when he wrote directly to him – acknowledging that his view, as expressed to Rowland H., was one of the originating cornerstones from which AA had arisen (McCabe, 2015, p. 7). In the fifth appendix to his book, McCabe also includes copies of correspondence regarding their spiritual experience with a member. While these mystical/ethereal events may be somewhat difficult to comprehend, similar incidents are recounted by participants in this current research (e.g. Anne, 23:718-722). McCabe (2015) describes the need for an alcohol-dependent person to reach "rock-bottom" before they are open to change. In Jungian terms, he describes this process *"...may mean that the lesser ego may be deflated enough to give way to the true Self"*(p.70).

2.4.6. (ii) Religiosity

Winzelberg and Humphreys (1999) studied religion's role in AA attendance of males

entering a VA (U.S. Department of Veterans Affairs) inpatient substance abuse programme (n=3,018). They found that religious behaviors such as praying, thinking about God, and so forth affected AA attendance, whereas religious beliefs (specifically, belief in God) did not. Neither religious belief nor behaviour contributed to abstinence or the absence of substance abuse problems. However, they did not directly address the effect or impact of the word "God" on impressions at first meetings attended. Kaskutas et al. (2003) investigated the question of religiosity in AA and long-term sobriety through a three-year study (n=587) using the same Religious Beliefs and Practices Scale as had been used in Project MATCH. At year 3, participants who reported a spiritual awakening at were at the highest odds of continuous sobriety for the last year; religious self-definition was not associated with a significantly higher odds of sobriety at year 3, controlling for other considered influences.

Further, the recency of a "spiritual awakening" correlated with higher odds of being sober, and the majority of those who were not continuously abstinent for the previous 12 months had never reported a "spiritual awakening," suggesting a clear distinction by participants between a belief in God and a spiritual dimension to their existence. What seemed to make more of a difference in sobriety levels at the end of year 1 had more to do with AA involvement and not just AA attendance immediately after treatment. Davis et al. (2006) examined student counsellors' attitudes towards spirituality in AA through a survey (n=155). Correlations were found between students' spirituality and attitudes towards spirituality in treatment. Most of the students agreed that spirituality ought to be included in treatment, but they tended not to subscribe to the core principles of AA.

2.4.6 (iii) Spiritual awakenings in Alcoholics Anonymous: Empirical findings

Galanter et al. (2014) carried out a survey (n=161) at a scientific session providing continuing medical education to an association of doctoral-level health professionals who were AA members (but not directly affiliated with the fellowship of AA). While AA itself does not retain its members' identifiers, this group does so – to contact themselves about the organizational activity. They reported that spiritual awakenings had most often taken place gradually (60%), while members were working the steps (52%), and right after "bottoming out" (57%). This finding agrees with the AA view that, for many, a spiritual awakening is a gradual process rather than an inspiration moment (AA World Services Inc., 2001, pp. 569-70). They concluded that spiritual awakenings were a major transformative

event across many long-term AA members. Gutierrez et al. (2021) explored what exactly happened during a 'vital spiritual experience' citing AA's, 2001, (p. 27) description when *"Ideas, emotions, and attitudes which were once the guiding forces of the lives of these men are suddenly cast to one side, and a completely new set of conceptions and motives begin to dominate"* (AA (2001) give an expanded explanation in their Appendix II (p. 567). They found that this 'vital spiritual experience' has "*several unique characteristics, such as transcendent drives, somatic and emotional sensations, and the experience of sacred emotions."* (p. 27) Although Gutierrez et al.'s (2021) findings demonstrated how, for some individuals in recovery, a spiritual experience strengthens them and provides a new outlook on life, they also found that *"...not every individual in recovery may feel equally as enthusiastic about having spirituality integrated into their recovery process."* (p. 27)

2.4.6 (iv) The role of 12-step-related spirituality in addiction recovery

Kelly and Greene (2014, p. 10) suggested that the psychological factors that explain spirituality in AA were:

(1) Spiritually oriented, AA-specific, conditioned cues (e.g., the serenity prayer) that activate recovery schema and increase active coping.

(2) The provision of a compassionate framework for self-forgiveness that decreases shame and guilt.

(3) The focus on the positive cognitive reframing of suffering and stressors.

(4) Enhanced cognitive vigilance and continuous exposure to aversive substance- related memories.

(5)Providing a coherent spiritual framework that gives meaning and purpose to individuals' survival, suffering, and life experience.

Dermatis and Galanter (2016) also explored the role of 12-step-related spirituality in addiction recovery in a review and quantitative survey (n=322). Their key finding was that believing in a higher power as a universal spirit and serving as an AA sponsor were predictive of positive outcomes. As quitting drinking might be perceived as nothing short of a miracle from God, it would be expected that 12-step programme members who have maintained sobriety might experience increases in spirituality relating to the attachment to God and mystical experiences. Rather than reflecting good luck or chance occurrence, attaining sobriety in AA was viewed as originating from what has been referred to as a

"transcendental intervention" reflecting a larger purpose or reality (Connors et al., 2008). McInerney and Cross (2021) examined the meaning of spirituality in long-term recovery in AA in an IPA study with three subjects who were abstinent, on average, for 30 years. They found that spirituality was conceptualized as secular and existential phenomena reflected through three "higher-order" themes – (i) trust (a key to change), (ii) being in the world in relation to others, and (iii) finding greater meaning in a secular spirituality. Two of the interviews were conducted via video link due to Covid-19 restrictions; the difference between face-to-face and video meetings is unknown.

2.4.6 (v) Whether AA is religious, spiritual, or neither

Kelly (2017, p. 929) posed the question *"Is Alcoholics Anonymous religious, spiritual, neither?"* and, to answer it, he carried out a literature review, summary, and synthesis of studies examining AA since 1990. He concluded that AA appeared to be an effective organization that aided recovery through its ability to mobilize therapeutic mechanisms similar to those mobilized in formal treatment centres. He found that the religious/spiritual elements of its programme played a lesser role in its functioning. AA's main advantages are that it is free, it endures over the long term and operates in the communities in which its members live. However, his review accepts that it only addresses 50% of the mechanisms of behavioral change involved and suggests that in response to the question posed, *"the answer would appear to be 'yes'"* (p .934). While Rettie et al. (2021) reaffirms the findings of Moos (2008) and Kelly (2017), they identified other important components of recovery groups that had not been identified in previous literature, such as the *"presence of like-minded individuals and developing self-awareness and reflection skills"*(p. 847) at self-help groups.

2.4.7 AA sponsors – their multifaceted role as "more-knowing figure" and "wounded helper"

While writing extensively on the history of "the wounded helper", White (2000a; 2000b) remained silent on identifying or discussing AA sponsors despite their significance to and role within AA and it is not unreasonable to view them as such. White's focus was on remunerated 'helpers' and not on volunteers. The topic of sponsorship has been the subject of considerable research and, more recently, it was found that that "*Sponsorship is a key transitional process that facilitates the sponsor's transition into non-using social groups in a way that maintains the sponsor's sense of self as a congruent and accepted social group*

member" in McGovern et al. (2021, p. 11)

The role of wounded helpers was acknowledged and seen by Jung (1983) as providing a therapeutic experience beneficial to both client and counsellor. Dunne (2015) cites Jung as saying, *"In the end, only the wounded physician heals and even he, in the last analysis, cannot heal beyond the extent to which he has healed himself"* (p. 119). Yalom (2010) suggested that dual role occurred because they could *"empathize with the wounds of the patient"*(p. 109) or could engage more closely and personally in the healing process. Deurzen (2015) suggested that clients were more often helped by the therapist's failures than their merits, as long as the therapist themselves was prepared to learn from them – including stigmatization and discrimination. From the psychotherapist's perspective, the dilemmas and difficulties in reconciling the two roles of victim and counsellor are described by Zerubavel et al. (2012) and also discussed in Edmonds (2020) regarding cancer. The existing flexible "*yet historically loaded construct"* of the wounded healer is challenged by Hadjiosif (2021) as being amenable to scrutiny, leading to a more helpful positioning within professional practices.

Within AA, while members are encouraged to share their experience, strength and hope in a *"general way"* with each other at meetings (AA World Services Inc., 2001, p.58), there may be a need for more personalized guidance through the 12 steps and with matters arising from them. In this context, the sponsor's role is regarded as necessary and central to the recovery process and affects both parties. It goes right back to the initial encounter between Bill Wilson and Dr. Bob Smith (AA founders) when Bill explained to Bob, that he (Bill) was not there to get just help Bob get sober but that his visit was essential to his keep himself sober by passing on to him what it was like, what happened and how he was then. AA describes its conception of what a sponsor is and is not as follows:

> *"An AA sponsor is not a professional caseworker or counsellor of any sort. A sponsor is not someone to borrow money from, nor get clothes, jobs or food from. A sponsor is not a medical expert, nor qualified to give religious, legal, domestic or psychiatric advice, although a good sponsor is usually willing to discuss such matters confidentially and can often suggest where the appropriate professional assistance can be obtained. A sponsor is simply a sober alcoholic who can solve only one problem: how to stay sober, and the sponsor has only one tool to use – personal experience, not scientific wisdom*." (AA World Services

Inc., 2005, p. 27).

Therefore, this section explores the literature in detail on aspects of nature, efficacy, function, benefit, sponsor attributes, sponsee attributes, and effect of AA attendance. It also explores in detail how sponsors frequently take a therapist or counsellor's place – being available 24 hours a day, seven days a week.

2.4.7 (i) The nature of the sponsor/sponsee relationship

Kelly et al. (2016) investigated the therapeutic alliance's recovery benefits among 12-step mutual help organization attendees and their sponsors (n=208). The study was quantitative and longitudinal. The researchers wanted to know whether the "therapeutic alliance" between sponsor and sponsee confers similar benefits to a standard psychotherapeutic setting. The methodology utilized was that participants were assessed at entry to treatment, then again after three, six and 12 months after discharge. Hierarchical linear modelling was used. Having a sponsor and a strong sponsor allegiance were significantly associated with greater 12-step participation and abstinence. Contact increased participation, and alliance increased abstinence. Kelly et al. (2016) comment that similar to the professional-clinical realm, the "therapeutic alliance" between sponsees and sponsors predicts better substance use outcomes.

2.4.7 (ii) Function of sponsors in AA

Whelan et al. (2009) considered the role of AA sponsors through a pilot study. The study was quantitative and qualitative. The object was to explore the roles of AA sponsors and describe the characteristics of a sample of sponsors (n=28). Their survey used questionnaires and unstructured interviews. Whelan et al. (2009) found that sponsors had three main tasks: (1) encouraging sponsees to work the programme of AA; (2) providing support (regular contact, emotional support, and practical support), and (3) carrying the message of AA. The roles identified broadly corresponded with the AA literature delineating the duties of a sponsor. Median lengths for sponsors were (1) membership 9.5 years, (2) sobriety 11 years. Sponsee numbers varied from 0-17. Sponsors had a high affiliation with AA. (0 may seem a *non- sequitur*, it simply means that, at a particular moment, a member may not have a sponsee.

2.4.7 (iii) Efficacy of sponsorship

Pagano et al. (2004) used data from the Project MATCH Research Group (1997) (n=1,726)

to examine the relationship between helping other alcoholics and relapse in the year following treatment for alcohol use disorders prospectively. They used Kaplan-Meier survival estimates to calculate probabilities of time to alcohol relapse. Proportional hazard regressions were conducted to determine whether the likelihood of relapse was lower for helping other alcoholics. Their results showed no demographic differences between participants regarding helping other alcoholics, except for age (i.e. 3+ yrs.). Those who were helping were significantly less likely to relapse in the year following treatment, independent of the number of AA meetings attended. The findings of Pagano et al.'s study (2004) provided evidence that recovering alcoholics who help other alcoholics maintain long-term sobriety following formal treatment are themselves better able to maintain their sobriety. Pagano and colleagues revisited this topic in 2009. Their quantitative study (n=11) examined the change strategies that promote ongoing sobriety. The range of sobriety length was 16-25 years. The method was the use of questionnaires (self-reporting) and telephone follow-up. Their findings were that across time, alcoholics increased their participation in helping behaviours specific to 12-step programmes. They concluded that helping other alcoholics, instead of helping others at home or work, was rated as contributing the most to staying sober.

2.4.7 (iv) Benefits of sponsorship

Tonigan and Rice (2010) questioned whether it was beneficial to have an AA sponsor through a quantitative prospective study (n=142). Their methodology was used through questionnaires, semi-structured interviews, and urine toxicology screening. During early AA affiliation, but not later, having an AA sponsor predicted increased alcohol abstinence. They concluded that there were overall reductions in alcohol use over 12 months and increases in AA meeting attendance due to having a sponsor. Reductions in other drug usages were also noted. Therefore, sponsorship did provide a range of benefits. More recently, and interestingly, O'Sickey et al. (2020) suggested that, when explored over a 12-month period, members' perceptions of group cohesion did not change and was the only AA meeting group dynamic that predicted a new member getting a sponsor.

2.4.7 (v) Sponsors' qualities and attributes

Stevens and Jason (2015a) explored the important qualities and characteristics of Alcoholics Anonymous sponsors. The study was qualitative in nature (n=245; 128m; 117f). Convenience sampling was used to recruit participants. The result was that effective

sponsors were personally engaged in the programme; they were trustworthy and available. A wide variety of other attributes were cited. A limitation to this study was that the convenience sampling had affiliations with Oxford Houses – a system of "recovery accommodation" – a concept and organization that AA would have no view on or contact with. Stevens and Jason (2015b) also evaluated AA sponsor attributes using conjoint analysis (n=225; 116m, 109f). The key attributes of sponsors were confidentiality, experience, availability, goal setting (structure), and knowledge. Again, their convenience sampling had affiliations with Oxford Houses – clouding the results somewhat.

2.4.7 (vi) Characteristics of sponsees

Young (2013) considered the characteristics and practices of sponsored members of AA. The purpose was to ascertain whether 1)unsponsored and sponsored AA members differed in AA characteristics or practices, and 2)whether AA sponsees differ in AA characteristics or procedures based on the length of their sponsorship (n=264; sponsored 195; unsponsored 69). The methodology used was online surveying after using non-random sampling methods, including purposive and snowball sampling. Compared with the unsponsored, the findings were that sponsees had less sobriety and greater spiritual surrender; they were more frequently engaged in a range of AA practices, and sponsorship was an essential component of recovery for most members of AA. Sponsorships, over time, evolve toward less engagement with both the AA fellowship and the sponsor. Generally, of the participants, 11.2% reported having less than a year sober, and 46.5% reported having 10 or more years. A limitation of the study was bias – by how representative the respondents were.

2.4.7 (vii) Sponsors and impact on AA attendance

Witbrodt et al. (2012a) questioned whether sponsorship improved outcomes above Alcoholics Anonymous attendance using a latent class growth curve analysis (n=495). There were one-, three-, five- and seven-year follow-ups. The purpose was to test the added benefit of having a sponsor above attendance benefits in predicting abstinence over time. The methodology was phone-based, using the same follow-up instrument each time. The finding was that there was more benefit from maintaining a sponsor over time than attending meetings alone. They concluded that any pattern of AA attendance, even if it declines or is never high for a particular 12-month period, is better than little or no attendance in terms of abstinence. As attendance levels and sponsorship involvement

levels increased, so too did the odds of abstinence. There were no significant limitations to this study. However, the limitations typical of AA studies apply, such as little corroboration of data supplied by participants.

2.4.7 (viii) Sponsors and *"... and to help other alcoholics achieve sobriety"* (AA, 2001, p. 61)

Pagano et al. (2010) investigated this concept (the "helper principle" (Riessman, 1965)) through designing an appropriate tool – the SOS (Service to Others in Sobriety). This tool was a multi-dimensional construct designed to assess recent participation in "Alcoholics Anonymous Helping (AAH)" (n=32). The SOS was determined to be a valid measure of AAH activities pertinent to the daily lives of recovering alcoholics. The least common forms of AAH activities were taking calls or spending time with a sponsee (66%), guiding another through the 12 steps (59%), and holding a service position (53%). The most common form of high AAH activity was putting away chairs (75%). Compared to participation in AAH activities, engagement in other involvement components of the 12-step programme was higher: 81% answered "yes" to the AAH item, "do you have a sponsor?" However, the findings' generalizability is questionable – participants were mainly white, middle class, educated and insured. No research was located that considered the harm done by ineffective or incompetent sponsorship (a problem highlighted by Eysenck (1952) concerning psychotherapists).

2.4.8. AA fellowship and its social networking role

Kelly et al. (2009), in their systematic review of behaviour change mechanisms, referred to the need for facilitating adaptive social network changes. *"The concept of fellowship in AA has been studied but has most often been reframed as social networks"* (p. 248). Two earlier studies, by Humphreys et al. (1999) and Kaskutas et al. (2002), found that social network influences were partial mediators of 12- month abstinence in mixed samples of inpatients. However, Bond et al. (2003) concluded that only AA-specific network support mediated alcohol abstinence three years following treatment. Kelly et al. (2009) found that while aspects of fellowship had the potential to be a mechanism of change, the evidence for network support derived from mediation research was far more compelling, suggesting the theoretical roots of its efficacy lie in social cognitive theory (Bandura, 1986). Through network support, participants acquired self-efficacy, motivation for abstinence, and

commitment to recovery rather than religiosity.

> *"But the evidence regarding the importance of social support and social network changes in recovery through AA is to date more compelling than that on the role of spirituality"* (Kelly et al., 2009, p. 251).

Groh et al. (2008) carried out a literature review on social network variables in AA. Kelly et al. (2009) did not advert to this review – possibly it was not available at the time. The number of papers deemed suitable for review was 24. Although previously distinguished by structure and function, this detailed paper distinguished between *generality* and *specificity* of social networks suggested by earlier researchers (e.g., Cohen, 2000; Cohen & Wills, 1985). They suggested the model created by Longabaugh et al. (1993) had merit – that abstinence-specific support promotes abstinence, whereas general support promotes psychological functioning. Cobb and Jones (1984) described social support literature as having fuzzy concepts, lacking definitions, utilizing inconsistent measurement methods, and possessing weak research designs; Groh et al. (2008) concurred with these criticisms. However, Groh et al.'s (2008) review found that AA involvement is related to various positive qualitative and quantitative social support networks. The most significant impact was with friends, but not so much with family. Individuals with harmful social networks supportive of drinking benefited the most from AA involvement. The review suggested that social support variables consistently affected AA's impact on sobriety and is a mechanism of AA's effectiveness in promoting sobriety.

Rynes et al. (2013) investigated whether the quality of social interaction in 12-step groups predicts reduced substance use (n=130). Participants reported their perceptions of engagedness, avoidance, and conflict in their 12-step groups and their substance use through four assessments. The key finding was that, although perceptions of group engagedness but not avoidance or conflict decreased over time, engagedness predicted increased 12-step-related behaviour and reduced alcohol use. They concluded that positive group interaction plays a significant role in 12-step affiliates' recovery efforts. The limitation of this study was its sample size and generalizability. The necessary change in social networks and the need for fellowship appear to be satisfied through full participation in AA activities (Kelly et al., 2009; Groh et al., 2008). The meetings provide the fellowship or platform for sharing experiences and expressing and developing hopes. Its worldwide spread also provides a social and support network readily available almost anywhere

worldwide – AA meetings take place in 180 countries (AA World Services Inc., 2019). AA sponsorships provide necessary individual emotional support to counteract loneliness and isolation brought on by the perceptions of stigma, prior wrong-doing, and other miscreant behaviors. However, no literature was located that considered negative issues – the development of inappropriate intimate relationships, exploitation, or nefarious acts of an undesirable nature. In an organization of the size and nature of AA, such occurrences are not improbable.

2.4.9 Alcohol, AA, and gender-based issues

Women have specific and identifiably different responses to alcohol than men do. This section explores gender-specific specific alcohol-related issues for women and also examines research into the exploitation of vulnerable women at AA meetings.

Fama et al. (2020) describe a construct known as 'telescoping' as follows:

> *"The accelerated or compressed progression of alcohol-related problems and their consequences observed in women relative to men, referred to as "telescoping," highlights sex differences in the pharmacokinetics, pharmacodynamics, cognitive, and psychological consequences of alcohol. Brain volume deficits affecting multiple systems, including frontolimbic and frontocerebellar networks, contribute to impairment. Taken together, sex-related differences highlight the complexity of this chronic disease in women…"* (p. 1)

Citing McCaul et al. (2019), they also highlight that blood alcohol content levels rise faster and stay elevated longer in women than men. and that alexithymia in women with AUD is more prevalent than found in men (Craparo et al. 2014).

.

2.4.9 (i) Low rate of gender-based research on AA participants

From its origins, AA has been a male-dominated organization, and up to recently there has been a paucity of research on issues underpinning substance dependence peculiar to women (Brett et al., 1995; Gomberg and Nirenberg, 1991; Sandmaier, 1992). Emrick's 1974 review of 265 studies reflected that women represented only 6.2% of the sample studied. Ten years later, the rate had only increased in research terms to 7.8% (Gomberg and Nirenberg, 1991). However, this is now changing (Kelly and Hoeppner, 2013), but it was unclear whether women benefit from AA in the same or different ways as men. Using Project MATCH data, Kelly and Hoeppner (2013) found that while days abstinent were nearly equal, 70% of the effect of AA for men and 41% for women were based on changes

in social factors.

More recently, data was further quantified by Holzhauer et al. (2020a). The latter reported between 2000 and 2013 a prevalence rate increase of AUD among women of 84% and 35% among men (citing Grant et al., 2017).

One primary gender difference identified by several researchers in the 1990s was an underlying history of child sex abuse. The Centre Against Sexual Abuse (CASA, 1996) and Swett and Halpert (1994) reported that anywhere from 69-75% or as high as 98% of substance-abusing women had histories of child sex abuse compared to 12% of males. This figure may be no longer valid in light of the Catholic church scandals involving child sex abuse that have emerged since then.

2.4.9 (ii) Accessing treatment by women

Despite the National Institute of Health mandate in 1994 (updated in 2017) that biomedical research includes female participants, their alcohol-related issues did not appear to be reflected in the level of literature published until more recently – despite being highlighted by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 2006. McCrady et al. (2020) state that *"Only 15% of women with lifetime AUD ever seek treatment for it, and women experience multiple individual-based barriers to accessing treatment. In addition, systematic barriers to treatment need attention..."* (p. 13).

2.4.9 (iii) Gender-specific alcohol-related issues for women

Apart from the rationales advanced in Section 2.3.2 above, there is literature on specific gender issues. Witbrodt and Delucchi (2011) carried out a longitudinal quantitative study to determine if women differ from men on Alcoholics Anonymous participation and abstinence (n=926). Recruitment was from consecutive new admissions to treatment. They carried out multi-wave analysis with telephone follow-ups at years 1, 3, 5 and 7. They found there were few differences in general. Women and men were alike on most factors associated with AA participation and abstention across time, including abstinence goal, drink volume, negative consequences, prior treatment, and encouragement to reduce drinking. Notwithstanding, men were less likely to be abstinent over time and also reduced their participation at meetings Krentzman et al. (2012) carried out a study to determine whether gender and extroversion were moderators of the association between AA and sobriety. The study was quantitative and prospective over 2-3 years (n=276; 180m, 96f).

Timeline follow-back interviews took place using the Alcoholics Anonymous Involvement Scale. AA attendance significantly increased the odds of sobriety at year 1 for women, and extroversion was not a moderating factor. They also found that women did benefit more than men from membership.

However, Holzhauer et al. (2020a) paint an entirely different picture. They elaborate on the gender pharmacokinetics of biological differences and the greater chances of alcohol-dependent women developing severe medical conditions such as more overall brain atrophy, cancers and other significant maladies secondary to drinking. They point out that hormonal differences are also a factor in the female reaction to alcohol. Holzhauer et al. (2020a) also point to research on psychosocial differences, stress (Fox & Sinha 2009), trauma/PTSD at a rate up to 55% (Hien et al., 2009), and negative affect as contributors to AUD for women. The authors found a paucity of literature on gender-based outcomes, but it seems that increasing compliance with the NIH mandate (1994 & 2017) to analyze gender differences in treatment and outcomes may now be remedying the absence of literature on gender-specific mechanisms of treatment outcomes. No significant gender differences were noted concerning psychosocial and pharmacological treatments, but this is qualified by the low rate of women participating in clinical trials.

Noteworthy is Holzhauer et al.'s (2020b) citing of Epstein and Menges' (2013) comments about gender differences on clinical presentation:

> *"Women tend to have more severe alcohol and drug use histories, lower education and income, higher unemployment and housing needs, more children living at home, and higher parental stress, and they tend to be younger in age."* (2020, p. 5)

Another study by Peltier et al. (2019) re-iterates the alarming increase in women with AUDs – increasing by 84% over the years 2000 to 2013 compared with men (35%). They do, however, strongly suggest that stress is a major underlying factor, beginning in adolescence, and how it affects

> *"…the critical structures and neurotransmitters that may underlie sex differences in stress-related alcohol use (e.g., prefrontal cortex, amygdala, norepinephrine, corticotropin-releasing factor, and dynorphin), the involvement of sex and stressin alcohol-induced neurodegeneration, and the role of ovarian hormones in stress- related drinking".* (p. 1)

In Ireland, the National Drug Treatment Reporting System 2013-2019 Alcohol Data (Condron et al., 2020) reported 7,546 cases. Of that number, AUD in men was 64.3% compared to 65.9% in women in 2019. Although overall new cases dropped by 3.7% in the 7 years under scrutiny, increases in AUD prevalence rose from 56.9% in 2013 to 68.1% in 2019; the number of new alcohol dependent persons increased from 50.7% in 2013 to 64.6% in 2019.

The harm caused by this rise in numbers contributes to the increase in affect-related psychiatric comorbidities and alcohol-induced neurodegeneration arising from chronic and problematic alcohol use, particularly for women (based on Peltier et al.'s (2019 suggestions). An early study by Timko et al. (2002) showed that, when adjusted for baseline drinking (at which women were generally worse), women benefited more than men did from more AA attendance during years 2-8 of follow-up, even though AA was predominantly designed for men. A later systematic review of relapse determinants by Sliedrecht et al. (2019) confirmed that finding when reporting relapse rates of 59% for men and 41% for women. However, an earlier study by Walitzer and Dearing (2006) found no difference in relapse rates but found evidence of different predictors of relapse by gender.

Regarding recovery, a 20-year study in Spain by Bravo et al. (2013) (n=850; f=19%) found that while women started treatment earlier and with more severity than men, this did not predict outcomes over 20 years. Further, women had fewer breaks of abstinence than men and better outcomes. However, their study found that gender was not associated with poorer outcomes concerning psychosocial stress and social function, contradicting Fox and Sinha's (2009) findings. Later, Holzhauer and colleagues (2020b) examined mechanisms of behavioural change in two groups – female only and gender-neutral – and they found that these groups had improved outcomes with higher levels of self-confidence, increased use of alcohol-related coping skills, improved outcomes and decreased sociotropy.

Overall, there seems to be insufficient empirical evidence as to whether gender-based treatment would lead to better or longer-lasting outcomes – both primary and secondary ones.

2.4.9 (iv) Exploitation of women at AA meetings

Bogart and Pearce (2003) researched a behaviour within AA known as "thirteenth stepping". This behaviour entails targeting new vulnerable people, especially women by men, for dates and sex. The research purpose was to determine if women were subject to unwanted attention at AA meetings (n=55). Bogart and Pearce (2003) found that 50% of women reported such advances. Two reported rapes. They concluded that women with histories of sexual abuse should be referred to female-only groups when possible.

2.4.10 The effect of psychiatric comorbidity and long-term abstinence for alcoholic individuals

Di Sclafani et al. (2007) researched (1) whether an individual needed to be relatively psychiatrically healthy to achieve long-term abstinence, and (2) if ongoing abstinence could be maintained in the face of a current psychiatric disorder (n=52; n=60 controls). Participants had a mean length of abstinence of 6.3 years. The research methodology utilized was as follows: Lifetime and current psychiatric diagnoses were assessed in the mood, anxiety, and externalizing disorder domains using the computerized Diagnostic Interview Schedule (c-DIS). A key finding was that 85% of alcoholics had a lifetime psychiatric disorder, but there was no association of abstinence duration with lifetime or current psychiatric diagnoses. They concluded that lifetime mood, anxiety, and externalizing disorders do not preclude a lifetime of sobriety. This finding reaffirms the AA assertion *"There are those, too, who suffer from grave emotional and mental disorders, but many of them do recover if they have the capacity to be honest."* (AA World Services Inc., 2001, p.58)

2.4.11 Alcohol dependence and recovery research over time

The absence of scientific definitions of AUD and recovery presents difficulties with constructing definitive approaches to the subjects. The term "long-term recovery" (LTR) is frequently mentioned in the literature but has not yet been quantified. In early studies, and depending on the context or subject, this could be as short as three months or many years depending on the researcher's perception and study context, so the term in literature has no particular set meaning.

To better contextualize recovery changes, the Betty Ford Institute Consensus Panel (2007) drew on the medical/oncological definition – that less than one year was early recovery, one to five years' abstinence was sustained recovery, and more than five years was stable or long-term recovery. Other than a consensus view by experts, there is no scientific

validation of this scaling. However, the general move to examining long-term recovery, ongoing before this, had given rise to information that enabled the measurement of some of the mechanisms of change in recovering people. These mechanisms were already reviewed in earlier paragraphs. Other research over time gives a greater understanding of the mechanisms that underpin recovery approaches, and the following sections explore them.

2.4.11 (i) Linking professional treatment with attendance at meetings of AA

Kaskutas et al. (2009) investigated the link between professional treatment and AA attendance over time (n=586). The methodology involved the use of telephone follow-up after baseline at years 1, 3, 5 and 7. The key finding was that attendees were divisible into four classes – low (less than five meetings at each follow up), medium (about 50 meetings a year), descending (about 150 meetings at year 1, then descending sharply), and high (200 meetings per year at year 1, then descending gradually). Decreases in abstinence did not always accompany declines in meeting attendance. Kaskutas et al. (2009) concluded that professional treatment was minimally associated with subsequent meeting attendance over time.

2.4.11 (ii) The type and timing of help

Timko et al. (1999) studied how the type and timing of help received over eight years by previously untreated problem drinking individuals linked to drinking and functioning outcomes (n=466). Participants self-selected into four groups at the time of the eight-year follow up: no treatment (n=78); Alcoholics Anonymous (AA) only (n=66); formal treatment only (n=74); and formal treatment plus AA (n=248). The result was that individuals who received some form of help – AA, formal treatment, or both – were more likely to abstain at eight years than untreated individuals. Although the AA-only group was better off than the formal treatment group at one and three years, the informally and formally treated groups were equivalent on drinking outcomes at eight years. Timko et al. (1999) concluded: (1) individuals who seek treatment early do somewhat better than those who do not, but (2) there is little difference between formal and informal treatment on long-term drinking outcomes. These results echo the findings of the Project MATCH outcomes; the main difference is that the period of review is eight years instead of three years.

Dunn et al. (2017; n=954) showed that early abstinence was significantly associated with a longer time to first drinking and first heavy drinking day. This effect was apparent from week 1 and increased in the first few weeks of abstinence. Drinking at the commencement

of treatment is strongly indicative of the continuation of alcohol abuse disorder post-treatment. Their study demonstrates the use of monitoring early behaviors and adapting programmes to participants' needs in line with a personalized medical approach.

Blaine et al. (2020, p. 1048) described how they used

> "*...a novel functional MRI (fMRI) approach to assess brain responses during sustained exposure to standardized visual stimuli of stressful, alcohol cue, and neutral control images combined with prospective assessment of drinking outcomes during early outpatient treatment...*"

They carried out two tests and showed an association of prefrontal-striatal functional pathology with alcohol abstinence days at treatment initiation and subsequent heavy drinking after treatment initiation. Sullivan (2020) suggests that this forms *"compelling evidence that the first few days of detoxification are critical for promoting prolonged sobriety"*(p. 1023). Karch et al. (2021) also reported that using real-time fMRI neurofeedback in early recovery has an impact on anger and impulsiveness but could not suggest that it was efficacious for those treated in remaining abstinent after 3 months.

2.4.11 (iii) Social and employment stability

Vaillant (1988) reviewed treatment for dependencies after 12 and 20 years (n=100 alcoholics and n=100 heroin addicts). His key finding was that premorbid social and employment stability were more significant predictors of abstinence than addiction severity. He concluded that addiction severity is an unreliable guide to long-term outcomes. Jin et al. (1998) considered the predictors of relapse in long-term abstinent alcoholics. They carried out an average of 11 years of follow-up in male alcoholics who had achieved long-term abstinence, to determine later relapse predictors (n=77). Participants had at least 18 months of stable abstinence at the time of entry and were followed for two to 17 years (mean follow-up = 10.9 years). During follow-up, detailed information regarding relapse or abstinence was recorded. Potential predictors of relapse collected at enrolment included past drinking history, the severity of alcohol-related life problems, degree of neurocognitive impairment based on neuropsychological (NP) tests, psychological distress (MMPI), and past medical health. The result was that 24 of 77 (31%) long-term abstainers relapsed during the follow-up period. The average annual hazard rate of relapse was 3.8% in the first five years of follow-up and 2.6% over the next 6-11 years. Jin et al. (1998)

concluded that there is approximately a 3% annual risk of relapse in alcoholics who had achieved long-term abstinence, even after five years of abstinence. Predictors of relapse are long-standing psychological trait disturbance and history of more alcohol-related social difficulties, but more enduring personality traits predict long-term success in remaining abstinent.

2.4.11. (iv) Demographic, baseline psychological problems, depression, professional treatment, AA, and other social and community resources

Humphreys and colleagues (1997) evaluated the role of demographic factors, baseline alcohol- related problems and depression, professional treatment, Alcoholics Anonymous (AA), and other social and community resources in predicting remission and psychosocial outcome over eight years. Untreated alcoholic individuals (n=628) were recruited at detoxification units and AUD information and referral services. Of these, 395 (62.8%) were followed up at three- and eight-year intervals. Participants completed a self-administered inventory that assessed their current problems, treatment utilization, AA participation, and relationship quality. The results were that (a)the number of inpatient treatment days received in the three years after baseline was not independently related to eight-year remission or psychosocial outcomes; (b)more outpatient treatment in the first three years increased the likelihood of eight-year remission but was not associated with psychosocial outcomes; (c)the number of AA meetings attended in the first three years predicted remission, lower depression, and higher-quality relationships with friends and spouse or partner at eight years, and (d) extended family quality at baseline also predicted remission and higher quality friendships and family relationships at eight years. Given that alcoholism is a chronic, context-dependent disorder, it is not surprising that short- term interventions have little long-term impact. Humphreys et al., 1997 concluded that short-term interventions have a little long-term impact. Social and community resources available for prolonged periods are more likely to have a lasting influence on AUD.

2.4.12 Risk factors into relapse in older abstinent adults

Schutte et al. (2003) investigated the risk, predictors of relapse, and the effects of successfully sustained remission on the drinking behaviour and life function of older adults who were problem drinkers earlier in life (n=447; n=339 controls). This study was a prospective follow- up after 10 years compared to lifetime non-problem drinkers. Schutte et al.'s (2003) conclusion was that there was a relapse rate of 11%. The majority (63%) of

former problem drinkers who successfully achieved sustained remission continued to drink alcohol. This finding seems to be supported by Witkiewitz et al.'s (2020b) findings and recommendations regarding post- treatment heavy drinking episodes. However, a caveat to Witkiewitz et al.'s (2020b) findings is appropriate as their follow-up at year 3 numbered 694, whereas and at years 7-9 the number was 127. Therefore, inferences from this study must be formed with caution. However, Schutte et al.'s (2003) results suggest long-term costs associated with earlier drinking problems, even when remission is maintained. Those in remission had a higher mortality rate of 1.6%. Although stably remitted abstinent and stably remitted non-abstinent both experienced improvements in functioning over the ten-year interval, they both continued to experience financial, health-related and life context deficits relative to older lifetime non-problem drinkers.

2.4.13 Cross-sectional views of recovery

Laudet et al. (2002), using questionnaires, carried out a preliminary cross-sectional investigation into recovery processes over time (n=51). Sobriety periods ranged from one month to 36 years. The respondents indicated that they had all attended AA – the median was 12 years. The key factors they identified in their recovery were social and community support, and affiliation with their 12-step organization. Conclusions were that social and life domains play a significant role in long-term sobriety. This study was a precursor to the Life in Recovery series of surveys mentioned earlier in this review.

2.4.13 (i) Attendance vs non-attendance at AA meetings

Moos and Moos (2004) carried out a quantitative naturalistic longitudinal study of attendance versus non-attendance at AA meetings (n=473). The survey was carried out via questionnaires and follow-up telephone calls. The key finding was that early affiliation led to better outcomes in years 1 and 8. Continued affiliation led to better outcomes than for those who dropped out. Moos and Moos (2004) concluded that, in general, the frequency of participation was independently associated only with a higher likelihood of abstinence. Individuals who delayed participation in AA had no better outcomes than those who never participated. In their discussion, Moos and Moos (2004, p. 89) cited Chappel's (1993), reference to

> *"…the need to consider indicators of AA involvement other than participation in meetings, such as working the steps, reading 12-step literature, relationship with a sponsor, and number of friends in 12-step groups"*

2.4.13 (ii) Decreases in impulsivity association between AA attendance and whether age was a mediator

Blonigen et al. (2011) carried out a quantitative naturalistic study at years 1, 8 and 16 into changes in moderated mediation from a developmental perspective on drinking and impulsivity, to determine a) if decreases in impulsivity account for links between AA attendance and better drinking and psychosocial outcomes, and b) whether these mediational "effects" are conditional on age (n=628). The methodology was self-reporting at baseline, year 1, and follow-ups. The key findings were (i) that decreases in impulsivity statistically mediated associations between longer AA duration and improvements; (ii) indirect gains occurred for under 25's only; and (iii) decreased impulsivity appears to mediate reductions in alcohol-related problems over eight years in people attending Alcoholics Anonymous. However, they noted that decreases in impulsivity were unrelated to year 16 outcomes. Longer AA duration was associated with a significant decrease in impulsivity over this time frame for younger but not older individuals.

2.4.13 (iii) Twelve-step meeting attendance and trajectories of sobriety

Witbrodt et al. (2012b) considered whether 12-step meeting attendance trajectories over nine years predict abstinence (n=1,369). They were measured in five waves ranging from high attendance to low/no attendance. Reporting was collated by way of follow-up phone calls. Key findings were that low/no attendance had the lowest abstinence rates, and female gender and high alcohol severity predicted attendance all years. Their conclusion was consistent with a sustained benefit for 12-step exposure; abstinence patterns aligned much like attendance profiles. Limitations to the study were that participants self-reported and were predominantly white, educated and working.

2.4.14 A 60-year multi-disciplinary follow-up of alcoholic men

A 60-year follow-up on alcoholics is the most comprehensive quantitative prospective multi- disciplinary follow-up study of alcoholic men (Vaillant, 2003). The purpose was originally to study alcohol abuse over 50 years from age 20 to age 70-80 (n=768), but it proved possible to continue it 10 years later. Two hundred and sixty-eight men came from a college sample and 456 from non-delinquent inner-city adolescents. Key findings were: (1) By age 70, chronic alcohol abuse was rare for both groups; (2) In the city group 54% had died, 32% were abstinent, 1% were still using, and 12% were still abusing; (3) In the college

group 58% were dead, 21% were abstinent, 10.5% were "controlled" drinkers and 10.5% were still drinking. Vaillant concluded that alcohol abuse could persist for decades in both groups without remission, death or progression. For both samples, prior alcohol dependence and AA attendance were the best two predictors of sustained abstinence. Valliant's comment on these findings was that AA and Jellinek's (1960) suggestion of the inexorable progress of the "disease" might be in error. Men who achieved sobriety attended 20 times more AA meetings than those who did not. The least and most severe alcoholics appear to enjoy the best long-term chance of remission (contradicting Valliant's 1988 suggestion). Reports of returns to controlled drinking are often a mirage – in stark contrast to the suggested rate of 63% reported by Schutte et al. (2003) and suggested by Witkiewitz et al. (2020b).

The long-term studies outlined above highlighted the advantage of time-based reviews of approaches to substance dependence amelioration. Some of their findings were in contradiction of long-held beliefs. Vaillant's two studies showed that (a) social and employment stability is more important than addiction severity; (b) Jellinek's (1960) charting of the progressive nature of AUD may well have been inaccurate, and (c) Kaskutas and colleagues' (2009) study showed that professional treatment outcomes were only marginally related to AA meeting attendance over time.

2.4.15 Summary

In the preceding paragraphs, the literature reviewed focused on (1) the core elements of the AA message of their 12-step fellowship; (2) AA's suitability for a particular cohort of alcohol- dependent clients; (3) efficacy; (4) effectiveness; (5) mechanisms of change; (6) religiosity/spirituality; (7) sponsorship system; (8) social network role; (9) gender-based issues. (10) comorbidity of mental health issues; (11) alcohol dependence and recovery research over time – the linking of professional treatment with attendance at meetings of AA, professional therapy, AA and other social and community resources, the type and timing of help, social and employment stability, demographic baseline psychological problems and depression; (12) risk factors of relapse in older abstinent adults; (13) cross-sectional view of sobriety – attendance vs non-attendance at AA meetings, decreases in impulsivity association between AA attendance and whether age was a mediator, 12-step meeting attendance and trajectories of sobriety; and (14) a 60-year multi-disciplinary follow-up of alcoholic men.

2.5 Gaps in literature

From this literature review, limitations were identified among studies into SHGs that deal with alcohol dependency. Difficulties arose with issues such as self-selection and or bias (e.g. Emrick & Beresford, 2016), representativity/coercion (e.g. Rehm et al. 2021; Humphreys et al., 2004), and inclusivity attached to Internet availability/usage (e.g. Laudet, 2013). To further confound matters, there is an absence of any clear, science-based definition of either addiction or recovery (e.g., Witkiewitz et al. 2020a; Cobb & Jones 1984: Groh et al., 2008).

Regarding AA, despite its longevity and the considerable volume of research into its functioning, no literature could be located on how exactly it is supposed to work. Common to all its meetings, at the outset, a preamble is read, stating that its members' primary purpose is to stay sober and *"carry the message"* to the still suffering alcoholic both present and not present (AA Grapevine Inc., 2017). Again, that "message" is not clearly stated or elucidated in literature and its own written texts. This exhortation "*...to carry this message..."* is also stated in the twelfth step of AA's programme.

Early research into its efficacy and efficiency suggested that that organization had little or no effect and was no better than other treatment approaches. There were similar findings in respect of any short-term interventions. These studies generally relied on sobriety as a determinant of recovery and took no cognizance of the more recently identified mechanisms of change their programme employs, which perhaps had given rise to such earlier mediocre findings. As literature has developed into more aspects of the enduring impacts of attendance at AA meetings and recovery, more positive outcomes have begun to emerge, particularly regarding members' underlying mechanisms of change. According to Kelly and Greene's (2013) conclusions, the 12 promises of AA (AA World Services Inc., 2001, pp. 84-5) are one of the few documented explications of *"the distinctive cognitive, affective and behavioural benefits"* that could materialize for those who participate in the AA programme. Kelly and Greene (2013) suggested that the 12 promises of AA may fully represent "recovery", adding quality of life to abstinence – as also indicated by the Betty Ford Institute Consensus Panel (2007). The 12 promises of AA (AA World Services Inc., 2001, pp. 83-4), and as converted into numeric format by Kelly and

Greene (2013), are set out in Appendix 9. However, Kelly and Greene's (2013) purpose was to develop a psychometrically valid Twelve-Promises Scale and not research the merits or otherwise of the promises.

Despite the longevity of AA and the considerable amount of research into its functioning, no literature could be located that explored or investigated the merit of those promises. While a concept of "promises" may not lend itself readily to academic scrutiny, the passage of time since the promises of AA were first published in 1939 enables those promises, as made by them, to be scrutinized for validity as outcomes. Eighty years later, even the qualification that they will come true *"sometimes quickly, sometimes slowly, but they will always materialize if we work for them"* (AA World Services Inc., 2001 p. 83) will have no material impact on any such research results since the onset of alcohol dependence does not commence until the early teens.

Neither were any studies located that explored the evolution of the long-term or lifetime recovery process on a cross-sectional basis (where cross-sectional is by reference to specific points of sobriety on the continuum of recovery and not cross-sectional at the time the survey or research was being undertaken). This absence constitutes a significant gap in the literature as the findings of such research would help understand how participation in SHGs in the AUD field may lead to a lifetime of recovery from the psychological, social and spiritual constructs of alcohol dependence.

For this thesis, a lifetime of recovery is considered as 50 or more years of abstinence – as close to lifetime recovery as can realistically be explored – having regard to the facts that actual alcohol dependence does not start at birth and the consequence of natural brain atrophy, or another age-related physical and or psychological condition may impact materially on specific recollections.

2.6 Theoretical frameworks relevant to this study

Throughout the review of literature, no papers were located that suggested that any individuals had volunteered for alcohol (or other) dependency. Certainly, they may have initially indulged in behaviours that intentionally temporarily changed how they felt in differing circumstances. But once they discovered that alcohol provided them with a 'miracle-effect', some people found it almost impossible to step-off this path of self-destruction. This suggests that there are circumstances or events that, inadvertently, and

unknowingly left them with triggers that principate an almost inevitable outcome of their becoming victims to substance dependence. In a 'natural sciences' or medical terminology context, the DSM defines this condition as existing in three forms -Mild, Moderate or Severe Alcohol Use Disorder (AUD; Appendix 18, p. 298). This lack of intentionality or comprehension suggests that, from within their early childhood development, there may well be significant repressed psychopathologies where the seeds of this complex non-intentional maladaptive behaviour may be located. Taking these unknown factors into account, a flexible appropriate research methodology was called for to answer the research question.

2.6.1 Interpretative Phenomenological Analysis

As interpretative phenomenological analysis (IPA; Smith et al., 2009) is an analytical approach that is not purely theoretically constrained but whose findings are contextualized within an extant theory, various theoretical frameworks were considered. Based on the review of the literature and professional experience of the researcher, it was considered most germane to situate the data collected primarily within the context of the framework of Bowlby's attachment theory (1969; 1972; 1982), Maslow's Motivational Model *Towards a Psychology of Being* (2014) and Erikson's *The Life Cycle Completed – Extended Version* (1997) as they explore the common phenomena - that of the constituents of lifespan development - through differing theoretical lenses and highlighting key issues that may become problematic.

A detailed explanation of these theories now follows, explaining how they will assist in the exploration of the alcohol dependence recovery process with the participants.

2.6.2 Attachment theory

Bowlby (1973) defined attachment as "…*any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, usually conceived as stronger and/or wiser*" (p. 292). Failing to form such attachments in the early months of life may lead to a subsequent inability to form meaningful relationships. Bowlby's (1958) earlier descriptions of attachment styles (secure, anxious-ambivalent and anxious- resistant) suggested that such styles persist throughout life. Although first outlined in three papers (1958; 1959; 1960), Bowlby's three leading publications on the subject were in 1969, 1973, and 1980 and were substantiated through the works of others such as Ainsworth et al. (1978). Main and Solomon (1990) added a fourth category of disoriented/disorganized attachment deriving from parental

unpredictability in responding. Whether trauma or parental behaviour is also linked to disordered attachment styles is discussed by Main and Hesse (1990).

Initially, attachment styles were thought to be enduring and unchangeable, but this was shown as inaccurate by Rutter (1971; 1981). Bowlby (1988) later conceded that it is not impossible, but that attachment patterns prove difficult to change in adulthood. Kirkpatrick and Hazan (1994) then showed that such changes were possible for 30% of a sample group (n=177) over four years. Main (2000) found when using the Adult Attachment Interview – a semi-structured interview protocol co-designed by herself and Kaplan and Main (1996) – that while actual individual life history cannot be changed, how it is recounted or interpreted by the individual can be told or reconstructed in many differing ways. Main (2000) also suggested that attachment states of mind should not be viewed as immutable; *"…these…categorical placements…must be understood to reference only current, and potentially changeable, states of mind with respect to attachment"* (p.1094). Thus, more recent developments in attachment theory suggest that attachment states of mind can change in the context of an appropriate and safe attachment relationship.

Flores (2004) developed the concept of addiction as an attachment disorder and suggested that the path for the alcohol- or substance-dependent person is to develop a secure attachment style with their counsellor. Once it has become secure, the counsellor should detach and end the therapeutic process, encouraging the client to engage in positive relationships through mutual support groups or other positive relationships or activities. Flores (2004) stated,

> "*Attachment theory holds the position that it is impossible for individuals to completely regulate their affective states alone (Lewis et al., 2000). Consequently, until substance abusers relinquish their dysfunction attachment styles (e.g., insecure avoidant, insecure ambivalent, insecure disorganized) and develop the capacity for healthy interpersonal affect regulation (secure attachment and mutuality), they will forever remain vulnerable to substitute one obsessive addiction (e.g., alcohol, drugs, sex, gambling, work, etc.) for another".* (p. 3).

An earlier study by Finn et al. (1987) suggested that alcohol consumption relieves, changes or defers those uncomfortable feelings related to insecure attachment style without judgment or approval. Keefer et al. (2012) also reaffirm that attachment issues are not confined to intra- human behaviours. Fairbairn et al.'s (2018) meta-analysis of 34 prospective studies (n=56,721) found significant associations between insecure attachment and substance use. Goldstein et al. (2019) found that anxious (but not avoidant) attachment style preceded the development of later substance use problems, and the association

persisted regardless of the type of psychoactive substance such as alcohol or marijuana. Liese and Hodgins (2020) suggest that emotional dysregulation mediates the relationship between insecure attachments and addiction.

Recent developments in neuro imaging are beginning to facilitate the understanding of the link between early childhood attachments and the adoption of apparently disproportionate or disorganized reactions in given adverse situations. Stratham et al. (2019) explored in-depth the pathways relating to the neurobiology of attachment and drug addiction from three different levels: (i) the molecular, neuroendocrine and behavioral; (ii) an examination of the oxycontin affiliation system/dopamine system and (iii) the glucocorticoid stress response system (Reproduced below, Figure 7).

Figure 7. Insecure Adult Attachment Diagram:

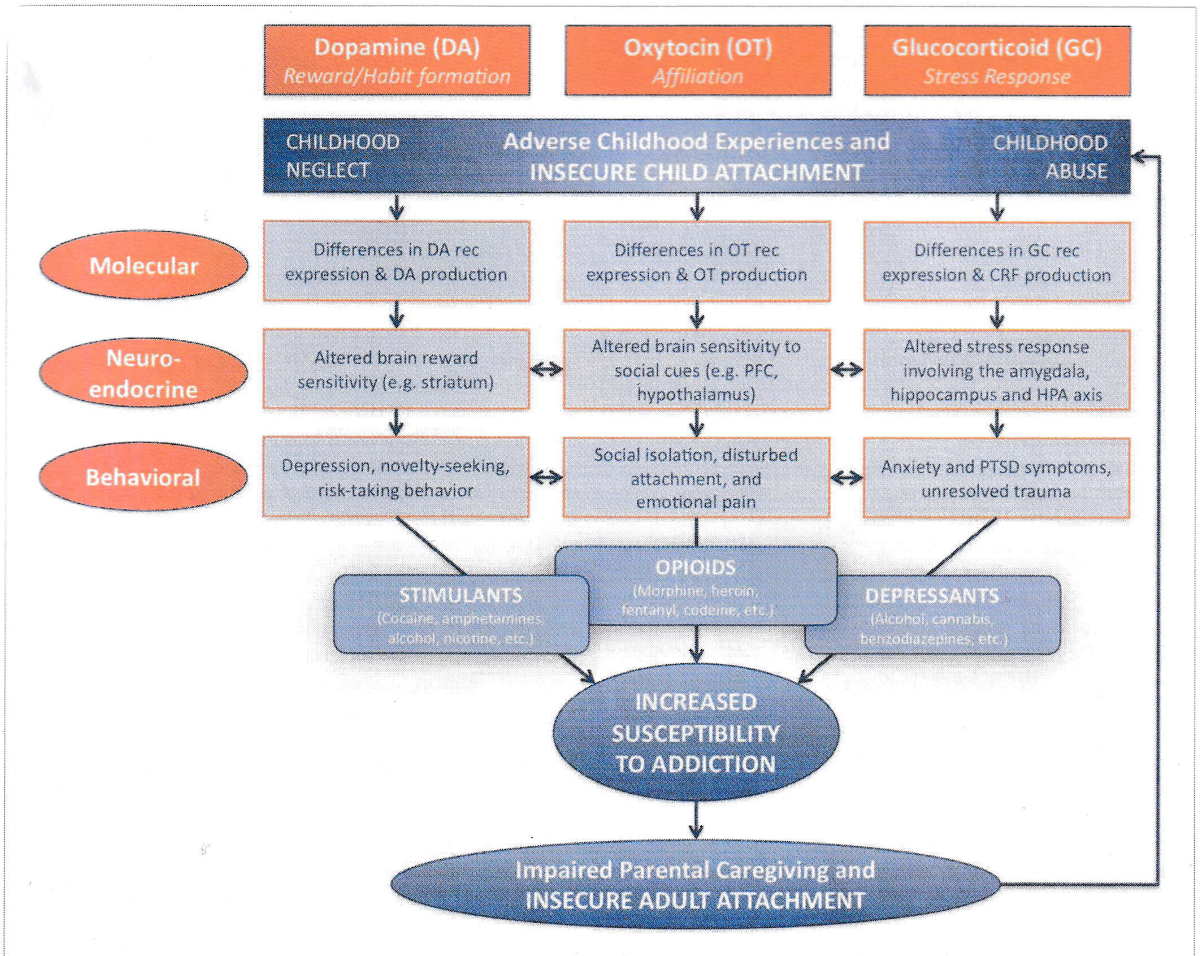


FIGURE 1 | Developmental and neurobiological pathways linking adverse childhood experience to susceptibility to addiction, *via* modifications in dopamine-related, oxytocin-related, and glucocorticoid-related systems at molecular, neuroendocrine, and behavioral levels. Childhood adversity, including abuse and neglect, may be associated with insecure attachment, and lead to behavioral patterns linked with specific patterns of substance abuse. Parental addiction may impair parental caregiving capacity as a result of insecure patterns of adult attachment, and perpetuate the cycle of childhood adversity and addiction. DA, dopamine; OT, oxytocin; GC, glucocorticoid; rec, receptor; CRF, corticotropin-releasing factor; PFC, prefrontal cortex; HPA, hypothalamic–pituitary–adrenal; PTSD, post-traumatic stress disorder. Adapted from (3) © 2016 New York Academy of Sciences. Used with permission from John Wiley and Sons.

Stratham et al. (2019) suggested that a better understanding of linked mechanisms will illuminate underlying targets for early intervention, and they will also better inform those related to attachment and addiction. They concluded

> *"By employing a lifespan developmental perspective, we may most appropriately address and target the intergenerational risk of substance use and addiction and provide more hope for future generations."* (p. 11)

However, while substance use may influence both brain and behavior, it is still not clear why some individuals become dependent, and others do not. Alvarez-Monjaras et al. (2019) integrated psychodynamic and neurobiological approaches to addiction and provide a framework for placing addiction within a development perspective. While their paper is quite complex in nature, they concluded that :

> *"The neurobiological approach allows biological mechanisms to be identified that may contribute to substance abuse and dependence; the psychodynamic approach provides an alternate framework for understanding relational and representational aspects of addiction within a developmental perspective. Attachment theory may present a unique opportunity to bring together these lines of enquiry, enabling an integrative developmental model of addiction with early experiences laying the foundation for psychological as well as neurobiological trajectories to substance use, abuse, and dependence*."
>
> (Alvarez-Monjaras et al. (2019, p. 629)

Scigala & Scigala (2020) demonstrated a statistically significant difference between groups of alcohol addicts and non addicts relating to attachment style, intensity of trauma, alexithymia and dissociation. But their finding must be interpreted with care as they showed that the impact is indirect and from one side only, differing for different situations. They concluded

> *"The strongest direct relation was proven in the case of the anxious-ambivalent attachment style and alexithymia (p <.01) and avoidant attachment and alexithymia (p. 1) which turned out to a stronger predictor fostering the development of alexithymia and the occurrence of traumas related to emotional negligence and mental violence and finally addiction".* (p. 1)

and

> *"The absence of empathy, impulsiveness, non-adaptive strategies of emotional regulation, suppression of emotional regulation suppression of negative emotions, with depression (Martinotti et al. 2009; Lyvers et al 2018b) all contribute to experiencing a strong fear of intimacy and rejection in a relationship ending in a persistent addiction, despite attempts to overcome it"* (p. 11).

The literature suggests that AUD may develop because of a failure to remediate an attachment issue. At the time of the development of the aberration, the person may well be too young to appreciate or self-determine the problem and address it. Through this research, participants' recovery accounts may add to understanding the interlinkages between these problems and how they came to terms with them.

2.6.3 Maslow's "Hierarchy of Needs"

When initially written in 1943, Maslow described a series of five stages that people grow through. He described the first four as "deficiency needs" (d-needs) and the fifth as growth or "being needs" (b-needs).

Briefly, the stages are as follows 1. *Physiological needs* – the basic biological requirements for survival, such as shelter, food, air, water, and sleep. 2. *Safety needs* such as security, order, law, stability, freedom from fear. 3. *Love and belongingness* – the need for social interaction and having feelings of belongingness. Maslow views the need for interpersonal relationships such as friendship, affiliation, intimacy, trust, acceptance, receiving and giving affection and love as a motivational factor. 4. *Esteem needs;* these are divided into two categories: (i) self- esteem and (ii) acknowledgement or respect from others. This need for respect or reputation is most important for children and adolescents and precedes genuine self-esteem or dignity – hence the need to be alert to attachment issues when using this theoretical approach. 5. *Self-actualization needs* – becoming the best version of oneself.

Initially, Maslow suggested that development occurred hierarchically. However, as he developed his theory over later years, he demurred from his hierarchical approach and stated that it *"...it is not nearly as rigid"* as he had initially postulated (Maslow, 1987, p. 68). He also suggested that most behaviour can be multi-motivated by being subject to pressures from other needs simultaneously.

During the 1960s and 1970s, Maslow expanded his original fixed five-stage model to eight stages. They are now as follows: 1. *Biological and physiological needs;* 2. *Safety needs;* 3. *Love and belongingness needs;* 4. *Esteem needs* – (i) esteem for oneself and (ii) the desire for respect from others; 5. *Cognitive needs; 6. Aesthetic needs;* 7. *Self-actualization needs* – self- fulfilment; 8. *Transcendence needs* – being motivated by values beyond the personal self (e.g., service to others, the pursuit of science and religious faith*).* Maslow suggested *"Transcendence refers to the very highest and most inclusive or holistic levels of human consciousness, behaving and relating, as ends rather than means, to oneself, to significant others, to human beings in general, to other species, to nature, and to the cosmos"* (Maslow, 1971, p. 269).

He was negatively critiqued for his somewhat unusual research methodology in his own work – which he described as *biographical analysis* – looking at the biographies and writings of 18 famous people he identified as being self actualized, and from those sources developing a list of qualities from people, he deemed as being "self actualized". While that methodology may tend to draw comments paralleling those levelled against the DSM-V by McHugh (2004) at the American Psychiatric Association's annual convention, the Tay

and Diener (2011) survey of 60,865 participants in 123 countries showed that the needs identified by Maslow are universal, save for the order in which they occur. However, in the discussion of their findings, Tay and Diener (2011) state, *"For instance, when social isolation is experimentally manipulated, feelings of well-being are affected"* (p. 363). They refer to one self-explanatory article title: *"The KKK won't let me play: Ostracism even by a despised outgroup hurt"* by Gonsalkorale & Williams, (2007). That may be an extreme example, but it has relevance to the current study in that it reflects how habituated alcohol abusers' distance themselves and "look down" on active alcohol-dependent people. Tajfel et al. (1979) explore the need for acceptance and the effects of belonging to social networks through categorization, social identification and social comparison. Their theory illustrates how the destructive behaviour of "*labelling*" may occur (Mead, 1934). This behaviour is of particular significance regarding AUD, where the severely dependent person becomes disowned by family, friends and society. Both Kelly et al. (2009) and Groh et al. (2008) discuss the counteracting effect of joining new social network groups – leading to a social identity transition and improved security (Best et al., 2016), and an improved perception of self-worth.

2.6.4 Erikson's psychosocial theory.

Erikson's theoretical approach was that individuals are required to go through eight stages in life (or crises) in a sequential manner. For each stage he offered both a positive and a negative outcome such as in the first *Trust v Mistrust".* However, Erikson (1964) acknowledged his theory was more a descriptive overview of human social and emotional development and failed to explain how the handling of one stage could affect a later stage. Erickson (1997, p. 106-114) gives a basic outline of the stages leading to her contribution of the additional 9th stage of *gerotranscendance* and a chapter on *Old Age in the Community*. Quoting her husband (but not referencing it) she repeats Erik's comment *"Lacking a culturally viable ideal of old age, our civilization does not really harbour a concept of the whole of life. "* . (1997, p. 114)

In the context of this study, the lack of explanation of the effect of not, or only partially completing one stage, is unhelpful. For example, if the question of mistrust is not resolved by the age of 5-12, it is questionable how the child supposed to through the 4th Stage of "Industry *v Inferiority"* when Erikson suggests that *"The adolescent mind is essentially a mind or moratorium, a psychosocial stage between childhood and adulthood, and between the morality learned by the child, and the ethics to be developed by the*

adult."? (Erikson, 1963, p. 245).

In a seriously dysfunctional household where none of first four stages are resolved, that would suggest the movement of a seriously troubled individual into adulthood.

The results of unmet attachment or developmental related needs, according to Bowlby (1958, Main & Solomon, 1990; Main & Hesse, 1990) lead to insecure attachments. They result in feelings of rejection -'not being good enough'; that failure cannot be an option; the individual must be best at everything to be loved/liked/accepted. These feelings of low self-esteem; self-worth or human value are 'merited' and these negativities form a self-perpetuating circle. This 'circle' becoming more sinister when 'self-medication' as postulated by Khantzian (1997) via alcohol abuse starts and develops into a dependency.

AA (2001. p 62) accurately describe the necessity to address these positions directly.

> *"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."* (AA World Services, 2001 p. 62)

While this statement may not be entirely correct as it ignores the role of external factors such as genetics or child abuse, it does, however, transfer the ownership and responsibility of remedying the dependency to the individual.

2.7 Rationale for research

A combination of the overall picture presented by literature, and the working experience of this researcher (as a practicing counsellor/psychotherapist), noting how clients with different decades of recovery present differently, suggests that there are evolutionary/developmental stages in the process of learning to live a sober life that have not yet been explored in the literature, such as:

(i) How their practice of the 12-step programme helped them evolve and develop over the decades of their sobriety.

(ii) What did they believe was "*the message*" passed on to them?

(iii) Whether when and how they believed the 12 promises of AA came true for them.

(iv) If non-abstinent recovery was an option for someone with a severe AUD

By exploring these issues, a substantial contribution will be made to understanding the process of recovering from alcohol dependence over the life course. This research will also have significant implications for developing a generalizable framework for the other spin-off organizations such as Narcotics Anonymous, Overeaters Anonymous, and similar bodies. Further, it will also facilitate the development of broader frameworks for those who have had an obsessional lifestyle (as opposed to addictional) such as top-class athletes, footballers and runners, whose high-activity lifestyle abruptly ends with them prone to adopting a cross substitutional dependency or behaviour. Finally, in a broader way, it may provide educators with information on how to better equip young people for the downs and ups in life by being a pre-emptive resource, possibly deliverable as part of early school curricula.

2.8 Research question

How do people with alcohol use disorder (AUD) use self-help groups to achieve a lifetime of sobriety ?

2.9 Aim

To explore the experiences of people with alcohol use disorder (AUD) using self-help groups to achieve a lifetime of sobriety, using Alcoholics Anonymous (AA) as an exemplar.

2.10 Objectives

1. To explore the experiences of people with AUD at the first meeting of their self-help group, on which their current sobriety is based.
2. To understand the core elements of the message from the self-help group for people with AUD in developing a lifetime of sobriety.
3. To understand how people with AUD interpret and develop these core elements underpinning their recovery at 10 years, 20 years, 30 years, 40 years, and 50 years.
4. To understand the challenges of incorporating the core elements of the message

from a self-help group into a lifetime of recovery from AUD.

5. To provide recommendations for self-help groups on supporting people with AUD in maintaining a lifetime of sobriety.
6. To provide recommendations for spin-off organizations, educational and preventative services, and other professionals interested in alcohol and or substance use disorder in the wider community to address AUD.

3. METHODOLOGY

3.1 Introduction

As this research aimed to explore the developmental changes that occur in recovery from alcohol use disorder over a lifetime, a quantitative approach was deemed unsuitable as it would not capture the essence of the experiences of those who had gone or were going through this process. Quantitative data collection tends to be objective-driven, geared towards investigating human behaviour in a statistically predictable way (Lock, 2010, p. 295).

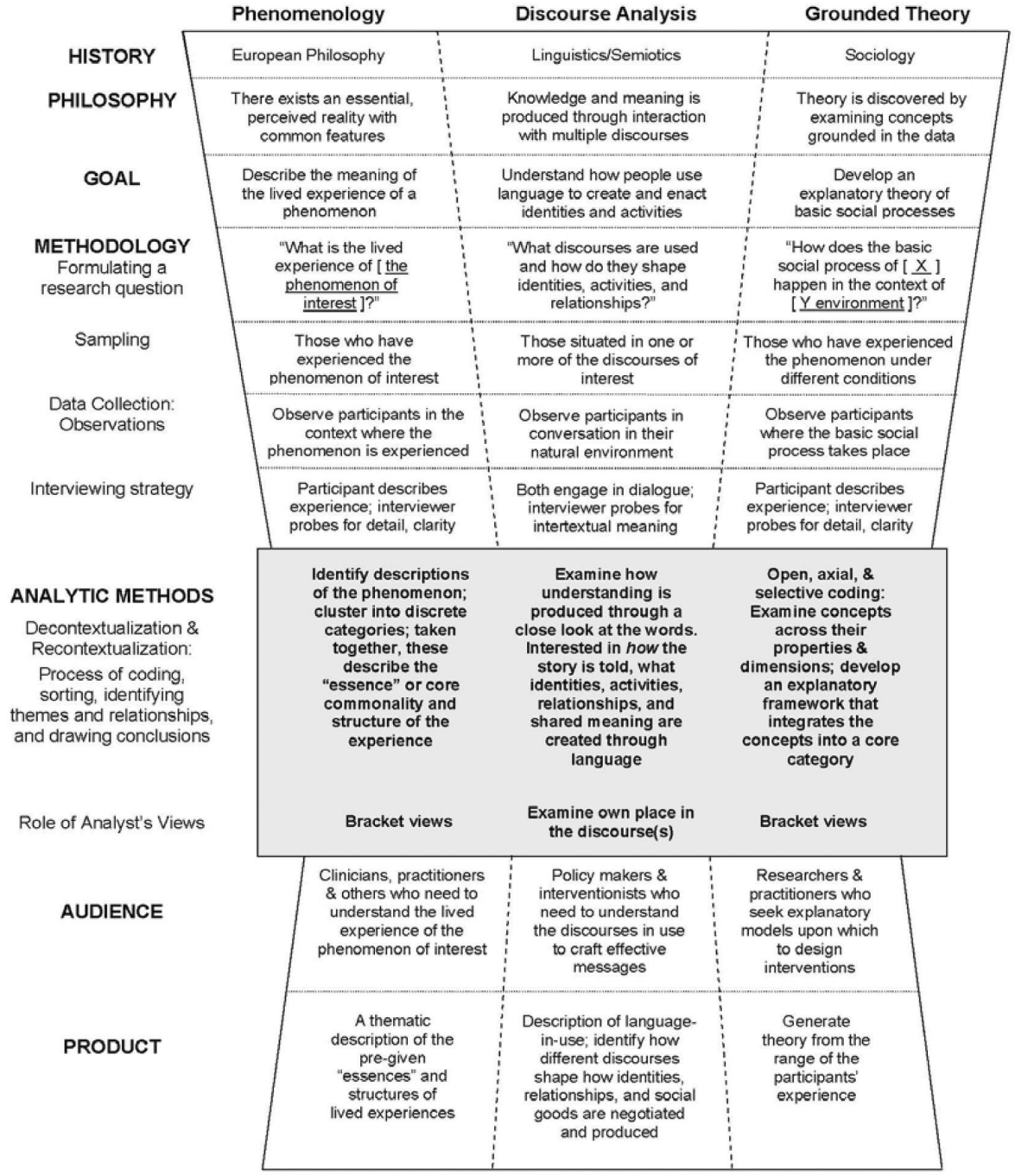
On the other hand, a qualitative approach could explore and interpret personal and social experiences. A qualitative approach can give complex personal accounts, enabling a far greater depth of interpretation and context. While quantitative studies tend to be a theory-testing approach, a qualitative study tends to be theory-generating or illuminating, as it may also query divergences within the data (Braun & Clarke, 2006 & 2013). A qualitative approach is particularly apt when the subject matter is personal and sensitive to highly individualistic reactions (Aten & Hernandez, 2005).

3.2 Research design

In deciding which method would yield the most informative outcome, consideration was given to several approaches. Narrative psychology focuses on how a story is told based on the belief that individuals interpret events to bring order to events in disorder, giving them meaning through constructing narratives. Narrative psychology is concerned with *how* an experience is constituted rather than *what* was said (Tallodi, 2019). However, the focus of this approach would not provide the type of data required for this thesis. Discourse analysis was also considered – but that emphasizes that social reality is linguistically constructed in the form of discourses and constructs, and constitutes life and social reality (Coyle, 2007). Any data is analyzed with an emphasis on examining intonation, pauses and discourse practices in a "dialogue". Grounded theory was also considered. There are several grounded theory variations (Smith et al., 2009), the constructivist grounded theory being the most popular approach. While the latter is based on larger samples, it requires a combination of systematic rigor in analysis and an essentially creative and interpretative research process (Henwood & Pigeon, 2003). Grounded theory also requires that data collection only be considered finished when the illuminated theoretical categories have

reached saturation point (Charmaz, 2015) – possibly requiring multiple rounds of interviews to reach such a stage. Starks and Trinidad (2007, p.1373) map the differences between three of the approaches considered as follows:

Figure 4: Similarities and differences between three interpretive approaches



As suggested from their graphic and the detailed description in their article (pp.1372-80), a phenomenological approach would allow the participants to describe their own experiences of recovery and then allow for a close analysis of individuals' recovery experiences to be

undertaken, enabling the "essence" of the phenomenological experience to be illuminated.

Phenomenology is the philosophical approach to the study of an experience (Smith et al., 2009). According to Giorgi and Giorgi (2008), phenomenology investigates the meanings that constitute a phenomenon by examining and analyzing lived experiences of the phenomena, focusing on what and how the participants experience the phenomena, with little attention given to how it is communicated. Their approach contrasts with a grounded theory one that seeks to generate theories based on participants' experiences.

3.3 A qualitative study drawing on the principles of an interpretative phenomenological analysis approach

It should be noted at this point that this is not a study of Alcoholics Anonymous, but it involves members prepared to participate in their capacity as private individuals. Appendix 20 is a generally circulated memo from AA's General Service Office on the subject and explains quite clearly that while AA is in favour of research, it will not, in or of itself, participate, but its members are entirely free to do so if they are comfortable with and fully aware of the nature of the study.

An evolved methodology, based on interpretative phenomenological analysis (IPA, Smith et al., 2009), was chosen as the most suitable approach in answering the research question – how do people with alcohol use disorder (AUD) use self-help groups to achieve a lifetime of sobriety?

The concept underlying IPA, exploring both the meaning of a lived experience for a participant in context and its significance for them, facilitates a participant with more freedom in their sense-making. It centres on meanings and processes rather than actual events. IPA does not seek to develop new theories regarding phenomena, but rather to fill gaps in knowledge in established theories. It also explores the psychological significance of these experiences and psychological processes behind participants' accounts (Wood et al., 2009).

Further, the adoption of the current methodology, an evolved IPA approach, in this research enabled capturing the quality and meaning of each participant's lived experience in their own words. IPA is centred around the concept that individuals actively interpret

events in their lives through "sense-making" (Smith & Eatough, 2006). Its usage also allowed their developmental stages to naturally emerge in their narratives while exploring their progress through the objectives on subjects such as how they came to accept their AUD and began to address ingrained dysfunctional beliefs. The research focus was on the recovery from what would appear to be an illogical and self-inflicted condition – the dependence on a substance that has no beneficial effect and only reduces the individual to a depraved state emotionally and physically, lonely and lacking any self-worth. Thus, the double hermeneutic of IPA was particularly apt in that it allowed the participant to make sense of what they went through and are going through, while allowing the researcher to make sense of that sense-making. Interviews were not driven by any theoretical orientation, giving them a neutral, unslanted and unbiased base. When the data were collected and analyzed, the findings were then considered in the context of the existing theory derived from developmental psychology. As discussed below, Smith et al. (2009) explain how IPA draws on three key areas in psychology – phenomenology, hermeneutics, and ideography.

3.3 (i) Phenomenology

In describing the background to IPA, Smith et al. (2009) go back to the works of philosophers Husserl, Heidegger, Merleau-Ponty and Sartre. Smith et al. (2009) describe how Husserl was concerned with the concept of *intentionality* – that phenomenology was concerned with something experienced by an individual and that it was the process of reflecting on that event that was phenomenological. This reflection could be achieved through a process of bracketing/reduction (*eidetic reduction),* allowing access to the essence of the experience. However, IPA is more limited to capturing particular experiences experienced by particular people rather than the general essence of experiences. Heidegger, a student of Husserl, developed a narrower view in his main work *"Being and Time"* (*Dasein*) (1962/27) and developed the concept of *intersubjectivity* – that a person is always a "person-in-context" and has an overlapping shared and relational experience interaction with the world. This interrelatedness of experience means that it is necessary to communicate and make sense of each other. Merleau-Ponty's approach displayed a pragmatic interconnection with the world in the example cited by Smith et al. (2009, p.19). He suggested that while one can view emotion in another, it cannot have the same impact for the observer – the actor living it while the observer can then only empathize since the emotion belongs to the actor's own embodied position in the world and the observer can never "own" it. Merleau-Ponty's (1962) view, fundamental to IPA

research, is that the body shapes the fundamental character of our knowledge about the world, that physical and perceptual affordances of the body-in-the-world activities and relations are more significant than abstract or logical ones (Anderson, 2003). The point is that the lived experience of being a body-in-the-world can never entirely be captured or absorbed but must not be ignored or overlooked. Sartre introduced the existential element to phenomenology – that we are always becoming ourselves and that there is no pre-existing self to be discovered. The phrase most associated with his extending existential thought is *"existence comes before essence"* (1948, p.26). Through his views on *nothingness,* Sarte connects that which is absent as equally crucial to that which is, in who we are and how we see the world (Smith et al., 2009).

While Husserl emphasized the importance of focusing on experience and its perception, Heidegger, Merleau-Ponty and Sartre moved phenomenology from descriptive commitments and transcendental interests to a more personal interpretive and worldly perspectival directness on one's involvement in the world. Thus, IPA research can only understand people's relationships with the world interpretatively and can only make meanings by focusing on their activities and experiences.

3.3 (ii) Hermeneutics

Hermeneutics is a theory of interpretation, and its origins lay in the distant past. In the early 1800s, Schleiermacher (*translated 1998*) was one of the first philosophers who sought to differentiate, when interpreting, between the grammatical and the psychological interpretation. He considered that text is not just influenced by the conventions and expectations of the writer's linguistic style but also by their use of that language. For Schleiermacher, interpretation was an art, not just following a set of "rules" but requiring a set of skills, including intuition. He believed that part of the interpretative process involved was understanding the writer as well as the text and, if one engaged in a detailed, comprehensive and holistic approach, this could end up with "*an understanding of the utterer better than he understands himself*" (Schleiermacher, 1998, p. 266). In his approach, Heidegger was concerned with things that may be latent or disguised as they emerged into the light and the effect of fore-conception on their interpretation. Fore-conception will always be present, and our understanding of new things may work the other way around – changing our understanding of the fore-structures. Gadamer (1990/1960) agreed with this argument to some extent – that a reader may not recognise their pre-conceptions until they

have begun their interpretation of a particular object. This circular logic is a fundamental part of hermeneutics. To understand a particular part one looks at the whole, and to understand the whole one looks at the parts. The effect of this may be iterative – as a part is examined in detail or as part of the whole, one's understanding of parts of the text may then change, giving new or different insights into the subject. This logic is one of the fundamental aspects of IPA studies.

3.3 (iii) Ideography

The third essential aspect of IPA is that it is idiographic. Rather than the more usual nomothetic study approach (where data is collected, transformed and analysed in an aggregated manner in statistical outputs), an IPA study is committed to the particular in the sense of the depth of detail accumulated during the data gathering stage. This approach requires that the research must be thorough and systematic. IPA's commitment is to understand experiential phenomena from the participant's perspective in a particular context. Consequently, it requires a participant who has had the subjective lived experience under scrutiny to be purposively selected. While several participants can be included in a study, each interview's focus remains unchanged – on how each one made sense of the experience they went through. Since the interviewer attempts to make sense of how the participant made sense of their own experience, there is a double hermeneutic operating. This double hermeneutic is embodied in the interviewer's dual role, employing the same mental and personal skills as the participant while also sharing the fundamental property of being a human being. However, the researcher's sense-making can only be second order, not having lived the experience but only accessing it through the participant's sense-making lens. Where there is more than one participant with a common issue, convergences and divergences can be identified in their understandings that can then be reviewed in the context of existing literature. While IPA is concerned with specific case studies, Platt (1988) showed how a single case study could highlight flaws in existing theoretical claims for a population and then suggests a way to revise the theory. In the current study, this idiographic approach was applied to small groups at similar points in the alcohol use disorder (AUD) recovery continuum to identify the changing patterns at different stages. As stated by Goethe (quoted in Hermans, 1988, p. 785 and cited by Smith et al., 2009), *"The particular eternally underlies the general; the general eternally has to comply with the particular".* It follows that the deeper one digs into the particular, the closer one comes to an understanding of the universal.

3.4 Benefits and limitations of using IPA in this research.

Despite the limitations of an IPA approach, it was determined that this approach to IPA has been particularly relevant to my study because I sought to explore the development of the general process of recovery from a condition that would have entailed impaired memories and recollections of events and thought processes. Within its suggested weakness of not providing definitive accounts of events lies the strength to re-visit and make sense of processes and events through those subjective personal accounts from participants, detailing in their own words how they believed their recovery began and developed, while allowing the researcher to make sense of their accounts through the double hermeneutic process employed by IPA.

Typically, IPA studies have a small, selected group of participants (Smith et al., 2009, p. 29). In the current research, by dividing the participants into small groups of specific decades of recovery, both the individual experience within their group could be interpreted in that context, and then also an across-group comparison could be made – identifying recovery features that endure, encourage and flourish, or pose a risk to the participants' well-being in experiencing a lifetime of recovery.

Regarding producing good IPA research, Smith (2011, p. 24) provides a list of seven criteria required in producing quality reports based on an examination of 293 papers covering the years 1996 to 2008. They are: first, the research has a clear focus; second, the paper has high-quality solid data; third, the research is rigorous in its analysis; fourth, sufficient space is given for the elaboration of themes – having subsets if necessary; fifth, the analysis should be interpretative, not just descriptive – demonstrating the double hermeneutic approach; sixth, the analysis should point to convergence *and* divergence in individual experiences; and seventh, a reader should consider what they have learned in detail about the participants' experience through a carefully written paper.

The main limitations to IPA research are the low numbers of participants and the non-generalizability of results. However, Willig (2008) suggested that the depth of analysis may illustrate experiences present in the wider community but overlooked in large-scale studies. Hefferon and Gil-Rodriguez (2011) suggest that IPA outcomes, rather than being generalizable, may be usefully transferrable from group to group. On the other hand, IPA studies are not explanatory and do not attempt to map all of the data set's complexity and

reach a point where no further insights can be drawn from the data. It can also be argued that IPA does not offer a map of concepts that explain experiences, that it only captures participants' experiences and meanings in depth. Its results constitute a co-construction of both the participant and researcher and not a participant's definitive account (Willig, 2008). A study's findings are not the only possible credible ones (Pringle et al., 2011). The necessity of native language during interviews to capture nuances and colloquialisms precludes a cross-cultural contextualization. Criticisms have been made against IPA because it has no theoretical underpinnings, fails to meet recognized scientific criteria, and finally is not prescriptive nor replicable.

On the other hand, the merit of findings can be validated through several methods, one of which is triangulation (Creswell & Miller, 2000, pp. 126-7). This triangulation is achieved by the researcher systematically going through all of the data and finding both common themes and overlapping areas and eliminating overlapping ones. That method is particularly suitable for studies where there are many participants.

Despite the limitations of an IPA approach, it was determined that its usage best served the purpose of this research – which was to explore the development of the general process of recovery from a condition that would have entailed impaired memories and recollections of events and thought processes. Within its suggested weakness of not providing definitive accounts of events lies the strength to re-visit and make sense of processes and events through those subjective personal accounts from participants, detailing in their own words how they believed their recovery began and developed, while allowing the researcher to make sense of their accounts through the double hermeneutic process employed by IPA.

As considerable "spare" time was available while attending and meeting Public Information Officers at conventions and subsequently meeting participants for interviewing, I, the researcher, was in a position to attend about 30 open meetings. These meetings are open to non-members. There, I could hear other non-participants speak of their experiences, facilitating my interpretation of others' real-world narratives and getting to understand the organizational structures.

3.5 Participants and sampling

Many one-time alcohol-dependent persons stay abstinent or in recovery for 50 + years (Vaillant, 1988). While Vaillant's study (1988) was a comprehensive study, the participants were subject to continuous monitoring throughout.

In order to illuminate how recovering severe AUD's change over time un-monitored, and bearing in mind the time, locations, anonymity limitations of prospective participants and human limitations of a sole researcher, decade-length periods of sobriety were selected.

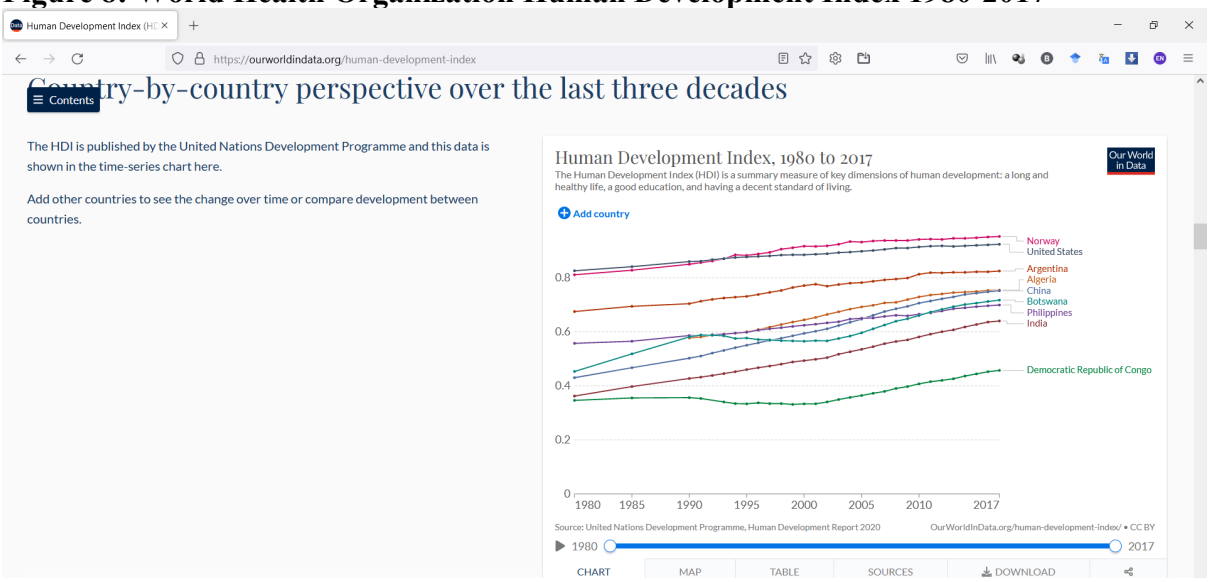
The aim of the research was to explore the development of a lifetime of sobriety and thus it was appropriate to recruit participants who had lengthy but also sufficiently different periods of sobriety to explore changing and developmental experiences and perceptions over a lifetime. By year 10, the first decade explored, abstinence and recovery would have become reasonably well established, and a level of reliance could be placed on the participants' understanding of how they were achieving their sobriety over this lengthy period. From working in the field and as counsellor/therapist, my experience suggested that, often by 10 years of sobriety, an intrinsic or extrinsic need to artificially change how they felt in any given circumstances using alcohol had, in most cases, changed through new perceptions that were becoming ingrained.

Thus, groups were selected by decade, that is after 10 years, 20 years, 30 years, 40 years and 50+ years making the project both manageable and realizable.

While figures are compiled by the United Nations annually, they do not address this research's topic specifically (United Nations Development Programme, hdro.web@undp.org) A sample table explored by Rosen M. (2014) taken from one of their frequent reports is set out below. The World health Organization (WHO Human Development Index (WHO) covered 189 countries in 2018.

While that time frame may be more informative for the current thesis, it was simply not feasible for one researcher to carry out.

Figure 8: World Health Organization Human Development Index 1980-2017



(Rosen, M. 2014)

Further, apart from the logic of being slightly greater that the natural replacement seven-year period of the entire person's individual eco system, attempting shorter review periods of less than decade length by one individual would create an almost impossible task and lead to far shallower findings.

On a more pragmatic basis, older people tend to recall the considerable changes in their lives that occur by decade rather that on an annual, bi-annual basis.

They were interviewed in the context of their recovery and not as members of their fellowship. Initially, the sample size was to comprise six people from each of the four age ranges set out in the proposed inclusion criteria – a total of 24. This number was determined as sufficiently representative and manageable bearing in mind three points: (i) Smith's recommendation (2009) of having small groups to facilitate the in-depth analysis of every case; (ii) the separation distance of 150 miles between participants required under Ulster University's Ethics Committee approval terms; and (iii) the necessity of a common native language during interviews to capture such aspects as nuances, colloquialisms and culture-specific terms.

Regarding item (ii) -the separation distance- the Ethics Committee meeting had raised the issue of 'long-termers,' i.e., 40-50 year-long members possibly being able to recognize one

another in publications in breach of the assured anonymity being offered by the researcher since there were such low numbers of meetings and members, particularly in Ireland, in the 1960s and 1970s. To avoid such a breach of anonymity or confidentiality, the researcher agreed to a 'participant separation' distance of 150 miles. (e.g., approximate distance from Dublin to Cork or Kerry). In addition, this effect was to limit potential participants in Ireland to a maximum of four. Further impacts of observing this 150-mile limitation were (i) it led to widespread data originating throughout Europe, and (ii) it enhanced the research outcome in that it demonstrated that there is very little difference in the recovery development process through the British Isles and Spain.

Inclusion criteria

1. Adults aged 18 years and over.
2. Individuals recovering from AUD for 10 years (+/- 2 years); 20 years (+/- 2 years); 30 years (+/- 2 years) and >40 years.

Exclusion criteria

1. Not providing consent.
2. Non native English-speaking individuals.

The sample size consisted of six people from each of the four age ranges set out in the inclusion criteria, a total of 24:

Group 1: 10 years +/- 2 years' sobriety, n=6

Group 2: 20 years +/- 2 years' sobriety, n=6

Group 3: 30 years +/- 2 years' sobriety, n=6

Group 4: 40 years +/- 2 years' sobriety, n=6

However, Covid-19 conditions intervened and prevented interviewing the twenty-fourth participant – the interview could not take place in the same type of environment as the rest, and it was not feasible to arrange a meeting with the same ambience and relaxed atmosphere that had been eliciting such rich data as the earlier ones. After discussions with supervisors of this project, those interviewed were deemed adequate for this research project and fell into the categories listed below – giving a bonus insight into two cases with 50 years of sobriety. The final sample size of 23 consisted of:

Group 1: 10 years +/- 2 years' sobriety, n=6 Group 2: 20 years +/-2 years' sobriety, n=5

Group 3: 30 years +/-2 years' sobriety, n=5 Group 4: 40 years +/- 2 years' sobriety, n=5 Group 5: > 50 years' sobriety, n=2

The University Research Ethics Committee was advised of this change in an addendum to the annual report requested on 27 August 2020.

3.6 Recruitment of participants

The recruitment of participants consisted of four methods:

(i) Flyers posted in the environs of Alcoholics Anonymous conventions inviting participation
(ii) Via Alcoholics Anonymous Public Information Officers
(iii) Snowballing
(iv) Through fellow professionals in The Addiction Counsellors of Ireland.

Regarding conventions, either no response or a refusal to post flyers were received from various organizers. However, by attending the "open" part (i.e. that part not confined to members only) of several such conventions throughout the British Isles, France and Spain, the researcher learned that, apart from being a concentrated focus on the programme of AA, these conventions serve a significant social function where members meet up and socialize with others they had not seen in some time. The researcher got to know various Public Information Officers at these conventions and was subsequently contacted through them by attendees who wished to take part, well after the convention had ended but who had been unwilling to participate while at their convention. Tables G1, G2, G3 G4 and G5 (Index 1, p. 294) sets out the participants' pseudonyms, length of sobriety at the time of the interview, the country they lived their sobriety in, and the interview duration. Recruitment using process (iv) above proved unnecessary.

Initially and following ethics approval, it was proposed to recruit six participants with 10 years, 20 years, 30 years and > 40 years of sobriety with a deviation range of +/- 2 years. As recruitment progressed, two volunteer participants in the > 40 category proved to have > 50 years of sobriety. Having met them and noted their obvious well-being, mental faculties, cogency and enthusiasm for participation, the categories were amended, as indicated, to include six with 10 years of sobriety, five each with 20, 30, and 40 years, and

two with > 50 years of sobriety. Interestingly, those with 20 years of recovery were the only category where there was

any difficulty securing participants. Some Public Information Officers reported that they had approached several members, but they showed little or no interest in participation.

3.7 Data collection tool - interview

The data collection tool was an interview. The purpose of the interview was to explore how these members of alcohol self-help groups, in their own words, changed their world perspectives and developed personally, changing from a total obsession with their alcohol dependence into living a free and sober life.

Charmaz and Bryant (2011) suggested that interviews are special social spaces that facilitate participants' retrospective reflection on behaviors and enable them to link them to the present. According to Silverman (2011), there are several different interview formats. Based on his observations, an unstructured interview approach suggested itself as the most appropriate for this subject.

The opening question allowed participants to develop their sense-making of their subjective recollection of how their sobriety has evolved – in their own words – describing the experiences of what they had been through, and the evolving nature and benefits they now enjoy. Participants were then asked to comment on whether each of the individual 12 promises of AA (Kelly & Greene, 2013) had come true for them. The questions posed to each participant were as follows:

(a) *"When did you decide you had to do something about your alcohol consumption and what happened?"*

(b) *"Regarding the 12 promises of AA, would you mind commenting on whether you feel they have come true for you, or to what extent – I will read each one out to you separately so that you can comment on each one.*

First: "*We are going to know a new freedom and a new happiness."*

Second: "*We will not regret the past nor wish to shut the door on it."*

Third: "*We will comprehend the word serenity."*

Fourth: "*We will know peace."*

Fifth:	"*No matter how far down the scale we have gone, we will see how our experience can benefit others."*
Sixth:	"*The feeling of uselessness and self-pity will disappear."*
Seventh: "	*We will lose interest in selfish things and gain interest in our fellows."*
Eighth:	"*Self-seeking will slip away."*
Ninth:	"*Our whole attitude and outlook upon life will change."*
Tenth:	"*Fear of people and economic insecurity will leave us."*
Eleventh:	"*We will intuitively know how to handle situations which used to baffle us."*
Twelfth:	"*We will suddenly realize that God is doing for us what we could not do for ourselves."*

Their individual responses were recorded and explored where clarification was necessary.

AA does not endorse these "promises" per se. Their view is that *"We are aware that some groups and members make reference to 'twelve promises'— however, that did not originate from the collective group conscience of AA as a whole"* (AA World Services Inc., 2008, p.6). Notwithstanding this caveat, most group settings I, the researcher, saw had scrolls setting out these promises in that format.

3.8 Interview procedures

All interviews were arranged to be convenient for the participant and so that the terms of the agreed Distress Protocol could be applied, without delay, if required (Appendix 3; p.260). They all took place in locations that suited the participant best and lasted from 45 minutes to 1 hour 40 minutes. The interviewees were facilitated in telling their own stories of their recovery in their own way and time. Before each interview, the researcher had an informal talk with prospective participants over coffee to establish rapport and assess whether the participant had any incapacitation that might render the interview unusable or useless, such as any breach of their continuous sobriety or other physical difficulties such as auditory problems. A few of them did express reservations about re-visiting childhood issues as they felt such issues fell outside what they were to be asked about – their recovery. They were assured that I, the researcher, would raise no such issue.

3.9 Data Analysis Techniques

There are many methods of extracting relevant qualitative data as described in Ryan & Bernard's article "*Techniques to Identify Themes in Qualitive Data"* (2003): 85-109. This document was the outcome of a competition run to determine the best method of data extraction in 1998-2000 entitled *Methods for Conducting Systematic Text Analysis run by the National Science Foundation (SRB- 9811166).* However, they pre-dated Smith, Flowers and Larkin's (2009) distillation book which brings together the elements that constitute Interpretative Phenomenology Analysis (IPA). An updated version of this book was published in 2022.

The methodology used to obtain relevant data in the current thesis drew on IPA principles as follows:

1. All interviews were conducted, and transcriptions were carried out when 22 of the 23 were completed.

2. The recordings were sorted into bundles of increasing decades. Transcriptions were carried out by decade starting with year 10. Transcription and preliminary analysis were then carried out. However, each decade, in ascending order, had to be completed in order to avoid 'contaminating' earlier interview emergent themes.

3. They were then read over without inputting any markings to 'get a feel' of where the 'group-thinking' went.

4 Using a mixture of 'pawing', 'eyeballing', underlining of important concepts e.g. "*I wanted to die"* to lesser ones such as *"I wasn't sure what to do about staying sober"* and 'cutting and pasting' chunks of text together, themes became clearly identifiable. (Rand & Bernard, Sections, 11& 12).

5. The color scheme decided on by researcher and used for underlining text for possible themes combination or follow up were:

Dangerous or life threatening

Reckless inappropriate behaviour

Help-seeking behaviour

Hope; beginning to see a way out or staying away from alcohol

Action – what did they do to start their sobriety

Impediments: mental, physical and emotional

Irrational thoughts, behaviors, cognitive distortions (Beck, 1995) and depression inaccurate or unhelpful core beliefs (Fennell, 1997;1998; 1999).

6. Based on "cutting and pasting" relevant material together, Superordinate Themes, Themes and sub-themes then emerged and illuminated themselves.

The References sources for this approach were:

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes in qualitative data. *Field methods*, *15*(1), 85-109.

Ryan, J, (1998) *Methods for Conducting Systematic Text Analysis run by the National Science Foundation (SRB- 9811166).* [web resource, undated https://grantome.com/grant/NSF/BCS-9811166#panel-comment last accessed 4 July 2022)

Smith, J.A., Flower, P. & Larkin, M. (2009) *Interpretative phenomenological analysis: Theory, method and research*. London: Sage Publications Ltd

Smith, J.A. (2011) Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review,* 5(1), 9-27.

Smith, J.A., Flower, P. & Larkin, M. (2022) *Interpretative phenomenological analysis: 2nd Ed', Theory, method and research*. London: Sage Publications Ltd

These have all been added to the REFERENCES section in the thesis.

3.9. (i) Transcription, anonymizing and data analysis process

Each interview was transcribed verbatim. The transcripts were then reviewed, and distracting interruptions and grammatical errors were removed without affecting the participants sense-

making of their experiences. As a further measure of anonymization, colloquialisms in transcript quotes were changed to ordinary English, for example, the use of Scottish "tae" to "to".

These transcriptions were then read and re-read, group by group, to obtain a general overview. Each transcript was then individually re-read line by line to enable the researcher

to understand how the participants viewed their experiences. Using the technique known as "eyeballing" (Bernard, 2000), points of interest were underlined and subsequently used to "cut and paste" relevant data together to develop superordinate themes, themes, and sub-themes. An overarching theme emerged when completed, thus enabling the complete picture of the participants' stages during their recovery.

As part of each interview, the 12 promises of Alcoholics Anonymous – representing idealized recovery – had been discussed with participants to get both a sense of where they were at in the process of recovering and as a general cross-check against how they currently perceived their life improvements in recovery. These, too, were read and re-read to get an impression of any patterns emerging initially. The results of this scrutiny allowed the preparation of a "table of benefits" accretion to be written up. Interestingly and in general, it mirrored the length an individual was sober.

3.9 (ii) Risk and Ethical considerations

In common with other similar studies, several ethical issues required to be addressed.

The first is non-maleficence. By the very nature of this research - how alcohol dependent persons are recovering from their addictions for 10 years or more - the risk of maleficence was low. Maleficence would require an insensitivity and an intent by the researcher to intrude into or disclose a participant's psychological sensitivities for no good purpose with a disregard to the dignity of the participant. It could also have occurred if the participant began to show signs of distress and the researcher chose to ignore these early indications of the participant's presentation – either verbally or physically - and that did not occur either. A clear Distress Protocol (Appendix 3) was developed to cover any negative eventuality occurring and was presented to the Ulster University Research Ethics Committee when seeking approval for this research. A graphic representation of the Protocol is set at the end of this section.

Beneficence: The purpose of the research was to understand how alcohol dependent persons can recover for the rest of their lives and how the participants are doing that. The outcome of the study cannot but add positively to existing knowledge and would require distortion, misinterpretation of other willful act on behalf of the researcher for this to occur. Apart from the research being "*pro bono public"* (in the public interest), there is also a beneficial aspect for the participants in that as they discuss their recovery progress, the interviews give time to participants to reflect on their life's improvements and how they

were achieving that, and they expressed their appreciation of that.

Informed consent: This aspect of research has four elements. Firstly, that the participant has:

1. The capacity to make an informed decision – that is that they are competent to make it
2. Full disclosure of the nature, purpose and method of the research project is given to them, including the researcher's interest in the subject
3. That they give written voluntary consent to their participation and have the freedom to withdraw from the research at any time without having to give any reason
4. That the researcher is competent to undertake the research and has obtained ethical approval from their university or other competent entity.

For the current study and prior to interviews, participants were supplied with a Participant Information Leaflet covering the points mentioned above (Appendix 2) and a copy of the Distress Protocol so that they would feel their safety and well-being were taken into consideration (Appendix 3). Human behaviour being what it is, the researcher went over both forms with all participants immediately before the interviews began and made sure they all fully understood them.

Honesty & Integrity: These characteristics are fundamental to the research findings being of any value. They include openness and transparency through all stages of the research project. This includes the declaration of any bias by the researcher; and any other factor that may impact on the outcome of the research such as sponsorship of the research work. Integrity extends to the objective interpretation of data whether it is leading towards a particular desired outcome by the researcher or not.

Confidentiality: When there are issues are of a personal or sensitive nature, participants are entitled to be told how any data supplied by or about them will be treated confidentially and they should also be told how that confidentially will be implemented.

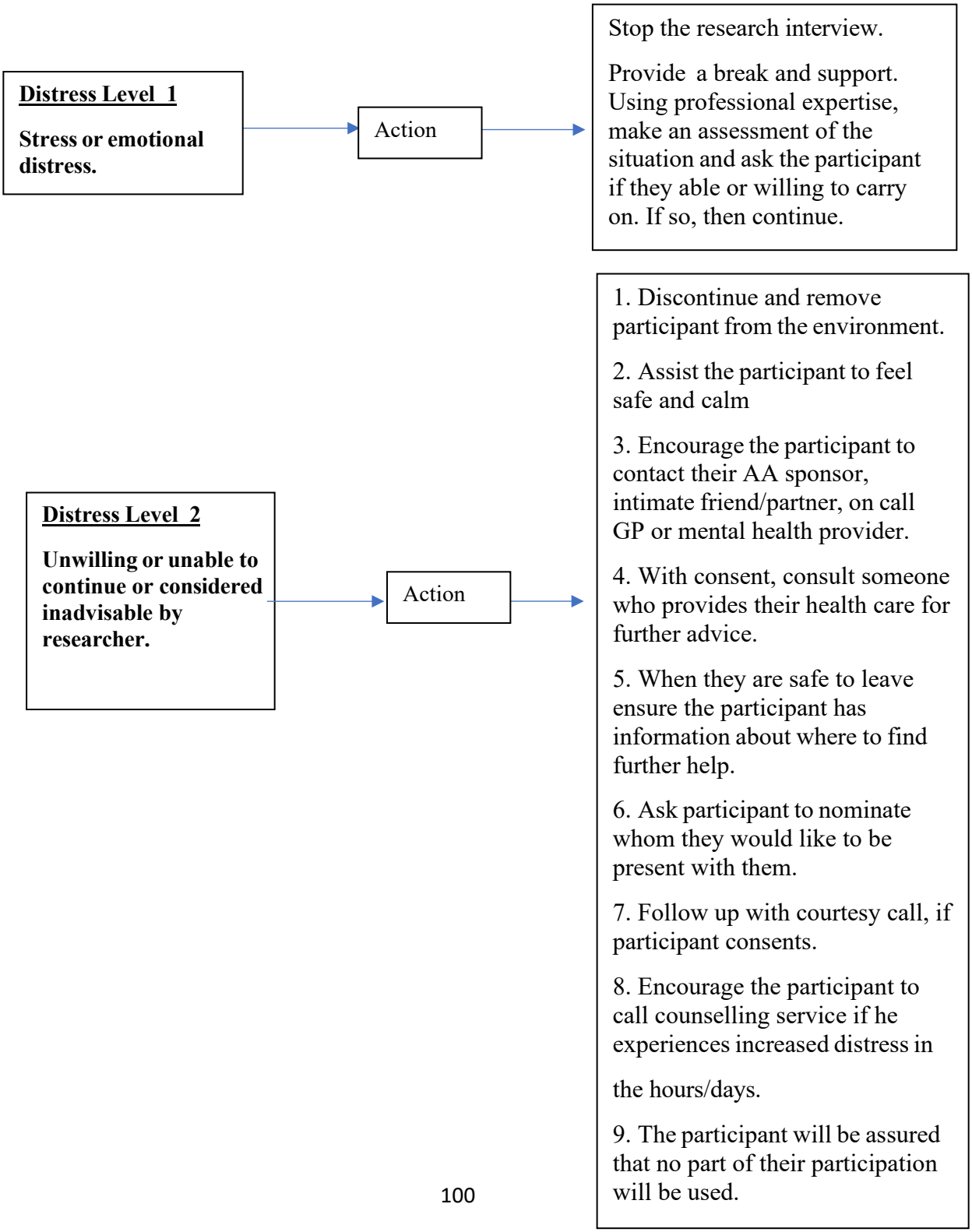
In this current research, the participants were told that their interview would be recorded, and then transcribed. Once transcribed, the recordings would be permanently destroyed and then the transcript reviewed to anonymize them, and any identifiable feature they mentioned would be removed. This is how the data was handled in this research – even to the point of removing colloquialisms. All participant data held prior to the destruction and anonymization was encrypted on a single computer held by the researcher with no external copies retained.

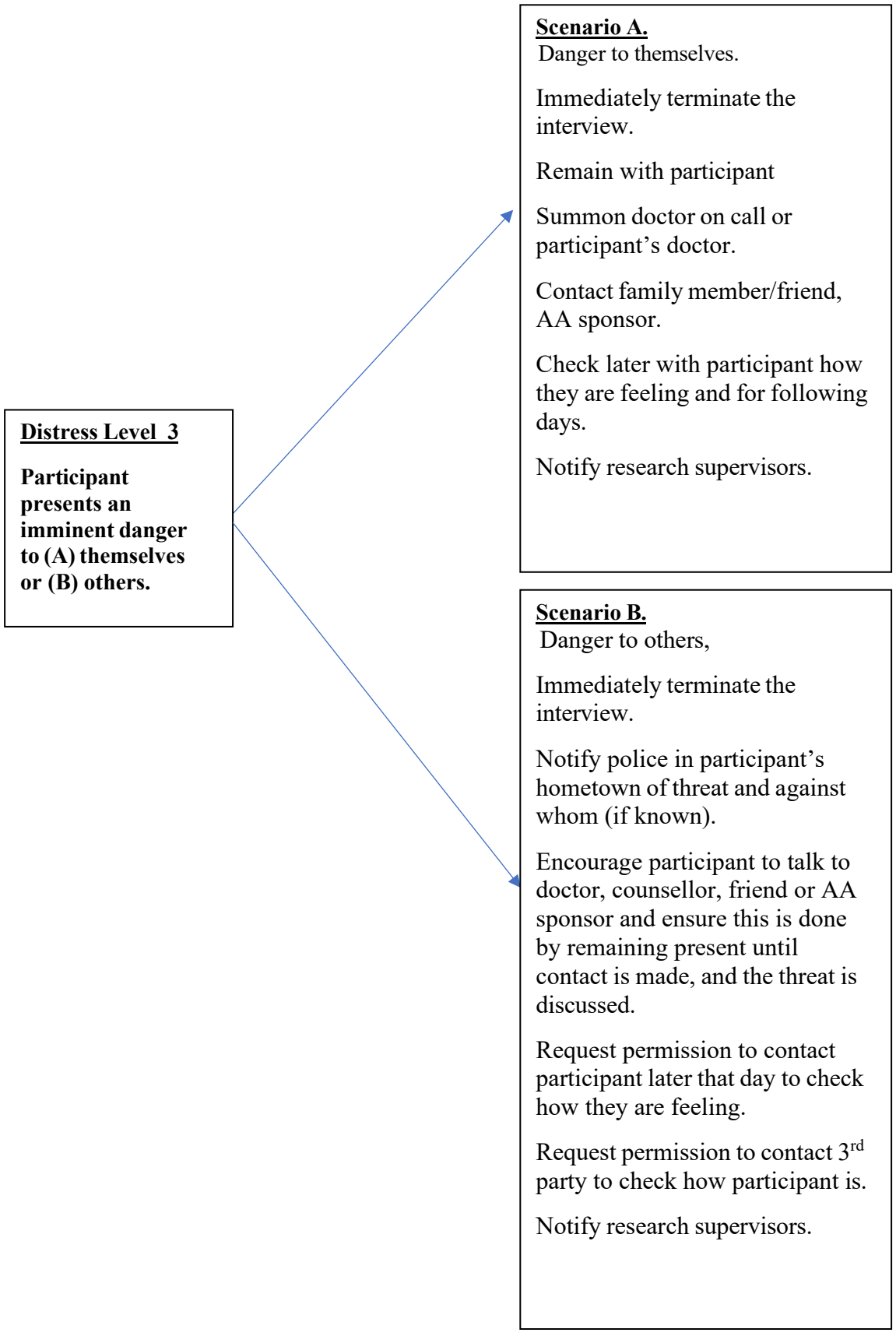
The ethical approach to this research was guided by the Ulster University Code of Practice for Professional Integrity in the Conduct of Research, the British Association for Counselling and Psychotherapy *"*87. All research that we undertake will be guided by the *BACP Ethical Guidelines for Research in the Counselling Professions"*, Irish Association for Counselling and Psychotherapy, Addiction Counsellors of Ireland and complied with overriding General Data Protection Rights 2018 Data Protection Act 2018 in all respects.

[Note: Although the United Kingdom left the European Union on 1 January 2021, in December 2020, an agreement was made with the EU to continue the provisions of the GDPR 2018 for a further 6 months. On June 28th, 2021, the EU agreed an "adequacy decision" that ensured the free flow of personal data between the two blocs for a four-year period (until June 2025). The UK now has its own UK-GDPR since 1 Jan 21 and that new regulatory document, the UK- GDPR incorporated the provisions of the Data Protection Act 2018.]

Risk issues have already been addressed in the Distress Protocol (Appendix 3), and the Distress Protocol did not need to be invoked at any stage. Two participants who spoke of emotive issues declined to take a break – without being asked. A graphic of how the Distress Protocol would work is set out on the next two pages, this formed part of the Research Protocol submitted to the University's Ethics Committee and was accepted.

Table 1. Diagram of Distress Protocol Levels 1, 2 & 3




Distress Level 3
Participant presents an imminent danger to (A) themselves or (B) others.
Scenario A.
Danger to themselves.
Immediately terminate the interview.
Remain with participant
Summon doctor on call or participant's doctor.
Contact family member/friend, AA sponsor.
Check later with participant how they are feeling and for following days.
Notify research supervisors.
Scenario B.
Danger to others,
Immediately terminate the interview.
Notify police in participant's hometown of threat and against whom (if known).
Encourage participant to talk to doctor, counsellor, friend or AA sponsor and ensure this is done by remaining present until contact is made, and the threat is discussed.
Request permission to contact participant later that day to check how they are feeling.
Request permission to contact 3rd party to check how participant is.
Notify research supervisors.

Within most meetings of AA, the members share in a general way *"...what it was like, what happened and what it is like now"* (AA World Services Inc., 2001, p.58), and they could not help falling back into that habit. This habit was not unproductive as they adverted to childhood events that contextualized their dependency and recovery. As the 12 promises of AA (Kelly & Greene, 2013) represent an idealized life in recovery, each participant was asked how they felt about each promise, and this also served to validate how they spoke about their current recovering process.

The only requirement by AA for membership is a desire to stop drinking (Tradition 3), which means that no matter how serious a criminal a member may be, or has been, at no stage did I, the researcher as a lone worker, feel any unease whatsoever.

The participants' ages ranged from 35 to >90. They were recruited in Ireland, England, Scotland, Wales and Spain, giving a comprehensive perspective on lived recovery experience. Their individual details are set out in Index 1.

3.10 Reflexive analysis

After taking early retirement from commercial enterprises, I voluntarily became involved in drug and alcohol treatment centres. Initially, this was part-time until I obtained a MSc. degree in Counselling and Therapeutic Communication from Ulster University in 2012 and qualified as a counsellor with the Addiction Counsellors of Ireland also in 2012. I increased my commitment to working as a full-time volunteer worker in treatment centres. I also provided counselling and addiction intervention services locally at no charge at the request or recommendation of local professionals. All this work was formally supervised. I have also provided a student mentoring service to fellow students, which expanded to students at other colleges that run addiction and or counselling-related courses. However, due to a severe illness in 2014, I had to step back from this work for a few years.

Based on practical experience, I believe that short-term, focused therapies risk causing more harm than good, as suggested by Eysenck (1952; 1964), as their focus is on the symptoms and not the underlying causation. They are also limited to "working to the clock". Therefore, I regard using CBT, REBT (Rational Emotional Behaviour Therapy) and so forth only as a beginning, dealing with symptoms rather than helping the client identify and address their unconscious and possibly very deep-seated, long-standing issues

Outcome rates for treatment centres are not good and are rarely made public. Most run for 4-6 weeks. Even treatment centres that provide a 12-16-week treatment regimen still have a low success rate and, based on two years' experience working in one 12-step facilitation organization, I had formed the following views:

1. That they are telling the client what they must do rather than helping the client find what works to help themselves and how to go about changing their worldview.
2. Clients come from diverse backgrounds where there has been, or they have, wreaked havoc and are expected to return to that location after a period in a protected environment. It is not easy to comprehend how clients are expected to stay sober/clean in such circumstances without readily available help or assistance. Thus, my particular interest area is exploring the transition from learning what sobriety entails for an individual to living life that way.

I am undertaking this research entirely on a self-funding basis with no obligation to report to any person or organization (other than my supervisors in Ulster University) in the hope that a better-informed understanding of the processes involved in alcohol and or substance addiction lifetime recovery will lead to improved success rates (Miller et al., 2017).

I do not have any specific therapeutic allegiance – my primary interest as a therapist is to have a client regain a sense of well-being and self-worth, belonging somewhere, and serving a purpose – irrespective of where they have been or what they have done.

3.11 Conclusion

As each participant's recovery story was unique to them, the conceptual framework devised worked very well. Although Smith et al. (2009) recommend using semi-structured interviews, the unstructured format gave them the freedom to discuss how they were doing it in their own words without interruption or direction. Consequently, they supplied very rich data, and indeed sufficiently detailed to be capable of being analyzed using methodologies other than IPA. Unusually, most participants expressed gratitude for the opportunity to review their recovery progress in full. Although lone working in disparate places, I never once felt ill at ease. Overall, the experience reinforced the merit of Gadamer's (1960/1990) observation that to understand the whole, one must look at the individual parts and to understand the individual parts, one must look at the whole.

4. FINDINGS

4.1 Introduction

This chapter analyses the lived experiences of 23 alcohol-dependent people who joined a 12- step fellowship and have remained sober since then. Their sobriety time frames range from approximately 10 to over 50 years. They joined their 12-step fellowship as a mixture of troublesome drunks, some with suicidal ideations. The combined summary tables in each section of this chapter show their progress towards the idealized life described by AA World Services Inc. (2001, pp. 83-4 and Appendix 9), and illustrate how far they have moved from their initial dysfunctional states to either being or becoming "*happy, joyous and free"*(AA World Services Inc., 2001, p. 133). The ages at which they joined their 12-step groups ranged from 23 to 59 years old.

Segregating the participants into groups by decade of sobriety facilitated the exploration over time of their development. Starting at year 10 and ending at > 50 years meant that any existing patterns of common lifetime change processes could emerge under scrutiny. While not all their pre-existing issues had fully resolved in their earlier years, it became evident that they had worked their way through them into becoming the productive or acceptable members of society that they are today.

The participants reside in five different countries, and considerable travel was involved in meeting with and interviewing them – bearing in mind the requirement, on anonymity protection grounds, directed by Ulster University's Research Ethics Committee, of a 150-mile separation between participants.

Each participant was met for coffee or tea for approximately 10-15 minutes beforehand to allow them to assess the researcher and decide how they would subsequently interact. This brief introductory period proved invaluable in establishing a rapport and led to interviews that provided profoundly personal and rich material. Although four participants work in the addiction or psychotherapy field, at no time did their work or their specific theoretical orientation enter or influence the conversation, nor, indeed, could I identify what they were. Two significant factors to emerge were that none of the participants had (1) previously participated in any similar research, or (2) been subject to any form of

monitoring or measurement during or regarding their sobriety. Four had been briefly through a treatment centre at some stage, and one joined AA directly after treatment, being so required by his employer (Index 2, p. 299).

After the interviews concluded and the recording stopped, each participant was "debriefed" in an informal chat. This procedure was adopted to ensure that the interview had had no residual impact on them, nor had any "door been opened" that might have required any follow-up or attention. Indeed, most expressed gratitude for participating and said they enjoyed speaking at length and reviewing their recovery journey; they do not get the opportunity to speak about it at length at meetings, as they are usually only allowed five to 10 minutes to talk.

As already stated, the findings from the analyses of the interviews were, initially, explored by group lengths of sobriety. For the sake of readability, pseudonyms are used and follow group ranges; that is, Group 1 members (10 years' sobriety) all have names starting with A; Group 2 members (20 years' sobriety) all have pseudonyms starting with B. The same rule applied to groups C and D. The two participants with 50 years of sobriety have pseudonyms starting with L. Where direct quotations are taken from a participant's transcribed interview, they are referenced as follows: page number: line numbers. For example, a quotation from Participant 3 interview will appear with his quotation as (23: 546-7), 23 being the page of his interview and 546-7 the appropriate line numbers.

Using an IPA-based approach, the data were analyzed. However, due to the numbers involved, the diversity of backgrounds and underlying conditions, and remedial methodologies already tried, my sense-making of the participants sense-making of events was mainly built into how their interviews unfolded. This approach is apparent from the extent to which the participants discuss some sensitive issues. My sense-making is somewhat limited within the findings as they are set out. However, at the end of each section, theme or chapter, my sense-making of participants interpretation is included. In reporting these findings in this manner, account is taken of the approaches suggested by Smith et al. (2009), Smith (2011) and Tallodi (2019). There are, however, two main variations. Smith (2011) suggested only 3-4 participants per theme be used to allow for detailed analysis when many participants were involved. The nature of this study and the large number of participants, divided into separate groups, meant that it was possible to

consider every participant's views – even bearing in mind the vast diversity of approaches embedded in their 12-step programme, the diversity of backgrounds or underlying psychological states, and the differing views regarding God/Higher Powers and spirituality – the participant being a person "in person".

Within each group, superordinate themes, themes and several sub-themes emerged, and such data were explored in detail. When considered together, an overarching superordinate theme and themes emerged, giving a comprehensive insight into the continuing developmental nature of recovery.

Like many other organizations, 12-step groups have colloquial abbreviations. A list of these abbreviations (in-text marked "abv.") was provided on page xxi above and is replicated in Section 4.2 below.

4.2 Copy list of abbreviations from p. xxi (for reader's convenience)

"Twelve-step" and "12-stepping" are terms deriving from the twelfth step of Alcoholics Anonymous (and other similar programmes) that states "*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"* (AA World Services Inc., 2001, p.60). Details of how this may be done are set out in Chapter 7 of that book (pp.89-103). It is the process whereby a person who is actively drinking or using may be approached and told there is a solution to their problem with alcohol/substance use through the programme. The member tells them how they did it themselves. The chapter starts with *"Practical experience shows that nothing will so much insure our immunity from drinking as intensive work with other alcoholics."* (AA World Services Inc., 2001, p.89).

"Big Book" is the name members use for the principal textbook "Alcoholics Anonymous" (2001).

"Doing service" or "service" is an integral part of the 12-step ethos. It can mean anything from preparing a room for a meeting, arranging a meeting, acting as Treasurer or Secretary, to representing a group at an Intergroup meeting (which coordinates groups within an area so that they do not send out mixed messages).

"Doing the steps" means going through each of the 12 steps sequentially with a sponsor in detail in the format laid out on pp .65-6 of the book "Alcoholics Anonymous" (AA World

Services Inc., 2001). The sponsee is supposed to write a detailed account before the discussion with the sponsor.

"God", "Group Of Drunks" and "Good Order and Direction" are used interchangeably in AA.

"Front-line group" refers to a group that is singular in the way it approaches its meetings. There are many differing bases for this label e.g., the type of attendees ('beginners' or 'old- timers'). Mainly, however, it means a group that remains focused on a particular Step, Tradition or AA topic - allowing only slight variation, and usually a speaker is time-constrained to a few minutes.

"Geographicals/geographics" is a term used to describe moving to a different place or country to get away from life problems. When used, it is to point out that the problems remain with the individual – no matter where they go – until they deal with them.

"Group sponsorship" is where a small number of members get together to discuss an individual problem and how they could deal with it.

"ISMs" is a term used by 12-step groups to describe the behaviors attached to alcohol dependence deriving from splitting the word *alcohol* and *ism*. Members believe they can still manifest themselves, even when not actively drinking or in recovery. It covers a diverse range of negative behaviors, such as ways of thinking, selfishness and self-centeredness. There are several colloquialisms for what it means, such as "I Sabotage Me". This colloquialism is often used in association with the term "dry drunk". It also draws on the WHO's ICD-10 classification of diseases 1993 definition of addiction as cited by Crilly (2002, p. 119):

> "*A state of periodic or chronic intoxication detrimental to the individual or society, produced by the repeated consumption of a drug, characterized by an overpowering desire or need (compulsion) to continue taking the drug, because of either psychological or physical dependence on the effects of the drug, and a tendency to increase the dose or frequency of use.*"

"Prison service" is seen as a vital role in carrying the message of AA/NA that alcohol and or drug abuse is the reason why many people are in prison. Prisoners, per se, could not set up a group in prison without a prison guard being present – breaching the twelfth tradition *"Anonymity is the spiritual foundation of all our traditions – ever reminding us to place principles before personalities"* (AA World Services Inc., 2012, p. 188). However, when

an AA/NA member from outside a prison approaches a prison governor hoping to set up a meeting within the prison, they are usually allowed to while in sight of, but not the hearing of, a prison officer. Many new members are recruited this way and go on to lead everyday decent lives when they are released.

"Sponsors" are members with several years of experience from whom a member may seek guidance or help. They are available 24 hours a day, seven days a week, but usually meet weekly at pre-determined times.

"Step meetings" are meetings that address a specific step of the 12 steps. The group usually addresses a step and then moves on to the next step at each subsequent meeting, week or month until all 12 are visited, and then they repeat the process. The focus is on how each of the steps works and impacts members. Generally, the discussion follows the subject as set out in the AA publication "*Twelve Steps and Twelve Traditions"* (AA World Services Inc., 2012).

"Open meetings" are meetings where non-members are allowed to attend, and the speakers usually include 1-3 active members, a member of Al-Anon and an addiction professional. Each speaker gives their perspective on alcoholism and recovery, and there is a question-and-answer session towards the end.

"War stories" are lengthy monologues given by alcohol-dependent people at a meeting describing, in detail, their drinking behaviour and careers. They are usually given by relative newcomers who are in the early stages of their recovery. "Long-termers" tend to find them repetitive and boring as they very rarely hear anything they have not heard before.

4.3 Where identified themes match exactly with quotations from 'The Big Book'

1. Certain parts of AA's Big Book make statements or contain information which stands on its own content. Chapter 5 (pp. 58-60 are an excellent example of this.) Page 60 contains the statement

"Our description of the alcoholic, the chapter to the agnostic, and our personal adventures before and after make clear three pertinent ideas:

(a) That we were alcoholic, and could not manage our own lives

(b) That probably no human power could have relieved our alcoholism

(c) That God would and could if he were sought."

The wording of section (b) is used for Group 1 Superordinate 2 (p. 128) because of its appeal to and experience of participants who had tried to stop drinking many times on their own or in treatment centers and failed.
Again Group 1 Superordinate theme 3 (p. 132) is drawn directly from page 58 because therein it describes for the alcoholic what it was like (in active addiction), what happened (to bring about their whole alteration in attitude and behavior) and, as a consequence, what their lives are like *now.* (i.e., enjoyable, respectable etc)

2. The next direct quotation from the Big Book is contained is in Group 1 Superordinate Theme 2 "*That God could and would if He were sought"*.
While a fairly simplistic aspiration, it contains substantial undercurrents. At the end of alcoholic disordered drinking, the majority have no belief or trust in God in any shape or form. This is discussed in pp. 128-131 whereby the alcohol disordered person requires to embrace a real element of spirituality into their lives – easier said than done but achieved by most not through sudden spectacular personal upheavals like that described by Wilson B. (AA World Services Inc., 2001, p. 14) but more likely through the form of experiences of the educational variety - described in p. 569 of the Big Book - and, although not adverted to in text, through the observance of beneficial changes in other members.

3. In Group B Superordinate 2 reads "*The spiritual life is not a theory – we have to live it."*
Rather than engage in a lengthy description of its underlying rationale, it is sufficient to point out that it is taken from Chapter 6 p. 83 which is called "*Into Action"* dealing with how action parts of the programme are implemented such as making good on previous wrongs <u>provided such actions harm no one.</u> The section goes on to point out that alcoholism is the alcoholics problem and not their families so that their spiritual improvements are theirs and theirs alone and should not be imposed on their families.
Significantly, this paragraph is a lead in to the recitation of the '12 Promises' and the ability to enjoy the benefits - the juxta positioning is highly unlikely to be a coincidence. More comments on these promises are addressed in a separate section.

Although staunchly catholic, Sr. Consilio, who runs Chuain Mhuire (by far the largest rehabilitation facility geared towards the indigent in the British Isles), in her non-published

11th week hand-out starts off with the statement "*Without spirituality, there is no recovery*". "Spirituality" *is* a fundamental part of 12-Step recovery programmes – irrespective of whether chapters addressed directly to agnostics, on how to handle this problem are or are not included.

4. Taken directly from the Big Book, Group 4 Superordinate's Themes 1,2 and 3 "*What we used to be like"; What happened"* and *What we are like now"* when reflected on by the participants 40 years later clearly demonstrate how they have developed physically, mentally, socially and spiritually [1].

5. Group 4 Superordinate theme 9 "*To practice these principles in all our affairs"*. (AA World Services, 2001, Step 12, p.60.

While it would be possible to write extensively on the underlying meanings to this phrase, it is just as useful to take it at face value in the words it uses. It does, however, have a very

[1] [For this author while writing about them immediately brough to mind the scene from the movie The Shawshank Redemption when the prisoner "Red" is being asked if he is rehabilitated after serving a prison life sentence since his childhood which goes as follows:

Parole Board: You've served 40 years of a life sentence; do you feel rehabilitated?

Red: Rehabilitated? Let me see if I know what that means. I don't have any idea.

Parole Board: It means you're ready to re-enter society.

Red: I know what you think it means sonny. To me its just a made-up word. A politicians word so fellows like you can wear a suit and a tie and have a job. What do you really want to know? Am I sorry for what I did?

Parole Board: Well, are you?

Red: "There's not a day goes by I don't feel regret. Not because I'm in here, or because you think I should. I look back on the way I was then: a young, stupid kid who committed that terrible crime. I want to talk to him. I want to try and talk some sense to him, tell him the way things are. But I can't. That kid's long gone, and this old man is all that's left. I got to live with that. Rehabilitated? It's just a bullshit word. So, you can go and stamp your form, Sonny, and stop wasting my time. Because to tell you the truth, I don't give a shit." [1]

Maybe out of place or tasteless and lacking a reflection of gratitude this scene reflects the attitude of the participants – that they have wholly come to terms will all aspects of their lives – the good and the bad - of their lives as they are now.]

important secondary function – to act as ambassadors for a programme that can teach almost any person with an AUD, feeling hopeless, that they too can live relatively normal again.

6. Group 5 Superordinate theme "*From alcohol dependence to living happy, joyous and free"* This is one of the few contradictory parts of AA literature (p. 132-133) that is difficult to comment on. On the one hand the AUD person is told in Chapter 5 that if help was sought *"God would and could if he were sought*" - see above.) Yet this chapter states "*We are sure God wants us to be happy, joyous and free"* (p. 133, lines 2-3). Either God, is or is not a non- interventionist allowing humankind to decide their own fates -or not.

Some repetition of themes is inevitable as many of these AUD people in different groups went through similar stages of recovery.

The purpose of the thesis was to explore the developmental nature of recovery over time and combining the same theme for different groups could lead to even greater confusion.

4.4 Group 1 – Learning to live sober: Participants with 10 years' sobriety and recovery +/- 2 years

4.4.1 Introduction and demographic information of Group 1 participants

This first group of participants had the shortest period of sobriety– approximately 10 years. Although they came from different countries and different backgrounds, they found that the answer to their alcohol dependence was that there was no answer – just a common solution based on adopting a suggested way of living outlined in a 12-step programme.

Table 1: Group 1 – setting out participant number, age, gender, location over the majority of sobriety years, and sobriety length (n=6)

Participant ID	Age (years)	Gender	Location of residence over the last 10 years	Length of sobriety (years)
Participant 1	51	Female	Spain	12
Participant 2	53	Male	Wales	10
Participant 3	60	Male	England	9
Participant 4	47	Male	Scotland	10
Participant 5	50	Female	Ireland	12
Participant 6	35	Male	Spain	12

All the unstructured format interviews began with the same open-ended question (*"When did you decide you had to do something about your alcohol consumption and what happened?"*) and were allowed to develop following the participant's responses. An analysis of the interviews provided three superordinate themes, with three themes and three sub-themes associated with the first, two themes and two sub-themes associated with the second, and three themes associated with the third.

Table 2: Group 1, superordinate themes (n=3)

Group 1	
Superordinate theme 1	From alcohol dependence to engagement in a 12-step programme
Superordinate theme 2	"That God could and would if He were sought"
Superordinate theme 3	"What we are like now"

4.4.1.(i) Superordinate theme 1: From alcohol dependence to engagement in a 12-step programme

The first superordinate theme was the need for total admission of their powerlessness over alcohol and their complete inability to deal with their problem independently. This admission is the only part of the 12-step programmes that requires 100% commitment.

Table 3: Group 1, superordinate theme 1: themes (n=3)

Superordinate theme 1: From alcohol dependence to engagement in a 12-step programme	
Themes	
1	A transtheoretical route to joining a 12-step group
2	Perceptions and experiences at first and early meetings
3	"I have a disease" – relief at hearing this diagnosis of an allergic reaction to alcohol

4.4.1.(i).(a) Theme 1 – A transtheoretical route to joining a 12-step group

This theme describes how the participants went from alcohol-dependent to joining the group that initiated their current sobriety. Three sub-themes set out the stages of this process – without analyzing the process's psychological reasoning.

Table 4: Group 1, Theme 1: sub-themes (n=3)

Theme 1 – A transtheoretical route to joining a 12-step group (Prochaska & DiClemente (1984)	
Sub-Theme	
1	Pre-contemplation
2	Contemplation/determination
3	Decision and action – joining a 12-step group

4.4.1.(i) (a).(i) Sub-theme 1 – Pre-contemplation

Each of the participants described a significant, immediate reaction when they took their first alcoholic drink. Their descriptions of how alcohol changed how they felt, reacted and behaved suggested severe underlying psychological issues before that time.

Table 5: (10 years) Name, first drink, dependency and main developmental issue (n=6)

Name	**Age of first drink**	**Abuse/dependency**	**Developmental issue**
Participant 1	14	Immediate	Father and brother alcoholic
Participant 2	18	Immediate	Stuttered and shy as a child
Participant 3	14	Immediate	Bullied at school
Participant 4	16	Immediate	Despair, worry and insecure
Participant 5	13	Immediate	Alcoholic home
Participant 6	11	+3 yrs. & drugs	Violent dysfunctional home

Index 5, Table 1 sets out in more detail early dysfunctionalities for this group.

Participant 1 said, "*When I started drinking at 14, it was too extreme. It was always to get drunk; I could never stop* (1:4-6). *I'd be very argumentative, full of anger"* (1:17).

Participant 2*: "It made me feel great; it took away my shyness, I felt a part of everything*

then" (1:1718).

Participant 3 also found an immediate response to his feeling of inadequacy, in that it gave him: *"...the front, the balls to stand up to people because I was bullied at school"* (1:31).

Participant 4 said that his first drink at 16 "*Took all my feelings, despair, worry, insecurities – they all started to disappear. I felt really good"* (1:20-1). *"It seemed that I'd found the elixir of life"*
(1:25) and he mentioned, "*....my mother had died when I was a child"* (2:58).

Participant 5 described herself as becoming a "*lightning bitch"*(2:57) from incredible anger within her.

Participant 6's drinking and drugging by the age of 15 were chaotic – he describes how "... *I lost the plot with the family"* (2:32*), "... this kind of stuff"* (2:34).

The participants described various negative feelings and self-perceptions, which dated back to childhood and developed as their dependency on alcohol increased. However, they had to remain unexplored as the participants had been told, in advance, that the interviews concerned their recovery process only. As the interviews progressed, however, it became apparent they had, by and large, *begun* to come to terms with their underlying psychological problems by working through the 12-step programme.

4.4.1.(i) (a).(ii) Sub-theme 2 - Contemplation/determination

The participants realized that they had reached a state of life-threatening dependency at different times, whether through contemplating suicide or their drinking's physical consequences.

Participant 1 said it was, after her first drink, "*...15 years later* (1:13). *I lost everything in the end. I lost my marriage. I lost my home, and I had nothing but the clothes on my back* (1:26-8). *I hit rock bottom, and I was contemplating suicide, basically"* (2:32-3).

Participant 2 reached that point of desperation when he said, "*I felt then I was left out of things"* (2:33).

Participant 3 described how, after a blackout, he found himself with a Stanley knife in his hands and blood on his wrists. He realized he had attempted to take his own life.

For Participant 4, it was a relatively specific turning point. He had been obliged to see his company's doctor. "*He recognised I had a problem, but I did not want to recognise it"* (5:141-2). He wanted to keep his job, so he decided he needed to address his problem.

Again, it was resulting from a blackout that Participant 5 realized she had to do something. She described, *"Well, I knew one morning when I woke up that something wrong had happened. I crossed a line in myself, and I knew it* (1:23), *and because of the guilt, the shame, the remorse, everything that was inside my body"* (3:81-2).

Participant 6, having outlined a life fueled by alcohol, drugs, prison sentences, described lasting three days in a treatment center and finding that "*...I wasn't in the right space*" (3:66) but found, later, in another center that "*It was their kindness, that kind of made the path for me to try to do something"* (3:73-4).

From this sub-theme, it emerged that the participants made their own choice to seek recovery.

4.4.1.(i) (a).(iii) Sub-theme 3 – Decision and action: Joining a 12-step group

Once the participants had decided to address their alcohol dependence, they acted on it by attending a 12-step meeting.

Only one of these participants had had experience of treatment centers – Participant 6. The others all joined a 12-step fellowship directly through prior personal knowledge of members or a "12-step" contact (abv.).

Participant 1 thought that treatment centers taught people how to stop drinking, so she "skipped them".

Participant 2 commenced his current abstinence period after several years of abstaining by himself and then relapsing. He went because he had heard and taken in that there was a solution available there.

Participant 3's wife got him to contact a local AA helpline, and a member brought him to his first meeting but told him that, ultimately, it was up to himself to "do" the programme.

Participant 4 described how he too phoned a 12-step group, was met by a member and brought to his first 12-step meeting.

Participant 5 decided that it was she, herself, who needed help after attending an Al-Anon convention.
She said, "*I'm straight in* [to AA] *off the street* (33:1028). *I can honestly say to you that if I had gone through a treatment center, I truly do believe that I would be drinking today"* (33:1031-2).

Although he had attended both NA and AA meetings while in treatment centers, Participant 6 was unclear about why or when he independently decided to go to a meeting except that he felt there might be "something" there for him.

This sub-theme shows how once the participants truly appreciated how bad things had got for them, they acted on it by finding and going to a 12-step meeting.

4.4.1.(i).(b) Theme 2 – Reactions to first and early meetings

Their initial meetings' perceptions and experiences were to have a profound beneficial and lasting effect on these participants – why they kept returning to meetings, got involved in the 12-step programme and service, and remained sober.

Table 6: Group 1, theme 2: sub-themes (n=2)

Theme 2 – Reactions to first and early meetings	
Sub-theme	
1	Perceptions at first and early meetings
2	Experiential impact of first and early meetings

4.4.1.(i).(b).(i) Sub-theme 1 – Perceptions at first and early meetings

Although the participants would not have been in good physical, mental or psychological condition, they found the courage to attend a 12-step meeting. They described a mixture of

fear, apprehension and gratitude.

Participant 1 said, "*I do not know how I walked in. It was this shame that came over me when I walked in the door. It's like, oh my God, I'm in AA...* (2:51-3)*... It was the most nerve-wracking thing*
I ever did, but the greatest" (2:61-2).

Participant 2's enduring impression was of the empathetic reception on his return. "*It was great, I loved it. I genuinely loved it because I was made to feel welcome. There were a number of years before that I wasn't made welcome anywhere really, not even at home"* (4:91-3).
Participant 3's perceptions were quite different. *"I sat there, and it was a bit of a blur* (8:234-5) *...but the thing what did strike me was everyone was so happy"* (8:238-9).

Regarding his first 12-step meeting, Participant 4 felt he was in the wrong place, relapsed, and nine years later – suicidal and empty inside – returned to meetings at his doctor's suggestion.

Participant 5's description was one of being fearful and apprehensive. She said, "*There was a lack of confidence, a lack of self-worth, a lack of self-esteem inside me"* (10:300-2) and that she was *"terrified"* (3:89). "*I crumbled, and people were coming up, shaking my hand, and I'm rattling"* (6:162-3). "*That would have come from my childhood, because I grew up in an alcoholic home"* (6:165-6).

Initially, Participant 6 had a level of ambivalence about which programme to follow. "*At NA I felt more comfortable. AA, I used to feel judged* (5:126-7)*. Well, at first in AA I did"* (5:139-40).
This sub-theme described the lasting impact of going to their first meeting on the participants as they started their current recovery journey.

4.4.1.(i).(b).(ii) Sub-theme 2 - Experiential impact of first and early meetings
In this sub-theme, the participants discovered hope that they might get out of their current predicament.

Participant 1 found it a compelling experience and had difficulty believing that people did not know she was coming – they told stories matching her own of their original physical and mental states. She said, "*I could relate to everybody that shared that night"* (3:79).

Participant 2 found hope. *"I'd seen the hope right at the very start, but the hope was different than it is now"* (4:100-1).

Participant 3 described his surprise to find that

> "*There was laughter, and I was in this dark place and there was all these people laughing around me. I thought, what the fuck are they all on. I thought this was like Alcoholics Anonymous, and no one is supposed to be drinking, and everyone's all laughing and joking and patting each other, and hugging and kissing. I thought, I can't be doing with this, but I will stay, I will sit here"* (8:234-41).

Participant 4, after a 9-year relapse (6:179), found, this time, "*When I saw these normal people, people trying to get sober, it was as if somebody had lit just one wee candle in the room. That was my first* [real] *AA meeting"* (9:279-81).

Participant 5's reaction was like that of Participant 1 – she could relate to all of what she was hearing *"...but hang on a minute, they're saying stuff inside here that I've been reared to keep my mouth shut around*" (7:195-6).

Because of Participant 6's prior experience, he had a certain ambivalence towards that first meeting. "*Then again people seemed happy, and I kept going back"* (5:129-30) "*...but I was not being able to receive kindness and love"* (5:143).

This experience was a significant turning point for all the participants. They experienced an open welcome and acceptance by like-minded people, who did not judge them for the first time. They all found genuine hope at the meeting to which they referred. They also heard that there was a way out for them. There is existing literature on the "hope" that the participants described.

4.4.1.(i).(c) Theme 3 – "I have a disease" – relief at hearing their diagnosis of an allergic reaction to alcohol

To the participants, hearing their condition described in such a way brought a profound sense of relief – that there was something 'wrong' with them, and there was a solution. AA, the precursor to other 12-step programmes, sets out a doctor's opinion (Appendix 10) in which he says that a specific class of people develop an allergic reaction to alcohol. This explanation gave the participants a new hope or perspective and evidence from those present that the AA remedy worked. They were not concerned with the merit of the wording of this "diagnosis".

Participant 5 took great comfort from hearing her dependency described as a disease. "*Now, when the disease says it's a disease of self, I was crippled"* (13:399-400). Participant 2 found describing AUD as an illness as "*aww...amazing"* (7:184).

This theme on 'reconceptualizing their problem' started to free the participants from their feelings of guilt, shame and remorse for their then-current predicament.

4.4.1.(ii) Superordinate theme 2: "That God could and would if He were sought"

The second superordinate theme was that *"God could and would* [relieve them of their addiction] *if He were sought"* (AA World Services Inc., 2001, p. 84) [i.e., His intervention was sought], and that was what happened for the participants, although the efficacy timescale varied widely.

As the only condition for membership of a 12-step group is "*...a desire to stop drinking"* (AA World Services Inc., 2012, p. 143), it is open to all regardless of gender, race, religion, creed, color, or belief system. To make the organization fully all-inclusive, the term "God/higher power" is qualified by the words "*...as we understood Him"* (AA World Services Inc., 2001, p. 59). One believes that there is some 'power' there that can help in restoring them to sanity. The textbooks of the prominent 12-step fellowships are almost all the same – except for the addiction specified – and all contain a chapter entitled "We Agnostics" dealing specifically with this issue. However, this differentiation between religion and spirituality was a significant dilemma for the participants. Nevertheless,

through the sharing of long-standing members, they learned how to be open–minded about the existence of a higher power – that there was one that they could "work with". It removed the restrictions associated with their birth's organized religions that relied on fear and guilt to promulgate that faith – fear and guilt being primary emotions that permeated their lives and exacerbated their addictions.

Table 7: Group 1, superordinate theme 2: themes (n=2)

Superordinate theme 2 – "That God could and would if He were sought"	
Theme	
4	Higher power – coming to terms with the concept; preconceptions of "God"/higher power or spirituality; "spiritual awakening"
5	Engaging with a sponsor (abv.); "doing the steps" (abv.) and "working the programme" (abv.)

4.4.1.(ii).(d) Theme 4 – Higher power – coming to terms with the concept; preconceptions of "God"/higher power or spirituality; "spiritual awakening"

Five of the six participants came to believe in a "higher power" concept, and one remains an atheist – but he did describe a "*spiritual experience".* When this happened for the five, it began changing their lives from being alcohol-free to living sober.

This subject of acceptance of a higher power (in whatever form a member chooses) or of a God
"*as we understood Him"* (AA World Services Inc., 2001, p. 59) is an integral part of the 12 step programme. Steps 2 and 3 require a member to believe in both concepts, and that such ethereal force could relieve their dependency. The participants had quite diverse reactions to this tenet.

Participant 1 said, *"...something deep down was telling me there was something there, so I never had a problem with God"* (5:141-2).
Participant 2 was much more emphatic on the God concept saying, "*The thing about – to me it's not a spiritual angle, the whole thing is that* (8:228-9). *"I knew then that solution was getting God in my life for me"* (7:2).
Participant 3 described himself as an atheist, and this aspect of the programme unsettled

him. He described his first impression of members as *"...a load of fucking Bible bashers.... God botherers"* (9:259-60). However, despite remaining an atheist, he did refer to an incident

"...which I feel was a spiritual awakening, whatever you want to call it" (22:665-6). Here, he is referring to when he came out of the blackout with his wrists cut:

> *"...it's difficult to explain it but whether I was dreaming, or I don't know* (6:17880). *Something happened, I saw a bright light, and I heard a voice and it's my father* (6:183:4). *He hardly ever used to swear, my old man, and I just heard his voice, "For fuck's sake sort yourself out boy"* (7:186-7).

For Participant 5, it presented an enduring difficulty until she addressed it after some years with her sponsor. She said:

> "*God for me was male. I had an allergic reaction* (35:1090-1). *When I thought of the word God, the one thing that came up in my body, that I've only shared in recent years, was where were you? Where were you when this happened to me when I was a child? Where were you when this happened to me as a teenager? Where were you when this was being done to me in my relationships? The whole lot. Okay? Where were you?* (35:1097-1102). *When I began my step 4, I knew somewhere, outside of myself, there was something walking towards me* (23:7089). *The next thing, I felt like two hands on my shoulders* (23:717-8). *This incredible sense of peace came over my body, and I started to cry, and I couldn't stop. I was that small little girl that started seeing them when I was four years of age, and I was – it was like, I was taken back, and they held me. So, inside in four, I was reconnected with my higher power* (23:718-22) *which I'm calling grandfather, was the only thing that had the power to go up against my head, which was my disease, and in its calmness, in its groundedness, in its sureness, in its calmness* (23:725-7*) to catch my hand, and very gently bring me through all of that shit until I felt myself in a space I hadn't been in since I was a small girl. A safe space, where I knew nothing but love* (24:730-2). *Today, God is in my life"* (37:1166-7).

Participant 4 came to believe in a higher power, a spiritual force that represented goodness, kindness, and love through association with other people (15:451 and 15:457-61).

Participant 6 found that he had a problem with the "*God thing"* (6:175) but praying to his 'nannie' worked for him as "*It was like someone holding your hand..."* (7:185-6) and he developed his own approach to spirituality (7:190).

From this theme, it emerged that the participants became prepared to and altered their ingrained God or religion based belief systems in favor of a new, more beneficent higher power but not in any discernible time pattern.

4.4.1.(ii).(e) Theme 5 – Engaging with a sponsor (abv.); "doing the steps" (abv.) and "working the programme" (abv.)

By not following the process suggested by the 12-step organization that specific actions need the guidance of a sponsor or another knowing person, some participants missed out on getting early benefits from the programme or had them substantially delayed.

Participant 1 *"...hadn't a clue what they were talking about"* (5:129) and took three years to engage a sponsor to guide her through the programme as *"It was trust for me"* (5:145).

Participant 2 quickly grasped that AUD was only a symptom of an illness and that getting a sponsor and doing the 12 steps were fundamental to his finding a solution.

Participant 4 came to believe that he had to go through them if he wanted recovery – through going to meetings and listening to what others were saying. He found "...*Step 3 and step 5 very, very spiritual, very emotional"* (13:383).

Initially, Participant 5 did not engage in the process for over three years, and when she did, she found them:

> *"Horrendous, because they put the fear of God into me"* (19:588). *"...the most incredible thing that has ever happened in my life, because inside of those steps I was reconnecting with my higher power"* (19:590-2). "*Right now, for me, that is stirring a little sadness* (16:498-9) *... a kindness or a softness... (*16:501) *... The last time I would have felt that* (16:501) *... from the age of three to five* (16:502) *I was sad for what that girl had gone through"* (22:681).

Participant 3's rebelliousness and atheism continue, and he has never gone beyond formally "doing" step 1 with a sponsor as he does not "...*like being told what to do*" (10:308). He talks to his dog instead about anything and everything.

Participant 6 (a practicing addiction worker) never got a sponsor in either NA or AA and relied on "*outside help"* (8:235-6).

Going through steps 4 to 9 (Appendix 7) – known as the "action" steps (working the programme) – is a necessary action, during which a member explores severe psychological and emotional issues or perceptions with a sponsor or other trusted person as opposed to a

Treatment Centre or counsellor who may well be time-constrained. While they are encouraged not to delay, the slogan "Give time, time" enables the participant to deal with their problems at a pace they can process without much distress. Talking on a one-to-one basis with a member who has had similar experiences and dealt with them provided a broader concept to view their historical difficulties. Regarding the 12 steps themselves, they are prefaced by the words "*Here are the steps we* took..." (AA World Services Inc., 2001, p. 59) – even though all the 12-step programme is an entirely suggested one.

Through the participants' accounts, this theme shows the effect of delaying or not going through this part of the programme – that the hope they gained in the first three steps must be followed by action or else the benefit of full recovery will take longer to experience.

4.4.1.(iii) Superordinate theme 3: "What we are like now"

The third Superordinate theme is about how life is for the participants now, what they need to do to maintain their recovery, what they believe their program's messages are, and its benefits so far. This theme also explores the participants' perceptions of where they are now regarding the idealized life that the 12-step programme promises may be available to them (AA World Services Inc., 2001 pp. 82-3; Appendix 9) if they thoroughly follow the suggested path laid out.

Table 8: Group 1, Superordinate theme 3: themes (n=2)

Superordinate theme 3 - "What we are like now"	
Theme	
6	Personal changes experienced and life improvements
7	Messages of the AA 12-step Group as perceived by participants of Group 1.

4.4.1.(iii).(f) Theme 6 – Personal changes experienced and life improvements

In this theme, none of the participants described an "instant cure" to their alcohol-related problems. They found it to be a gradual process. They all changed at different times and stages.

Participant 1 said, *"It was very, very slow for me"* (4:115-6). "*I was getting hard to accept I was [an alcoholic] and the reason for that was, I was comparing"* (5:122). She attended three or four meetings a week for five or six years but delved into spirituality and other mystical courses. Eventually, she left AA (6:170-2) for a while. She became irritable, discontented and argumentative again. She said, "*I was emotionally fucked again. So, I made a decision to get my ass back to AA because I knew I needed help"* (10:275-6). She got a new sponsor. When she "did the steps" this time around, it was a different experience:

> "*When we knelt down to do the third step prayer, I felt a presence, I felt something coming into me, and I started to shake. I don't know what the hell has happened to me, I just had to cry, uncontrollably"* (11:327-9). *I never felt so present in all my life as I did that day and I just put my hand on my heart and just said, was that you? Is that you? I could get this voice in my head saying yes, I'm here, I'm here* (12:334-7)*... After that then I just felt my higher power was with me* (12:339). *I just got it. It just made sense to me* (11:324-5). *There was a war going on inside me, all the time* (13:388-9). *That war is not there today, because I gave it my all, which I hadn't before"* (13: 390-1).

She has now come to terms with all her past and moved on with an improving sense of self-worth.

Participant 2, too, this time around, was determined to do it properly. "*I went back in, and I really harried myself to ask somebody to teach me the Big Book of Alcoholics Anonymous"* (5-6:152-
4). *"...that was a great experience for me, because that started this current journey"* (6:1578). He continues to develop his spiritual growth believing that it will always cancel out his "disease". For him, the most significant change is his relationship with God. He gave an example: "*Prior to coming here to do this today, I asked God to give me the words*" (9:255-9).

Participant 3 found the first few months were a struggle, "*...but as I went more and I started – people started getting to know people and getting to know – there was lots of tears, I'll be honest. I am quite an emotional person, and I never used to cry when I was drinking*" (10:281-3). While still atheistic in his beliefs, he no longer has an intolerance to using the word God. He ascribes his continued sobriety to his attendance at meetings and continuously participating in "service". Participant 4 describes life now as being like night and day – a series of miracles – based on AA and his doing service. He remains sober, "*One*

day at a time" (1:23).

While Participant 5 continued to attend meetings and stay sober, her sobriety was minimal: *"I wasn't sharing* [my own] *story* (11:324) ...*I was that disconnected from everything that I felt nothing ... I thought it was for them"* (12:359-61), despite her "spiritual awakening" described in 4.5.1 above. It took her eight years in the fellowship for her to be "*... beginning to come into a bit of understanding, coming into my own, because the steps were behind me, and service was behind me"* (31:967-9), and she had to *"... re-learn the language of fellowship.... the language of kindness, compassion, empathy, love, understanding"* (32:988-9).

Participant 6 said, "*At first in AA I did feel an outsider*" (5:140). "*In the first few months, I went every day. Maybe twice a day. I didn't know what else to do"* (6:153-4). He felt that emotional sobriety was necessary – or a price was payable for the lack of it. While travelling abroad after some years and not going to meetings, Participant 6 experienced loneliness, isolation and sadness. "*There were days I felt fucking, wow, what the fuck is going on here?*" (10:286-7). He still experiences difficulties with rejection. Despite this, he feels that the last 12 years were 100% worth it – if he had not aligned his ways to those of the fellowship, "*I'd be dead"* (13:411).

All the participants were grateful to find that they were not alone with their dependency and could see that others, like them, had recovered from the state they were in, back to enjoying life on life's terms. Both Hope and Gratitude play a significant role in addiction recovery.

4.4.1.(iii).(g) Theme 7 – Messages of the AA 12-step Group as perceived by participants of Group 1.

None of the participants could reiterate any direct message they had taken on board. Rather than picking up specific messages, rules or directions, all the participants spoke about it as an emotional experience: finding hope, identifying, and feeling reassured by hearing their condition referred to as a disease. Their separate verbatim understandings of the 12-step group's messages were:

Participant 1: "*Stick with it, give it your best shot and see how it goes; the door swings both*

ways. I would say give it your all, go with the flow and see what's ahead of you" (15:424-7).

Participant 2: *"I'd seen the hope right at the very start"* (4:100). [The programme gives me the ability] "*... to be the best version of me"* (14:409-11). *"We only know but just a little".*(10:284).

Participant 3: "*It is a day at a time. Big time, it's a work in progress"* (17:535-6).

Participant 4: "*If you don't pick up that first drink, you can't get drunk.* (15:445-6*). That's a constant message that stays basic and straightforward* (450-1). *"What AA has taught me to take life on a day-to-day basis. Not to worry too much of the future, and not to fret about things that went wrong in the past"* (16:482-3).

Participant 5: "*Hope* (6:176), *love* (8:242), *kindness* (14:425). *"Service has been the root of my growth"* (30:948).

Participant 6: "*What I took from that was I have to keep growing. I don't have to but it's important I keep growing"* (9:262-3).

Appendix 11 (p. 275) sets out a summary of all participants' impressions of the messages. It shows how wide a disparity exists between them regarding the message of their 12-step programme.

4.5 Group 1 summary

The close examination of these participants' transcripts demonstrates that no "quick fix" to alcohol dependence is realistic. Examples are Participant 1's state of mind at five years, and Participant 5 only beginning to fully address her underlying issues after eight years of sobriety/meetings. Undoubtedly, alcohol-free, their quality of life and behaviour improved substantially, but residual effects of long-standing underlying traumas still endured.

Of most significance to this group of participants were the facts that (a) they heard they had a "disease"; (b) they were not alone with their problem; and (c) unspecified childhood traumas had begun to lose their impact through practicing the steps without the necessity of confronting the perpetrator or otherwise. My sense-making of this group of alcohol-dependent participants was that four participants may have experienced unidentified

childhood abuse, not specifically alluded to, at some stage, and that they had never sought to address them formally in any way. However, step 9 showed them a way to deal with these issues without necessarily confronting the perpetrator.

The key point to emerge from these interviews was that this group was that they had found the courage to address their alcohol dependence and began the process of fundamentally changing their attitude from 'alcohol first' to staying away from alcohol as being their priority.

The differences between having a sponsor and a counsellor begin to emerge in this group. Participants may have multiple sponsors for different issues and changed them if they were not happy with how their relationship was evolving.

4.6 Group 2 – Living sober: Participants with 20 years' sobriety and recovery +/- 2 years

4.6.1 Introduction

The way all participants learned to stay sober through sharing their experience, strength and hope with each other at meetings meant that their accounts tended to follow a pre-defined pattern in their narration. This pattern led to a certain repetitiveness within the narrative structures in and between different groups. However, there are discernible changes regarding the emphasis they place on different aspects of their recovery process as they become longer term members. Furthermore, this group's noticeable difference in body language is not evident through the written data extracts. Although they spoke about serious life events that the participants in Group 1 had not experienced, they were much calmer and at ease throughout the interview.

Additionally, when discussing some of the more "amusing" aspects of certain events, the occasional laughter may not always carry through the data extracts' words. These non-verbal aspects of the interview process portray the depth that unstructured interviews have to gain insight into participants' experiences. In the words of their programme, these participants are *"... trudging the road of happy destiny"* (AA World Services Inc., 2001, p. 164).

Table 9: Group 2 – setting out participant number, age, gender, location over the majority of sobriety years, and sobriety length (n=5)

Participant ID	Age (years)	Gender	Location of residence over the last 20 years	Length of sobriety (years)
Participant 7	60	Female	Caribbean/London	22
Participant 8	78	Male	Glasgow	19
Participant 9	67	Male	USA/Ireland	20
Participant 10	65	Male	Lanzarote	20
Participant 11	60	Male	London South	22

As with the first group, the transcripts of the interviews were read, re-read, and then a line-by line analysis followed. Four superordinate themes emerged, with two themes associated with the first, second and third, and three associated with the fourth superordinate theme.

Table 10: Group 2, Superordinate themes (n=4)

Group 2	
Superordinate theme 1	From alcohol dependence to engagement in a 12-step programme
Superordinate theme 2	"The spiritual life is not a theory – we have to live it" [1]
Superordinate theme 3	Emotional sobriety and quality of life improvements
Superordinate theme 4	Living and enjoying sobriety

[S]uperordinate theme 2 is a direct quote from AA World Services Inc., (2001, pp. 83).

4.6.1.(i) Superordinate theme 1: From alcohol dependence to engagement in a 12-step programme

The first superordinate theme for this group may have much in common with the equivalent theme for Group 1. How the participants came to attend and participate in the 12-step fellowship is vital to remember – the precursors , how they got to their nadir and what made them decide to take action. Having done so, they feel a deep sense of gratitude about the present and know what they must do to keep what they have found.

Table 12 describes each group member's age and time from their first drink to severe dependency, along with one of their primary underlying developmental issues.

Table 11: (20 years) Name, first drink, dependency and main developmental issue (n=5)

Name	Age of first drink	Abuse/dependency	Developmental issue
Participant 7	15	1-2 years	Violent dysfunctional home
Participant 8	Not known	24/Marriage	Despair, worry and insecure
Participant 9	12	Immediate	AUD Home
Participant 10	16	Immediate	Both parents AUD's
Participant 11	Not known	23 yrs. of age	Completely emotionless despite 17 yrs of therapy

Index 5, Table 2 sets out in more detail early dysfunctionalities for this group.

Table 12: Group 2, Superordinate theme 1: themes (n=2)

Superordinate theme 1: From alcohol dependence to engagement in a 12-step programme	
Themes	
1	The onset of alcohol dependency through to acceptance and action
2	Experiential impact of first and early meetings

4.6.2.(i).(a) Theme 1 – The onset of alcohol dependency through to acceptance and action

As with the previous group, each participant described an immediate reaction when taking their first alcoholic drink. However, they refer to that experience in a slightly different way. It is more like a necessary "introduction" to the narrative of their recovery.

Participant 7 described her first experience with alcohol when she was 15. She got so drunk that she vomited, blacked out (1:13), and a doctor had to be called (2:45). She described how alcohol,

> *"... kind of turbo-charged my whole experience of the 'party'"* (1:17-8). *"I only like alcohol for what it allows me to do socially, which is, it disinhibits me on the dance floor, it disinhibits me in conversation, it disinhibits me sexually, it allowed me to live large"* (3:74-7).

Participant 8 had been drinking socially for a few years until his alcohol consumption became problematic by the age of 24, and he continued to drink daily for the next 35 years. Despite being hospitalized several times during this period from alcohol-induced seizures, he continued to drink. Nor did local stigmatization impede his behavior. "*It was my GP who suggested I contacted Alcoholics Anonymous.... and I thought, the cheeky bastard"* (3:59-61). *"I had no time for her whatsoever because she was telling the truth"* (3:86-7).
Participant 9's abuse of alcohol started when he was 12 and continued as *"It allowed me to be me"* (1:26) and "*Moderation wasn't part of it"* (2:36). "*It was immediately drink, get drunk, it was always like that. I never classified myself as a social drinker"* (2:39-40). He was living in the US and now acknowledges that his drinking was problematic from that age. He was getting picked up by the police numerous times by the age of 14-15. The problem, for him, was compounded by his use of psychedelics. He spoke at length of his adventures and misadventures with alcohol and drugs until he says, *"What brought me to AA was right at this time when the marriage broke up, I had no place to stay. I was homeless..."* (11:319-20).

Participant 10 started drinking around 16 years of age. From 18, he cannot recall a day or time he was not drinking. His regular diet was vodka mixed with Guinness. He kept up daily drinking until 41. *"My mum suffered with this illness and my dad suffered with it as well"* (3:61-2). He mentioned that "*there was never any kind of love* [at home]*"* (3:71).

Blackouts became a feature of his drinking, and he mentioned, *"I had 15 years of holidays with kids, and I've no recollection of it"* (5:137-8).

Participant 11 realized he had an alcohol dependency issue when he was 23. His drinking caught up with him, and *"then there were 17 years of – in those 17 years there was psychotherapy. I* [also] *went to a psychoanalyst for seven years"* (1:18-9) because he felt *"...there was something wrong with me, because I felt I didn't fit in, I felt less than, I was depressed. I didn't know what was wrong with me, basically"* (2:23-5). All this treatment was to no avail, and he drank his way through it (2:27). He said, "*You get used to being miserable"* (2:37).

All the participants spent many years drinking excessively before their condition forced them to decide that *"We stood at the turning point"* (AA World Services Inc., 2001, p. 59) – that is to take action about their drinking, go insane, end up in prison, or die.

4.6.2.(i).(b) Theme 2 – Impact of first and early meetings

Attendance at the first meeting for this group of participants was like the previous group. They felt welcomed, accepted precisely as they were, and began to get hope of living sober.

Despite watching her husband die from AUD, Participant 7 continued to drink. Two years later, and after a dreadful night of intoxication, she changed from being alcohol dependent to "*... one who's totally passionate and inspired and motivated to be abstinent"* (8:227-8). Although she had previously attended AA without much enthusiasm, she returned to re-try it seriously. *"So, I walked back to it – I was kind of skipping when I went back to it. I was kind of, 'I'm back'"*

(11:331-2), and they were all glad to "*Welcome me with open arms"* (12:335). Participant 7 referred to her altered attitude as a "*transition*".

Participant 8 did go reluctantly to an AA meeting that he sourced via an AA helpline on his doctor's advice.

> *"When I went into the meeting, it was very, very strange.*" (11:111). *"I got hope that first time. ... I'd stopped many times prior to that, but I could never stay stopped."* (4:113-5). *"The welcome I got in that first time was one thing that I think – I still believe that in AA the welcome you get into the first meeting is very important"* (5:125-7).

At first, he was apprehensive about the "*God thing*" until he heard it described as a spiritual programme. He lost his thoughts on suiciding, feelings of worthlessness and emptiness, and his alcoholic behavior changed "*I would say almost straight away"* (8:211). However, he feels that it took him two years to become a better husband, father and worker.

Participant 9's first experience of a meeting was, "*Yeah, the first meeting, I think I had mixed feelings"* (12:369*).* However, *"I recognized that what they were talking about was what I had. I was like them. I got identification from listening to the stories"* (13:388-90). He was also greatly taken by the idea that he had "*...a specific disease with specific symptoms"* (14:407-8). He also remembered some of the "slogans" (Appendix 13). However, after multiple relapses and trying Cognitive Behavioral Therapy, Rational Emotional Behavior Therapy (18:554-9), and various other treatment approaches on nearly 20 occasions, he became "*sick and tired of being sick and tired"* (15:468) and re-joined one of the local and longest-standing AA groups near his home, which he still attends.

Participant 10 still recalls his first meeting vividly. There were about 40 people at it. Again, the concept that he had a disease resonated with him and remains with him today. The first message he picked up from AA was, "*I have an illness and there was a way out"* (18:574). His newfound hope became more established as he went to more and more meetings because he began to identify with others; they had the same problems in their early years, and they had coped with them. Participant 10's experience was that, on going in,

> "*I mean I was welcomed, and I was given a cup of tea, they gave me a hug, they shook my hand you know I was made welcome... one man from my parish says, I've been keeping a seat for you."* (14:444-8) "*I was able to think they've done it you know I've done it"* (16:505-6). *"Yes, I do say you're the black sheep of the family and you've found your flock"* (17:531-2).

On his third attempt, when Participant 11 fully accepted his condition, he went to a meeting with that in mind. Like many meetings in the US, it had > 100 present "*But my experience of my first meeting is that I did say, my name is "Participant 11" and I'm an alcoholic. I'd never called myself an alcoholic before, certainly not in public and certainly not in front of 100 other people"* (4:11720). A member told him, "'*...keep coming back.'*

That was it really" (5:133-4). Participant 11 said that he still had that feeling of not having any feelings but, notwithstanding that, went every day for 18 months. One of the first messages he picked up was, *"You don't get well and do the steps; you do the steps to get well"* (7:202-3). He also got the message that he had to get a sponsor and "do the steps" (abv.).

From this theme, it seems there is a low level of general knowledge of what 12-step fellowships are about, how they function and how they unconditionally welcome new or returning members.

4.6.2.(iii) Superordinate theme 2: "The spiritual life is not a theory – *we have to live it"*

In this second superordinate theme, the participants (again) described how they reacted to being required to trust God/higher power. However, in this group the participants have an additional 10 years of experience; they now have a different, more accepting view of this premise and accept that it is fundamental to their continued sobriety.

Table 13: Group 2, Superordinate theme 2: themes (n=2)

Superordinate theme 2 – "The spiritual life is not a theory – *we have to live it*"	
Themes	
3	Higher power/God as an integral part of the 12-step programme
4	"Engaging with a sponsor" (abv.) and initial experience of "doing the steps" (Abv.)"

4.6.2.(iii).(c) Theme 3 - Higher power/God as an integral part of the 12-step programme

This theme shows that although God/spirituality are an integral part of the 12-step programme, not all the participants were prepared to accept this concept totally without reservation.

Participant 7 described herself as an atheist, but at her very worst moment, having been vomiting into a toilet bowl for eight hours, cried out, "*God help me"* (8:238), and in a split

second it was over for her.

> "*My relationship with alcohol was just totally removed. It was just gone, in that split second"* (8:240-2) *"and literally I was able then to lift myself off my legs – off my knees and walk back to my bath - back to my bed and go to sleep for a few hours before the next morning I woke up and actually went to work. Then at the end of that working day, I went to AA*" (11:318-21).

(Her first "real" meeting is mentioned earlier in Theme 2 above. Despite the event described and the consequences for her, Participant 7 retains an ambivalence towards the concept of "God", occasionally interchanging it with "Group of Drunks" (abv.)).

Although describing the programme as a spiritual one, Participant 8 did not discuss that part of his recovery and said he leaves religion out of it altogether now. His reticence was challenging to understand as, of all the participants, he exuded a total level of calmness – of being at peace with himself. However, he referred to it later when he said: *"I still have a faith"* (17:500). The effect of this "acceptance" is described later in Theme 5.

Participant 9, at around 17 or 18, was already alcohol dependent (compounding the problem with the use of psychedelic drugs) and described his "spiritual awakening" as follows:

> "*I took a fairly large dose, maybe about five times the normal dosage for that drug, and I had a spiritual experience. Something happened. It's hard to explain, but it completely altered my life. Since from that day on, I've never been the same from it. It was such a profound experience.... It's one of the strange properties of psychedelics is it can provoke spiritual-like experiences, what sometimes they refer to as the 'ego death'"* (5-6:149-155*). "But it changed me in a psychological way that I discovered that this thing, that people with religions talking about God, was inside me"* (6:157-9).

He got involved in yoga and other practices, but "*what I didn't realize was that I still was an alcoholic and I didn't really have a defense – even though I experienced God and different spiritual things"* (6:176-8).

Participant 10 had been reared a Catholic and has returned to the practicing of that faith. He did not expand on the spiritual dimension to the AA programme except to say that *"I honestly believe if you've never had a God in your life, then you might have some kind of hole in it and that you don't have a conscience"* (17-18:546-7).

Participant 11 was raised a Catholic but lost his faith and became agnostic. "*I often thought God was someone you found on your deathbed, just in case"* (14:391-2). His sponsor told him to pray for "a sober day" on his knees, and he was horrified by this suggestion, but he did it, despite his reluctance (14:394). He has built on this practice of praying in the morning for a sober day and thanking God at night for having had one. While he does use the steps 3, 7 and 11 prayers (Appendix 14), he said he is not one of the "*God Squad"* (14:402). He uses yoga and meditation and finds them quite spiritual. He still reflects doubts, though, "*Yeah, I say my prayers. I'm not sure about God"* (14:712).

This theme shows that, notwithstanding initial reservations about the 'God/higher power aspects, these participants became more open and accepting to this new grounding approach towards life and recovery.

4.6.2.(ii).(d) Theme 4 – "engaging with a sponsor" (abv.) and initial experience of "doing the steps" (abv.)"

This theme highlights the vital role a sponsor may play in the evolution of sobriety for newer
members.

Almost from the beginning, Participant 7 has had a sponsor. Sponsors have changed over the years for her, and she believes very much in sponsorship. However, Participant 7 did not discuss going through the 12 steps specifically but did advert to the profound effect of step 9 and the promises.

She had been moaning that she was so long into recovery, and she was *"grouchy, complaining and whining"* (21:611); that the promises had not come true, that it was all a bit of nonsense, and they "*weren't really true".*

> *"Then somebody pointed out to me that in the Big Book...it says this is what you'll experience when you're halfway through step 9... if we are painstaking about this phase of our development... So, I was quite arrogant and condescending in my attitude, saying, so, you're telling me, that exactly when I get halfway through my step 9, I'm going to suddenly have this cascade of these promises coming true for me, and I'm going to feel wonderfully and miraculously different from how I do right now"* (21:612- 20).

Her sponsor pointed out that was the way it was, and she could not help. Participant 7 was aware that one "amend" to her mother remained unresolved. She recounted the experience, describing it in advance as sounding a bit too wacky, but it was her experience.

> *"I sat on the stairs of the house that my mother and father lived in and talked to my mother about my journey of recovery, and I told her about what I was trying to achieve, which was to be sober, but also to be a better person, and in that moment, something happened between us. The woman that I had never been sure if she loved me, she hugged me and held me, and something very powerful happened between us, and a lot of my insecurities about who I was, and whether I was lovable, and whether I would survive in life just started evaporating as a result of that conversation with my mother"* (21:632-40).

Participant 8 has never either gone through the steps "officially" or had a sponsor as such. *"...but I know that there's plenty of people that I can talk to in Alcoholics Anonymous and share with on a one-to-one basis if I want no matter what ...the subject is"* (6:156-60). He said, "*I believe I work the steps in my life on a daily basis. That's what I believe"* (14:402).

When Participant 9 went through the steps of AA again with a sponsor, in his current period of sobriety, he heard something that *"...was almost like one of these magical moments"* (22:675-6).

Simplified, he described how, if a boat's compass is off by one degree over a few miles, it does not matter; but over 1,000 miles, the boat gets completely lost. Participant 9 finds his compass is realigned by attending at least five meetings a week, and he knows he cannot afford complacency based on his previous experiences.

Although Participant 10 had been sober over a year and attended step meetings, he found ordinary domestic life difficult. He mentioned this at meetings and, after one meeting,

> *"I had a guy with MS that was on two walking sticks, and he had me one day up against a wall in the meeting with his crutch under my chin saying you effing so and so. The life you've put – he didn't know much of my story but the life you've given them kids, knowing you're effing moaning about having to drop them off and be dad's taxis, it should be a privilege to you. So, I sort of learned that way, no, I learned the hard way"* (22-3:702-9).

On another occasion, a fellow member described him as "*an effin defect looking for a character*" (24:754-5). Soon afterwards, Participant 10 got involved in a small "group

sponsorship" (abv.), which significantly impacted his acceptance and attitude.

Participant 11 also got a sponsor at that second meeting, and the same man is still his sponsor to this day, 22 years on. At later meetings, he also picked up that "doing service" (abv.) was a vital element of recovery, and he has been involved almost continuously to this day. He went through the steps with him – during which his mother died. Participant 11 felt very little remorse or grief about her passing and has spoken to his sponsor about it. He still has some issues around the matter to this day.

This theme shows the effect of having a sponsor, even if that sponsor has no formal therapeutically related training, by providing an external overview or comment to a fellow member on some difficulty or situation troubling them.

4.6.2.(iii) Superordinate theme 3: Emotional sobriety and quality of life improvements

The third superordinate theme deals mainly with emotional sobriety – a concept of which both AA and academia are not unaware. However, only one participant within Group 1 (Participant 6, a counsellor) adverted to the subject. In this group, where negative realities of life have begun to occur, all the participants brought up the subject of emotional sobriety as a material factor in their sobriety.

Table 14: Group 2, Superordinate theme 3: themes (n=2)

Superordinate theme 3 - Emotional sobriety and quality of life improvements	
Themes	
5	Development of emotional sobriety
6	Changes experienced and quality of life improvements during their sobriety period

4.6.2. (iii).(e) Theme 5 – Development of emotional sobriety

This theme shows that while physical sobriety may come about quickly, emotional sobriety, an integral part of 12-step programmes, takes a great deal longer to acknowledge

and address in a non-professional environment.

Participant 7 described her "*...coming back to sanity has been a very long, slow process"* (13:383-4), and when talking about length, she is referring to 10 years. After six years of sobriety, her return to the UK was emotionally very unsettling as she had loved living in the Tropical Islands. Participant 7 feels emotional sobriety is as essential as physical sobriety. She also went through another emotional upheaval after nine years when a relationship she was in broke up. *"The emotional pain associated with that break-up was so huge, that I wanted to die"* (15:433-4). She joined SLAA (Sex and Love Addicts Anonymous) to deal with her emotional and love issues. She has also encountered other negative emotional situations, such as bullying at work and her parents' deaths. Her attendance dropped to two meetings a week, but she also works as a therapist. She balances her low numbers by attending many conventions every year, where she may attend six meetings over three days. I asked her directly whether, during any of the traumas discussed, she thought about picking up a drink, and she emphatically said, "*Not remotely"* (17:511).

Participant 8 was six years into his sobriety when his wife developed cancer, and he nursed her daily for two years. When Marie Curie nurses came in three times a week, he would go to a meeting.

Participant 8 was "*very grateful"* (9:250) to be sober and be able to look after her. He had "*No inclination whatsoever"* (9:265) to drink. After 10-11 years, he had a new partner who also died from cancer. Again, there was no question of him relapsing. He also had a subsequent partner, but they separated. Participant 8 considers that emotional recovery is imperative as it makes relationships more authentic. Almost from the beginning, he engaged in doing service – answering helplines, getting rooms ready, making tea/coffee, and so forth. He believes that service is an integral part of recovery – "giving back".

When acknowledging he was alcohol dependent, Participant 9 said, "*There are two parts to that for me. One is the dependency on an emotional and mental level, and then there was physical dependency where I would get withdrawal symptoms. Probably, the emotional dependence would have happened maybe a couple of years after"* (2:49-52). He does not advert, however, to how he dealt with these issues in his recovery. It may well have been difficult for him to pinpoint, having regard to the multiplicity of treatment approaches he

had tried before joining AA.

Participant 10 referred briefly to this concept when he said, *"I thought it was purely maybe God and prayers. I never knew there was a kind of physical, emotional, and just a chat or that whole thing"* (17:520-2).

Similarly, Participant 11 became aware of the emotional side of sobriety as he had said to his doctor, *"I just said to him, I'm completely emotionless. I've got no feelings about anybody or anything. I suppose a narcissistic sort of attitude"* (2:54-8). However, he went on to say that the good and bad news of the programme is that "*...you get your feelings back"* (10:286 and 10:289). It took him about five years to experience their return.

The significant point of this theme is that while emotional sobriety is a crucial element of the programme, it takes until their second decade of sobriety before it comes to the fore for members, and then becomes addressed and ingrained in the member's psyche – despite their having gone through the steps with a sponsor.

4.6.2.(iii).(f) Theme 6 – Changes experienced and quality of life improvements during their sobriety period

This theme sets out benefits the participants obtained through the programme, apart from remaining sober.

Participant 7 described what it was like and how things changed for her. She had called on a God that she did not believe in, and He helped her live through a painful change of homeplace; she made peace with a broken romance and found that her mother did love her. She currently has a husband she adores; she has her idealized job and a "God" of her understanding. When asked about having a life beyond her wildest dreams, she said

> *"One day, quite recently, I opened a book, and a piece of paper fluttered out that was a list of the things I'd wanted, and it was remarkable how much of it had come true... I think these were lists that I wrote since I moved over from the Tropical Islands, which is now 16 years ago. But there were lists that concerned my physical health, my general appearance, my owning property, my being in a relationship, my job situation, and I think it's all come true. Even stuff that I thought was impossible, has come true"* (20:591-9).

Participant 8 reflects "*no comparison whatsoever"* (12:336) between his life before he quit alcohol and now. He has recently made amends with his brother and wife, who live in New Zealand, as he will probably never see them again. He says, "... *biggest change is I'm able to do what I want when I want. Go to a sunny resort for six months of the year and enjoy the sunshine for six months, hopefully"* (12:338-40).

Participant 9 did not comment much on his life at this time or how his recovery evolved up to now. He is working as a counsellor and said he favored the Rogerian type of approach to his work.

Participant 10 expressed some uncertainty about whether there has been any improvement in his "conscious contact with God" (that he always had) over, maybe, the last 15 years. He does, however, have a definite daily routine of thanking God in the morning for his day. "*You know I woke up and thanked him for my day and then I went out there and sat and had a good 10, 15 minutes and just…went through, yes, went through my prayers and then even tonight at 11 o'clock"* (27:843-6). Step 10 is a daily practice that helps him deal with problems as they arise.

Participant 11 described how his attitude has changed during his membership in several ways, drawing on what he has learned and absorbed. Examples are "*Just for today, I will not criticize"* (12: 356), doing a daily inventory of how he has behaved (step 10) and feeling he is "...*free from the bondage of self*" (13:374). Participant 11 sums it up by saying, "*So, life has taken on a new meaning...my life has opened up"* (12:334-5). He could not pinpoint specific changes in the previous 10-20 years but says, "*I'm very content with life at the moment"* (17:503-4). Earlier, he did say that after five years, the good news was that he got his feelings back, and the bad news was that he got his feeling back (10:286-9). This comment contrasts with his lack of affect despite his attendance with psychiatrists and psychoanalysts before joining AA.

This theme identified that the underlying changes and improvements in the quality of their lives derived from addressing and incorporating an alteration in their emotional attitudes. They have learned to appreciate both the good and bad things that can happen to and within themselves, how to handle them and avoid causing difficulties for others.

4.6.2.(iv) Superordinate theme 7: Living and enjoying sobriety

In the fourth Superordinate theme, "life after alcohol cessation" is explored by the participants from three different perspectives – what they have learned from the 12-step group, what they believe the messages passed on to them by the forebearers to be, and how the idealized life promised by the programme is coming to fruition.

Table 15: Group 2, Superordinate Theme 4: themes (n=2)

Superordinate theme 4 – Living and enjoying sobriety	
Themes	
7	Personal perspectives of participants on the development of their recovery
8	Key messages as perceived by participants

4.6.2.(iv).(g) Theme 7 - Personal perspectives of participants on the development of their recovery

This theme elicited from the participants their perceptions of personal growth for them through their 12-step programme.

Participant 7 felt she was not self-centered anymore. She said, "*The difference is, whereas before, I could never see anything from another person's perspective, and I wouldn't take other people's struggles into account. Now I really do*" (25:732-4).

Participant 8 felt that it had been a gradual process, adapting his way of life to the AA suggested way of living by the 12-steps - on a daily basis.

Participant 9 did not speak much about how his sobriety is evolving except to say "*Well, I think one thing is that the disease concept is that I'm still alcoholic. If I go back to drinking, I drink alcoholically. So, the allergy side of it is..."* (21:650-1) and that the 12 steps help him steer the right course.

Participant 10 felt that his sobriety has evolved through his interpretation of the AA messages:

> *"...like my life is manageable, my manner, my thoughts and my actions are manageable. I have a daily routine where my higher power – like you were saying the third step prayer. You know, in the past, I've been – they have been done, my shortcomings and my defects are still there but I know how to – I can instantly recognize them. Or I can actually stop myself before I say something. Yes, that I seem to be influenced by them – I'd just be able to, I can place myself."* (26:8235).

About whether he felt it was a good idea to go to the first meeting, Participant 11 said that *"Without a doubt, I've no regrets ...I share it's been the best years of my life, that's not to say I haven't had difficult times*" (15:438-40). When asked if the programme helped with those difficulties he replied, "*Oh God (!!) yeah, Without a doubt"* (15:443). He feels that his sobriety has developed over the 22 years (16:470).

This theme's point was that none of the participants had any negative connotations concerning their personal development or growth; they had dealt with various personal traumas without reverting to alcohol and expressed that their evolving sobriety has all been positive.

4.6.2.(iv).(h) Theme 8 – Key Messages as perceived by participants

As with the first group, none of the participants could identify their fellowship's specific messages passed on to them.

Participant 7 did not specify any message except that "*life would be barren, dry and joyless*" (29:865). She felt that she could not survive indefinitely without it. She loves the fact that her journey of personal development will continue.

Participant 8 is sure he would be dead without the programme – he used to drink three litres of vodka per day. The key message he picked up from the beginning is *"I would say it's been a gradual process how I've adapted my way of life to AA way of living the 12 steps on a daily basis"* (18:514-5), and he tries to bring the principles into his everyday life (18:519).

When asked directly about what had carried him through the last 20 years, Participant 9

said it was the message of AA's disease concept – that he still has an allergy to alcohol, and if he picks it up again, he will revert to where he was at on his last relapse.

Participant 10's view of AA's key message is that AUD is an illness, and there was a way out.

Participant 11 identified four messages that resonated for him 1. Keep coming back; 2. You don't get well and do the steps; you do the steps and get well; 3. Get a sponsor and go through the steps with them; and 4. Get involved in service.

The overall point emerging from this group, as well, is that participants were unable to identify any specific message or messages from their fellowship that they were supposed to promulgate.

4.7 Group 2 summary

From this group of participants, the recovery process elements develop and become part of their lives. Participant 8's handling of two of his wives' deaths is a clear example of the developmental nature of psychological and emotional sobriety over time. Participant 7, too, went through some complex emotional traumas but never thought of relapsing. Participant 11, who had undergone multiple unsuccessful psychological therapies, regained his ability to "feel" things through practicing the programme. Participant 10, a qualified counsellor, gave no credit to anything he had formally learned in college and described his recovery solely in the program's context and attending meetings. Within the time limitations of interviews, some interesting points could not be explored in depth. However, the participants' view of the reality of the promises (Appendix 12) shows fewer qualifications and no outright denial of their veracity about gaining a better way of living. Even those who proclaim to be atheistic are now more open to the suggestion of having received help from a power greater than themselves.

Overall, my sense-making of this group's development was that they had learned that life without alcohol was infinitely preferable to that lived during active dependency, and that although life comes with no guarantees, there is a way to cope with any adverse situation. The slogan (Appendix 13) "One day at a time" is not a trite expression but a pragmatic response to addressing potentially deadly pitfalls as they occur – a type of situation that

would, when they tried to stay sober on their own in the past, have re-triggered their "dis-ease" at such an unguarded time.

At this point it is beginning to emerge from the interviews that, so far, 12-step groups may not be promulgating a specific message – only suggested modifications to internal belief and behavioural systems achievable through their 12-step methodology.

4.8 Group 3 – Enjoying the sober life: Participants with 30 years' sobriety and recovery +/- 2 years

4.8.1 Introduction

There was a change with the interviews' underlying characteristic spirit, which emerges from the participants' narratives with this group. Although they, too, tended to fall back on the format "*... what it was like, what happened and what it is like now…",* their focus on how they have changed and how they are now varied considerably in emphasis from the earlier groups. They are more settled in their present lives, learning what unsettles them and avoiding such situations. They were happy, and, in general, enjoyed how they live their lives now.

Table 16: Group 3 – setting out participant number, age, gender, location over the majority of sobriety years, and sobriety length (n=5)

Participant ID	Age (years)	Gender	Location of residency over the last 30 years	Length of sobriety (years)
Participant 12	67	Male	England	30
Participant 13	58	Male	Spain	30
Participant 14	66	Male	Ireland	30
Participant 15	61	Male	Wales	32
Participant 16	68	Female	Spain	30

As with the two previous groups, a line-by-line analysis of every interview took place. The interviews continued to begin with the same open-ended question posed to the participants of previous groups. The following superordinate themes emerged, with two themes associated with each.

Table 17: Group 3, superordinate themes (n=3)

Group 3	
Superordinate theme 1	From alcohol dependence to engagement in a 12-step programme
Superordinate theme 2	Spiritual and personal development
Superordinate theme 3	Key messages

4.8.2.(i) Superordinate theme 1: From alcohol dependence to engagement in a 12-step programme

The first superordinate theme again revisits the participants' alcohol dependency development, their acceptance of their situation and how they addressed it. However, their narratives were, by comparison, more dispassionate and objective but still formed an essential fundamental ingredient for their need for ongoing participation in their 12-step programme.

Table 18: Group 3, Superordinate theme 1: themes (n=2)

Superordinate Theme 1: From alcohol dependence to engagement in a 12-step programme	
Themes	
1	The onset of alcohol dependency, first meetings and perceptions
2	"Engaging with a sponsor" (abv.) and initial experience of "doing the steps" (abv.)"

4.8.2.(i).(a) Theme 1 – The onset of alcohol dependency, first meetings and perceptions

In this theme, the participants still remember the most damaging aspects of growing up, as did the participants in the last two groups. Recollections of early childhood traumas and subsequent dysfunctional behaviors were still quite clear for them. However, they contextualize them more about developing their alcohol dependence – becoming slightly less of focal points (war stories, abv.) and more as reminders of "mind sets" to be alert to, to avoid relapsing.

Table 19: Group 3, Name, first drink, dependency and main developmental issue (n=5)

Name	Age of first drink	Abuse/dependency	Developmental issue
Participant 12	16	Immediate	Mother alcoholic
Participant 13	13	Immediate	Felt lost as a child; illnesses
Participant 14	11	Immediate	"Never fitted in"
Participant 15	20s	5 years	3 family deaths, married at 19
Participant 16	25	1 year	Shy but extreme at all sports

Index 5, Table 3 sets out in more detail early dysfunctionalities for this group.

Participant 12 describes his childhood as "…*brilliant. It was fantastic"* (1:8) and *"I had a very liberal childhood"* (1:26-7). However, I felt an element of "euphoric recall" to his recollection because he subsequently described his father's frequent absences from home as a lorry driver and his mother's AUD. In the full transcript of his interview, he was rarely subject to any form of parental control. Participant 12 had his first drink at 16, and within six weeks of that first drink, drunkenness was to become a way of life for him. Even the loss of a limb in an accident while driving drunk did not stop him. He voluntarily walked out of the family home to sleep rough in a car for 18 months. He came to realize he had to stop or die *"... the pocket was empty, the soul was empty, and the bottle was empty, I had nothing"* (12:336-7). He met an old friend he knew to be in AA; Participant 12 told him that he was suicidal, and that friend brought him to his first meeting. He recalled that exact date and said of it:

> "*I knew something was going to happen* (15*:*406). *I have not had a drink since"* (16:438). "*I knew that a lot of them knew me because I drank with most of them. I didn't know where they had gone to; I thought they'd vanished off the face of the earth*" (17:461-3) and "*...coming out the door thinking... maybe, just maybe"* (17:470).

Participant 13, from early childhood, had chronic asthma and was reared on a mixture of hot whiskies and codeine-based cough bottles. He described himself as *"very unhappy and unsettled as a child"* (1:20). He felt that "*...as a young lad I was lost"* (1:25). He described how he was "*...in and out of hospital like McDonalds'"* (2:34). He started drinking between 12 and 14 and has no idea what social drinking entails. He was either on alcohol, Valium, Dalmane or some illegal drug all his life. *"I always had something in my system"* (5:130). While he was bullied in school, moving to a new house at a young age had a significant impact on him – he felt even more isolated and lonely. His drug and alcohol

"blackout" states were unpredictable. He could go into a blind rage [psychotic state] and injure people (4:103; 9:235 and 9:244-8). He described his family as dysfunctional due to drinking, drugs, sex, and gambling –*"the direct opposite of the Walton's"* (11:295-6). As things got particularly bad, he recalls:

> *"I remember sitting down in the kitchen and rocking with my daughter and asking her, how was I going to get out of this? I was just so broken and so hurt. I was lost, really, at that stage, and asking a six-month-old child for help"* (11:305-8).

Participant 13 was in and out of AA for some years before a sequence of events brought the reality of how bad things were really for him. A doctor in a psychiatric ward looked at his chart and commented, "*Another fucking drunk",* threw his chart on the bed and walked away; he ended up *"...on my knees saying God if you're out there just help me get a few hours sleep"* (18:4989). Finally, the catalyst for him was the guilt, shame and remorse that he would experience every morning he woke up. One day, in total despair, he asked a friend what he could do and his friend *"...wrapped his arms around me, and he said' I'm glad you're feeling so bad. He said, Participant 13, you need never feel this bad again"* (19;525-7) and brought him to the first AA meeting that he took seriously.

Participant 14's drinking started at 11. He believes he had the ISMs (detrimental dependency, overpowering need to consume more despite harmful consequences, and so forth; abv.) of AUD long before that. He felt he did not fit in in school and was "*...a bundle of nerves"* (2: 42) but after his first alcoholic drink *"... it gave me the delusion that it was the secret of life, that this is it, this is how a person becomes happy. It gave me ease and comfort"* (2:37-9). He does not describe much of his childhood. After years of family squabbles over lack of money and non-payment of bills, his extended family threatened him with psychiatric restraint. He had tried "geographicals" (abv.) but still faced ruin. His wife gave him an option – either go to an AA meeting or leave, so despite his best excuses and her insistence that she accompany him,

"*...that's the way I was driven to AA, kicking and screaming like a child going to kindergarten"* (3:81-2). *"But what I found there then was unexpected*" (3:82). He described his welcome to and his experience at his first meeting as follows:

> *"But what I found at the meeting was people like myself, and they were the kind of people I drank with, and I knew some of them. They'd done the*

> *impossible I'd seen. They'd stopped drinking and they were happy. Now' I'd stopped drinking thousands of times throughout my life drinking, and I'd be totally miserable."* (3:84-8).

Up to that moment, he had always believed that it was not the drink that was his problem – that drink was his friend. Again, his own words best sum up his experience:

> *"But the things that I heard that first night, I had a moment of clarity that lasted from 8:30 to 1 o'clock, the length of the meeting. I heard everyone that shared, I listened, and I identified with them. I thought the wife had gone ahead of me and told them everything because the identification was just total....* (4:115-22). *I knew they weren't bullshitting...* (4:116). *They were talking about loneliness and isolation and blackouts and trouble of every description"* (4:117-9).

His biggest worry after the meeting was what he would do next to "*stay sober under all conditions"* (6:163-4). He stated that he realized he was more allergic to being sober than to alcohol.

Participant 15's narrative was one of the more harrowing I encountered. Between the ages of 16 and 17, his sister died in a car accident. His father and grandparents (who lived with them) also died.

He was a father by 19, got married immediately, and shortly after had two more children. "*I was drinking alcoholically by my early twenties"* (2:32-3). He spent money for vital medication for his son on alcohol *"...he* [his son] *would end up in accident and emergency on a nebulizer while I was buying complete strangers pints..."* (2:50-2). He too tried "geographics" (abv.) to no avail. But after the threat of eviction and with assistance from his employers, he entered treatment and first encountered AA. He said, *"I joined AA because my secret came out, I didn't willingly join them"* (3:66-7). He had to attend, as it was a requirement of his Employee Assistance Programme. Although the group was a tough "front-line" one (abv.), he was "*...swamped. I just got loved"* (4:98). He was encouraged to get involved in service, and he described in a humorous way how once he was entrusted with £50 to buy literature and ran all the way (a few miles) to the Head Office in case he would stop and spend it on drink.

Participant 16 was initially able to drink socially until she went to London with another lady. Alcohol usage became problematic when that relationship broke up. Participant 16 seems to have never accepted her sexual orientation to this day, and it colors all relational aspects of her life. She was always a high achiever at whatever she did but, *"A thing that I*

found very hard to do my whole life was to have conversation with people. While having had drink in me, I found it no problem whatsoever" (1:30-2). After a car crash caused by her while drunk, her father offered her admission to a treatment centre, but Participant 16 declined the offer. She binge drank for some years until she reached a particular day in 1987 when she found that she could not stop drinking at all. Participant 16 recalls, *"... I called to some AA members...* (2:57-8) *I was suicidal. I just didn't want to live anymore because it was sheer hell, it was agony with it and agony without it"* (23:63-5) and was brought to a meeting by a friend. Even though she had been drinking all day, she felt "*...for some reason that I was in the right place"* (3:77). She told her mother about it, but her mother responded that she did not care what she did, and that remark rankles with her to this day. It was then she realized how much pain she had caused others. The welcome of other members and the phrase "*Keep coming back*" brought her to her next meeting. She prayed, *"God, please stay between me and the drink"* (4:115-6) and that kept her going to meetings *"...for a very, very long time*" (4:117-8). The significance of this is that, while she did admit to her alcohol dependence, she did not accept it or follow the suggested programme for many years.

This theme shows the disparate routes and misery that the participants endured before attending, for whatever reason, their first meeting, linking those experiences to the grounding of their present sobriety.

4.8.2.(i).(b) Theme 2 – "engaging with a sponsor" (abv.) and initial experience of "doing the steps" (abv.)"

This theme explores why some participants engaged with a sponsor to help them address underlying issues while others did not.

Participant 12 never formally "did the steps" or had a sponsor. It took more than 10 years before he began to take them seriously and, he did so by attending "step meetings" (abv.). He felt that a sponsor was too like a boss. Instead, he preferred to confide his problems with good friends that he could relate to and trust. There was one individual to whom he would turn with most of his problems. The man was abrupt, would give his response and walk away with no discussion. Participant 12 refuses to act as a sponsor but does advise

anyone how he, himself, would deal with any specific problem.

Participant 13 was "taken" by one individual almost from his first meeting who acted as his sponsor. He let him away with nothing and called a spade a spade. He seemed to have the ability to get inside Participant 13's head (20:557). He took him through the Big Book (abv.) and the 12 steps and remained his sponsor until he died. Participant 13 described him in this quote:

> *"He said to me one night, what do you do if you get a new television or video? I said, you fucking put it up on the counter and you play around with it for an hour. That's right, he says. What do you do after an hour? I said, after an hour, you get the fucking instruction manual to find out how it works. That's right, he says. He got his crutch and limped forward, and he picked up The Big Book and he fucking threw it at me. He said, there's the instruction manual"* (20:562-8).

However, the programme, the steps and sponsorship did not resolve every issue for Participant 13. He found that after 10 years he was reverting to his old ways of thinking and behaving, "*...an unease had come upon me again"* (24:682-3), and this required counselling or outside help to address issues going back to his childhood. This dis-ease recurred again after 16 years and required outside assistance, which he immediately sought.

After his first few meetings, Participant 14 realized that he needed to immerse himself straight away in the programme by getting a sponsor, going through the steps, and doing service. He did all three. Like all the others, he remembers the exact date of his first meeting and, instead of counting years, uses an "app" on his phone to count the number of days of sobriety since he genuinely believes that it is just "*one day at a time"*. The most influential advice he got from his first sponsor *"...was to design your own sobriety, and there's no bounds, and there's no conditions"* (23:593-5). He believes that having a sponsor and "doing service" (abv.) – especially prison service (abv.) – are vitally important to his recovery.

Participant 15 had started the first five steps in treatment and continued with the rest once he started going to "ordinary" meetings. He has had the same sponsor from the beginning until he (the sponsor) died recently. He strongly advocates that recovery results from doing the steps and doing service – a good portion of his time is devoted to "prison service" like Participant 14.

Participant 16 had found that the euphoria of her first six months sober began to wear off and, although she accepted that she was "*powerless over alcohol and that my life had become unmanageable"* (AA World Services Inc*.,* 2001, p. 59, step 1), she relied on the nine "slogans" of AA (abv.) to help keep her sober, saying them repeatedly during the day. It took her seven years to go through steps 4 and 5 with a monk, but I sensed some omitted issues in that discussion. She has never had a formal sponsor. After 10 years, she found she had come a long way and "*could see my character defects were very clear"* (9:261-2). She describes herself as a "*very, very, slow worker"* (10:299) and, by that time, had only got to step 6. Between 14 and 20 years, she tried numerous times to quit AA "*... but I would feel so bad in myself that I would run to an AA meeting"* (11: 325-6). Between 20 and 30 years, she appears to have completed the steps without explicitly saying so. "*I accepted myself totally, faults and failings but my good as well*
(12:351-2) and "*I am very much of the mindset that it's a daily reprieve"* (12:376). My sensemaking of her last comments was that she said what she thought I wanted to hear rather than being truthful or open about how she accepts or does not accept herself. Participant 16 has never had a sponsor, and the effects seem self-apparent in the slowness of her overall recovery.

4.8.2.(ii) Superordinate theme 2: Spiritual and personal development

The second superordinate theme demonstrates the broader encompassing of the 12-step programme into the participants developing a way of being and living. In the earlier groups, God and or a higher power was a factor for discussion. This situation changes entirely in this Group 1s little reference to this "outside agency" is made. This change is not a reflection of lessening its significance but demonstrating greater its total integration; they take it as understood.

Table 20: Group 3, superordinate theme 2: themes (n=2)

Superordinate theme 2: Personal and spiritual development	
Themes	
3	God/higher power as an integrated part of their lives
4	Developed sobriety: the lived experience

4.8.2.(ii).(c) Theme 3 - God/higher power as an integrated part of their lives

The point of this theme is that failing to maintain a spiritual dimension in their lives, in one form or another, impacts the personal development aspect of recovery and well-being.

Participant 12's brief comments were "*I have a God of my own understanding. I don't ask anybody else to understand it"* (25:696-7) and, in the context of the twelfth promise ("We will suddenly realize that God is doing for us what we could not do for ourselves", AA World Services Inc.,
2001, p.60), he simply replied, "*Definitely. Sure amn't I here?"* (30:826).

Participant 13, too, is rather succinct about his view on this subject. He says,

> "*Thirty years sober, I don't know what God is. I just believe there's something bigger than me out there, that's number one"* (31:881-3). *A spiritual life for me is hearing something in somebody's voice and then I have to give them 10 minutes of my time or a half an hour of my time* (31:890-2). *It's being able to do a random act of kindness"* (31:894-5) and "*For me, leading a spiritual life is just not hurting somebody"* (32:897).

Participant 14 quoted, verbatim, two paragraphs from Carl Jung and "The Doctor's Opinion" written in the book of Alcoholics Anonymous concerning vital spiritual experiences (Appendix 15) and believes that is what he experienced at his first meeting. *"God became a big part of my life"* (11:342-3), *I needed to turn to God"* (11:350), and since then "*I haven't had to have a drink from that day to this. By the grace of God, I don't take credit for it, because it's been done for me"* (7:208-10).

Participant 15 does not refer to God/higher power during his interview until asked about the twelfth promise, to which his response is, *"Yeah, definitely, an inability to do stuff that's – and the biggest one will be on a daily basis I'm coping without lifting a drink"* (25:752-3).

On the other hand, Participant 16's journey of recovery is prolonged, as previously stated. While she has never had a compulsion to drink from her first day of sobriety, "*That was my higher power working for me"* (10:290). The submission to a power greater than herself was an ongoing underlying problem, and she said she can now see that. It underpinned why she did not go through steps four and five for seven years. It took 20 years before "*...all*

that fell into place for me" (11:339). It was somewhere between years 20 and 30 that her sobriety began to develop and "... *Yes, they* [the changes] *continue and they're continuing every day of my life because I work on them every day of my life"* (11:347-8). My sense-making of her view is that her "sobriety" is still somewhat egocentric – she knows the words but cannot (yet) "sing the song". Although she was open and forthright, I felt that there are still unresolved issues relating to her childhood present in her life to this day. Although I did not encounter the same semi ambivalence in any other participant, I am confident that it does occur – hence the need for organizations such as One-in-Four (which helps survivors of childhood sexual abuse). Participant 13 described how long past unresolved similar issues arose for him within the first 20 years, but he acknowledged the potential danger of them and went and got professional assistance. I did not explore pre-recovery issues with Participant 16 as they were outside the terms of this research project.

This theme demonstrates the vitality of the program's spiritual side and how it interacts with personal development.

4.8.2.(ii).(d) Theme 4 – Developed sobriety: the lived experience

This theme highlights how the continuous practice of the programme can affect real-life situations. All the participants gave multiple examples of putting the programme into action in different ways in difficult circumstances.

Participant 15's description of one incident – quoted in full – gives a picture of how the participants, who had once been selfish, self-serving, dishonest and uncaring, changed entirely because of their total engagement with their 12-step programme.

> *"My eldest sister who, when I stopped drinking in 1986, didn't – I just had no time, we had no relationship. She rang me. So, I went down to the hospital and the little man was still lying on the bed, and all the detritus was – from when they were working on him and everything, that was still there, this little body was there* [dead from cancer]. *I had no experience of any of this. Two guards came in and my sister and her hubby had to identify the child, because it was a natural death. I was in the hospital with my elder sister, and she said to me, I'm not bringing our son – I'm not getting an undertaker to bring our son home. She said, you're bringing us home. I was saying to myself, the old-fashioned, this self-consciousness and the insecurity, what will people say if they look into the car and they see me bringing my mother – my sister and her husband and my dead nephew in the back of my car,*
> *I can't do it. Then I said to myself, hang on a second what are these men and*

women telling you, look at what you're being asked to do, look at the privilege that you're being offered, this is a woman who didn't talk to you 10 years ago and now she's asking you to do this for her. Again, I didn't factor in the physics because when we got to her house of course they were sitting in the back seat, how do you get the child. So, I had to bring this little man who I loved dearly, and bring him up and put him in his little bed beside all his cuddly toys, and on the wall there was a piece of paper that said, what I want to be when I grow up, and I was putting the child in the bed, and all of that – all the emotion of all of that – there's an amend" (1213:372-406).

This theme demonstrates that faith and belief in a Higher Power led to having the ability to participate in more altruistic actions, both consciously and unconsciously in daily living.

4.8.2.(iii) Superordinate theme 3: Key messages

The third superordinate theme explores the participant's understanding of their fellowship's key messages at their experiential length of sobriety and membership.

Table 21: Group 3, superordinate Theme 3: themes (n=1)

Superordinate theme 3 – Key messages and merits of 12 promises	
Themes	
5	Key messages as perceived by participants

4.8.(iii).(d) Theme 5 – Key messages as perceived by participants

Again, as with previous groups, there was no consensus or clear statement on what the actual messages of the 12-step Group were.

Participant 12 believes the message is threefold: "*First of all, to get me well. To get me out of where I was*" (25:693-5); that "*love and service"* (quoting from Dr Bob Smith's last words – Appendix 16) are essential ingredients and that the programme helped him "*...to become the person he was born to be and not became"* through its slogans and everything else that they promulgate.

Participant 13's view of the message is that "*...there's a nice, comfortable life out there. Now life happens and you just have to go along with it"* (29:822-3).

Participant 14 was quite clear that the message, as he believed it to be,

> "*... is very simple, that a) they were alcoholic and cannot manage their own lives,*
> *b) that probably no human power that can relieve them of their alcoholism and*
> *c) that God could and would if he were sought."* [Straight quote from AA World Services Inc., 2001, p.60]

and that "*The whole purpose of the AA programme is to find God...as we understand Him"* (14:435-41).

Participant 15 did not explicitly identify any but stated that his life had turned around 360 degrees and that the most significant thing for him was that he was coping on a daily basis without lifting a drink.

Participant 16 had to think for a few minutes and suggested that the programme is a solution for anybody prepared to give it an honest effort and an honest chance.

Considering the views of earlier groups, at this stage, the messages of the 12-step Group appear to be those that the participants themselves believe.

4.9 Group 3 summary

These participants found that there was a way out of their misery at their early meetings. Their identification with others, too, was an important factor in why they kept attending. However, now that identification is working in reverse. It keeps what is in store for them, if they pick up a drink, to the forefront of their minds. Again, the disease concept gave them something to latch on to and from which they could base a "recovery". Carl was the first, so far, to mention "loneliness" as part of his former alcohol dependence, and there is literature on this aspect of the "dis-ease". As commented on earlier, this group has a different nuance on the efficacy of their 12-step meetings. The earlier groups believed in it, but now, this group knows that it works for them and that there is no actual recovery; there is only a daily reprieve contingent on their maintaining spiritual well-being. Nowhere in AA literature is specified the need for or the number of meetings a member ought to attend. However, these participants find that meetings serve a multiplicity of purposes in their life's journey and attend a minimum of three to five meetings per week no matter where they are.

Notwithstanding the immediately preceding comments, Participant 16's ambivalence towards frequent or regular meeting attendance may well reflect more generally why some people in recovery take so long to achieve peace of mind in their life. AA does not claim to hold all the answers for its members, and outside help or other agency involvement may sometimes be required, and indeed is suggested when necessary.

4.10 Group 4 – "Normal service has been resumed": Participants with 40 years' sobriety and recovery +/- 2 years

4.10.1 Introduction

Although only 10 years ahead of Group 3 members, these five participants' narratives took on an entirely different attitude and approach. Not only have they learned to live and enjoy sobriety, and tolerate the ups and downs of life, but they live their programme – not in the sense of consciously following a set of rules, but it has become ingrained into their way of living.

They have found that life without alcohol or any lingering thoughts has become quite normal for them. It is queried through the interviews how they coped with various traumas, and they described how the knowledge of their programme helps them through severe difficulties. They did not have to think back to what they had learned in their earlier years; they just knew what to do and responded accordingly.

Table 22: Group 4 – setting out participant number, age, gender, location over the majority of sobriety years, and sobriety length (n=5)

Participant ID	Age (years)	Gender	Location of residence over the last 40 years	Length of sobriety (years)
Participant 17	69	Female	Spain	39
Participant 18	76	Male	Ireland	38
Participant 19	65	Male	Scotland	40
Participant 20	66	Male	England	38
Participant 21	62	Male	Wales	38

Again, all the interviews started with the same open-ended question. References to histories of drinking and childhood backgrounds, when recounted, were only used as a backdrop to other matters. An analysis of the interviews provided three superordinate

themes with three themes associated with the first, four associated with the second, and three associated with the third.

The issue of God/higher power, while remaining an enduring feature in their lives and wellbeing, was, as with Group 3, not discussed with the same "need to explain" as had happened with earlier groups.

Compared to the earlier groups, these interviews did not quite so readily lend themselves into subdivision by either superordinate themes or themes. The narratives are about 40 years living sober through the automatic working of a 12-step programme – a relatively long time since they joined. For that reason, specific details may be limited or colored to a certain extent. However, key points endured and formed the basis of the three superordinate themes elicited for this group. When I interviewed these participants, what was also quite different was that after the central part of the interview had concluded, the applicability of the promises explored and the recording stopped, all the participants availed themselves of the opportunity to supply additional comments that they felt relevant or helpful to my research.

Table 23: Group 4, superordinate themes (n=3)

Group 4	
Superordinate theme 1	"What we used to be like…"
Superordinate theme 2	"What happened" [1]
Superordinate theme 3	"What we are like now" [1] – having lived a sober life

[1] These themes are based directly on AA World Services Inc., 2001, p. 58, lines 16-7)

4.10.1.(i).(a) Superordinate theme 1: "What we used to be like"

In the first superordinate theme, all these participants have had the time, opportunity and facility to review how and why they believe they became alcohol dependent. The merit of their understanding is no longer really of consequence to them. They do, however, believe it to be factual. Further, whether there is any "science" behind the logic of the 12-step programme they have followed does not matter. It has worked successfully for them and endured for forty years. This sobriety period included recounting their experiences countless times to others at meetings, and so their narratives have become their truth.

Table 24: Group 4, superordinate theme 1: themes (n=3)

Superordinate Theme 1: "What we used to be like"	
Themes	
1	Self-perceptions of defects of character or dysfunctional upbringing
2	Alcohol dependence
3	Last alcoholic drink

4.10.1.(i).(a) Theme 1 – Self-perceptions of defects of character or dysfunctional upbringing

In this theme, some of the participants briefly adverted to childhood difficulties. Those who did not, look at their sober life as a separate life.

Participant 17 grew up in a non-alcoholic happy home, but she was full of fear for as long as she can remember, feeling stupid and inhibited, all without any good reason that she can recall. In school she won a "best figure" competition and promptly developed body dysmorphia. She also developed an eating disorder, bulimia, sugar addiction and other addictive behaviors.

Participant 18's recollection of his childhood and youth is full of fear – with good cause. "*I would say I was a very troubled person, from my background, … father was an alcoholic and poverty and stress and violence and fear"* (1:16-8). He had to get drunk to get married. "*I got flashbacks of when I was a kid. I seen a lot of things when I was a kid. I seen my mother and father using a knife on her. Bread knife. So here I am going to get married, and the past was coming to the future"* (1:25-8). Participant 18 enjoyed a long number of years with controlled drinking but was aware that there were "*...tell-tale signs"* (2:36) of developing problems.

For his own reasons, Participant 19 declined to reference his background, childhood, youth, or upbringing. His participation in the research was willingly given but related solely to his forty years of recovery. Whatever happened before his joining AA, he regards it as part of his other self. He sees and believes in two versions of himself – his alcoholic self and his sober self.

Participant 20 drank heavily for 20 years before joining a 12-step fellowship. He made no reference to early feelings of any nature except that before he would join a social gathering, "*I'd have a drink before going for a drink to make me feel at ease"* (1:17-8). He changed jobs frequently – primarily for alcohol-related reasons – until he decided he had had enough of that way of life. He did not speak of his background as he felt it was irrelevant (without rancor). "*I see my sober life as a separate life"* (10:260).

Participant 21 described a difficult childhood; both his parents died when he was very young, and he felt that he was the lesser one of two twins. He felt insecure, shy and "backwards" – that he had a learning difficulty. Participant 21 drank daily from age 15 to 27 years as he found it made him funny, talkative and like "Superman". After he got married his drinking got worse, and he tried "geographicals" (abv.). He had no choice but to address his dependency when his wife seriously assaulted him one night and threw him out of the family house.

Table 25: Group 4, first drink, dependency and main developmental issue (n=5)

Name	Age of first drink	Abuse/dependency	Developmental issue
Participant 17	16	Immediate	Shy, fearful, inhibited
Participant 18	Early teens	7-10 years	Father, a violent alcoholic
Participant 19	Early teens	12 years	"Drank - to go drinking"
Participant 20	Early teens	20 years	Declined to discuss early life
Participant 21	15	1 year	Parents died while young

Index 5, Table 4 sets out in more detail early dysfunctionalities for this group.

This theme showed that participants had pre-existing psychological problems they became aware of and accepted them as a prelude to making them who they are today. Only one declined to elaborate on his early years for undisclosed reasons.

4.10.1.(i).(b) Theme 2 – Alcohol dependence

This theme illuminates how or why the participants reached a decision point in their alcohol dependence careers.

Participant 17's first drink at a party comprised 16 glasses of champagne and, from that first day, she loved alcohol and felt this was her answer to all her self-perception problems

until one morning "*I kind of woke up. I was laying there with some boy that I didn't even know. I was laying there naked, and I sobered up instantly and I thought 'What am I doing?'"* (493-95). She quickly went on to develop other addictions such as drugs, caffeine, sugar, and chewing gum. She knew she was in trouble and tried Weight Watchers, TOPS (Take Off Pounds Sensibly) and Overeaters Anonymous – all to no avail.

Participant 18 said, "*Through my life, I was brought up by an aunt for a while, and my aunt had a husband that didn't drink. He was a very decent man, a farmer, and I always wanted to be like him"*
(2:48-50). *"I always wanted to be like someone else. The common denominator was that none of them drank. I knew that these people had a good life and could enjoy life without a drink, and here I am dependent on drink"* (2:51-4). Participant 18 returned to this element of fear numerous times and, strangely, despite saying that he had many years of enjoyable drinking while chasing women and so forth, he said he "*...was never comfortable drinking. I noticed a change in myself. I never got in a row... But I was near. Became angry"* (3:62-4). While it was not said, I suspected a fearfulness that he would have hurt someone badly in a row or trouble, as he had observed as a child (he is a big man.) I found it interesting that despite his insalubrious background he never got involved in nefarious activities, and given his openness, he would have spoken about them – he has innate integrity.

Participant 19 described how he drank for 12 years before it became problematic. He began drinking every day. His doctor proved to be of no assistance and simply observed his "*burning the candle at both ends. But never pointed a direction I could go for help in any way"* (1:16-7). He never went into a treatment center. On the advice of the Samaritans, he attended his first meeting. While not admitting to being suicidal, he found the stigma of being an alcoholic difficult and dangerous to his well-being.

Participant 20 decided that he had had enough alcohol-related problems, and *"I decided for myself"* (2:44) to do something about it by going to a 12-step meeting.
Based on the participants' comments, this theme showed how they became aware of their problem.

4.10.1.(i).(c) Theme 3 – Last alcoholic drink

This theme explores a significant point for the participants and how they moved from contemplating their condition to doing something about it.

Despite an antithetical view of AA, Participant 17's desperation to do something about herself kept her going to an occasional meeting but, on each occasion, she failed.

> "*All I could seen in the beginning was the differences"* (9:239). "*At that point, I decided to just accept that I had this illness instead of fighting it. I was always fighting it all the time. At that point I decided to just accept it and that it's never going to change"* (15:424-7). However, at one meeting, she heard, "*... a woman ... shared her story, I related to it so much. Then she got to this certain point and I really felt that someone had whispered in her ear before the meeting telling her, say this and this and this so we can hook Participant 17 into the programme* (9:247-50). *Her story went into losing the car, going to jail, losing the money and relationship, blah-blah-blah — all these things that hadn't happened to me,* yet*"* (9:252-4). *"... but something happened in that meeting when I realised, it was like a penny fell into my head and I thought, my God, I am an alcoholic. But I have not... my alcoholism has not progressed as far as a lot of the people in the programme. From that day on, I have not had a drink* (99:255-9).

Participant 18's last alcoholic drink came about through his being "12-stepped". He met a woman he had previously known as a "drunk", and she was sober. She told him how her life had improved and asked how he was. He told her the truth – awful as it was, "warts and all". Six weeks later she re-encountered him, asked him again how he was, and suggested he accompany her to a 12-step meeting. He did and never drank again.

After talking to the Samaritans, Participant 19 went to his first meeting near where he lived and never drank again.

Having decided that he had had enough alcohol-related misery, Participant 20 went through eight days of in-house alcohol detoxification, declined treatment in that unit, and joined AA the next day.

He has never drunk alcohol since then.

Participant 21 went into a treatment centre, but he felt he was not as bad as the rest as he did not merit placement in "the lock-up ward". Despite being rated as the most likely to relapse after he left the Centre, he went to a 12-step meeting the following day. He has never drunk alcohol since then.

This theme outlines why the participants attended their first meeting upon which their 40 years of sobriety started.

4.10.1.(ii) Superordinate theme 2: "What happened"

The second superordinate theme takes on an added importance in this Group 4ue to its effect's longevity. It explores how the participants recall their initial impressions, their understandings of the 12-step group messages, and the participants' actions that have led them to remain alcohol-free for 40 years.

Table 26: Group 4, superordinate theme 2: themes (n=4)

Superordinate theme 2 – "What happened"	
Themes	
4	Impact of first and early meetings
5	Getting or being a sponsor and "doing the steps"
6	Embracing the concept of God/higher power
7	Understanding of the messages of the group

4.101.(ii).(d) Theme 4 – Impact of first and early meetings

This theme explores the participants' current recollections of their reactions and the impact of their early 12-step meetings that kept them attending, participating and remaining sober. Their recollections vary considerably, but the overall outcome was the same – developing a sober way of living.

Although the very first meeting attended may not have the desired effect on an alcohol dependent individual, Participant 17 (as had Participant 1 in Group 1) described the importance of differentiation versus identification at a 12-step meeting. It determines

whether the individual stays at meetings or goes back drinking. However, this is not enough; it also requires an alteration of attitude – a new receptiveness (AA is often referred to as "Altered Attitude" by its members). Participant 17 described her own experience of this in theme 3 above. Although she never drank again, it took some time before she realized that the same programme also worked in other circumstances, and she successfully gave up drugs, hallucinogens, caffeine, binge eating, sugar, cola and chewing gum within a year. "*The solution was exactly the same, whether it was drugs, booze, sugar, caffeine; whatever the thing, the solution was always the same. Different branches of a tree, but the roots of the* [same] *tree* (17:476-9). "*I had to grow up"* (19:544). Participant 17 said, "*I can't imagine what my life would've been like if I hadn't gotten in the programme then*" (16:297-9). For most of her life, she has attended daily 12-step meetings per week. She has never been to a treatment center.

Participant 18 believes he got to his first meeting "*...I was just at the right hour of the day, the right night"* (11:283). *"What really struck me about the meeting I went to was the calmness in the room. The people in the room...it had this calmness. They were charging themselves in the room. Happy looking, looked smug. That's what attracted me to AA. I went to start going to meetings from there on"* (3:82-7). He was taken by this calmness, the serenity and the honesty of the members. Within a year, he realized that there was no need for his family to grow up with the endemic fear he lived with during his childhood. None of his four adult children has ever seen him drunk from birth, and he is proud of that (7:195). Although he had to see a psychiatrist after 10 years about childhood issues, it had no impact on his view of the fellowship's worth.

Participant 19's first meeting gave him understanding and hope – "*...as they'd walked the walk before me and giving out tips on what they'd tried and tested, and I could try them"* (4:77-9). He picked up immediately on the "illness" concept and said, *"...it made it much easier to cope with what was going on, that it wasn't just selfishness that was – it wasn't just giving in to yourself"* (4:88-90). "*Yes, it made a difference, I realised it answered a lot of questions that I was powerless over alcohol when I took it"* (4:92-3). "*I knew that what I'd learnt about alcoholism being an illness, that abstinence was the only key"* (8:199-200) and *"That to me is a big part of the mental illness. Not so much doing stupid things or saying stupid things. Defending alcohol"* (8:205-6). Participant 19 is a 100% believer in Dr

Silkworth's ideas that certain people are allergic to alcohol (Appendix 10).

Participant 20's experience of his first meeting was of getting *"Great hope. I was filled with great hope, and there was a chap there who mentioned about being a year sober, and I thought, oh, that's something to aim for"* (4:97-9). He felt very humbled "*...because a lot of them had lost so much during their drinking life"* (4:106), and he had not. He was also surprised about how open they all were sharing their experiences. He learned that he had *"... to talk about our emotions because if we don't, we're in trouble"* (5:135-6).

Participant 21, after treatment, went immediately to a 12-step meeting. He said, *"My impression is they were–- I couldn't believe the friendship. I couldn't believe the niceness of them"* (5:148-9). He continued to go every night and still attends the same group to this day.

Although they varied widely, this theme showed that each participant took away some significant alteration in their perception of their condition from their first meeting, and that was a way out that they could both manage and work.

4.10.1.(ii).(d) Theme 5 – Getting or being a sponsor and "doing the steps"

Although engaging with a sponsor while going through the steps is a strongly recommended part of the recovery process, this theme shows that genuine recovery can be achieved without doing so, as not all five participants followed that path.

However, Participant 17 was adamant about the role of a sponsor. *"I think having the sponsor is very, very important. Number one, I think probably the most important thing about getting and having a sponsor is the willingness to have a sponsor. A lot of people say well, I looked around, but I can't find the right person, to find the right sponsor, but in a way, it can be a cop-out waiting for the perfect person. We're all in this programme together. Nobody has all the answers. You can't really expect your sponsor to have all the answers, but what you do have there, when you have the willingness to get a sponsor and call your sponsor and be open and honest with the sponsor, that is the healing part there"* (29:596-605).

Participant 18 got a sponsor almost straight away that suited him "*I think the higher power put him in my way"* (5:133-4) and has always had one with whom he could speak openly.

Participant 19 was somewhat reticent about getting a sponsor because he was never really sure what it meant, preferring instead to have a few people who were "*unofficial sponsors"* (5:117).

Strangely enough, although he admitted to reading a great deal about the 12-step fellowships, Participant 20 never got a sponsor nor went through the steps individually with one.

Participant 21 got a sponsor almost straight away who is still alive and helping him, almost 40 years later.
He can be rather abrupt with him and limits his advice to "*Just don't drink no matter what you do"* (11:317).

From the participants' behaviour and attitudes, this theme highlights the absence of rigid or mandatory procedures. Not following particular suggestions may not necessarily negate or impact long-term outcomes.

4.10.1.(ii).(e) Theme 6 – Embracing the concept of God/Higher power

This theme explores how the participants' concept of "God/Higher power" evolved except for Participant 21, who adverted to unresolved blanks in his childhood recollections.

Participant 17 regarded her first "spiritual awakening" as occurring when she finally totally accepted
Step I.". *That I cannot stop, I'm never going to stop. It's impossible for me to stop"* (14:415-6). She experienced another "*spiritual awakening"* when one night, while parked in her car in pouring rain, she looked into the rear-view mirror and her image blurred into those of her friends and family, and she realized just how much they cared for her but felt so powerless to help her. She said, *"... this was a huge breakthrough for me"* (12:332). "*Something happened there where I could see how I had hated myself all that time. I just hated, loathed who I was. I was just sobbing my eyes out realising that. That, for me, was the beginning of learning to love myself just as I am, not as the person I wanted to be, that I was striving to be. That was really where my recovery started"* (13:356-61).

Participant 18 initially had a problem with the "God" concept but simply accepted "*He's in the room"*
(5:118-9). His doubts dispelled as "good" events in his sober life evolved or occurred, and he began to appreciate the veracity of the slogans (abv.).

Participant 19 simply believes that the program's spiritual side is a predominant component and has always asked his higher power for help daily in the morning and at night for assistance.

Participant 20 struggled with the God/higher power concept until he realized that alcohol was a higher power and could replace this negative power with a positive one. "*Then after a time, I did develop a concept of God after about 18 months that I've been quite comfortable with since"* (6:150-1).

Participant 21 is quite ambiguous regarding the God/higher power elements of the 12 steps. He says,

> *"...it's hard to believe that there is a God. It's a terrible thing to say. And it's hard to believe that there isn't... I'll give the credit to the programme, but it won't – for some unknown reason I won't give the credit to God, because there's a part of me that's inside and it's not fully, I suppose, processed... – there's something. There's a blank from my childhood from there to there"* (22:651-664).

From this theme can be seen how step 2 of the programme worked for four of the five participants who *"Came to believe that a power greater than ourselves could restore us to sanity"* (AA World Services Inc., 2001, p. 59). While Participant 21 would not "give in" on the question of "God", "something" or some higher power keeps him sober.

4.10.1.(ii).(f) Theme 7 – Understanding of the messages of the group

This theme continues the process of attempting to elicit what the participants perceive as the fellowship's messages.

Participant 17 put her understanding of the 12-step message as follows "*The phrase that comes to my mind is there is a solution, which is in the big book* [AA World Services Inc.,

2001, Chapter 2 pp. 17-29]. *I did not feel like there was a solution before I came in the programme and then I found that there was a solution for the drugs and the alcohol. Then I thought there was no solution with sugar, and then I found that there was a solution there"* (17:470-4).

Participant 18 had no clear view of the group messages but feels they have changed as people with other addictions join in. He believes that within the 12-step group, there is a solution to alcohol dependency – a way of life. Participant 18 is adamant that if he does drink again, he will not be able to stop. He attends meetings every day "*Because I need them"* (23:25). Gratitude for how his life and his children's success play a significant role in his sobriety.

Participant 19 believes the message of the 12-step group is "*That there was hope. A new life for an old life, there was a way out of the misery and that I could maybe pass on what was passed on to me, to somebody else, continue the chain"* (6:149-51). Gratitude plays a big part in Participant 19's day-to-day outlook – knowing how many have "not made it". He believes that AA's approach is holistic in its defense against the disease – that it is the future and the past that break a man. He appreciates his recovery "*...it's always today*" (18:467).

Participant 20's interpretation of the group's message was, "*Well, there's hope to start with. That's the whole message of AA and it's a different way of life. It's a new way of living. It's adopting a new way of living and then working on what needs to be worked on from your previous life. I see my sober life as a separate life"* (10:257-60).

Participant 21 picked up the message that *"The feeling I got was hope and it was possible"* [to live sober] (6:156), but found it was like a drip, very slow going. To this day he still finds it a challenge to trust himself every day.

This theme found that, even after 40 years, the participants could not identify their groups' specific messages. Instead, they described beliefs and feelings such as hope and gratitude.

4.10.1.(iii) Superordinate theme 3: "What we are like now" – having lived a sober life

Forty years is a long time in any context, and many life events may happen during that period. This third superordinate theme explores how the participants experienced living sober for this length.

Table 27: Group 4, superordinate theme 3: themes (n=2)

Superordinate Theme D3 – "What we are like now" – having lived a sober life	
Themes	
8	Carrying the message; verbal and non-verbal communication
9	"To practice these principles in all our affairs" [1]

4.10.1.(iii).(h) Theme 8 – Carrying the message; verbal and non-verbal communication

This theme explores a central process – that of *"...we tried to carry the message to the still suffering alcoholic"* (step 12 of the programme).

Participant 17 went on to enjoy a successful international career as a dancer and instructor and to marry a fellow 12-step member (who never relapsed) 25 years ago. She has always been involved in service, has been a sponsor multiple times, and, through her daily living, including some current horrific suffering, has shown that the programme does work – while living a happy and successful life sober.

Participant 18, too, has had a highly successful life and all his children have professional qualifications. He believes that carrying the message is an integral part of his recovery and speaks up at every meeting he attends – almost every day. Asked if he considered that there was any "quick fix" through treatment centers, meetings, or so forth, he responded, "*Certainly not. There is no quick fix. You just have to – it's a day at a time with no destination"* (21:563-4).

Participant 19, too, feels that "*You get out what you put in... carrying the message...you'll always get back three times it"* (10:252-4). As step 12 suggests, he tries to practice the principles in all his affairs. Thus, he non-verbally bears witness to the fact that the programme does work.

Although he has never had one himself, Participant 20 has sponsored many people over the years. He also believes strongly in "doing service" and questions anyone's commitment if they fail to get involved. Shortly after getting sober, he did 18 months of voluntary work out of gratitude for how he had achieved recovery. He gave the example of attending a World Convention where 60,000 people in a stadium said the Serenity Prayer together and "*...there wasn't – it was dead silent, and it was fantastic. It was a real kind of a spiritual moment, that was. It was amazing"* (12:321-2).

Participant 21 believes in the concept of giving back by passing on the message (step 12) and does so through providing voluntary counselling or 12-step facilitation.
In sobriety, he obtained a relevant Master's degree to improve his ability to do this.

This theme illuminates the quiet but determined effort that the participants put into their recovery, the importance they place on "passing it on" through recounting how they did it, and how their actions bear witness to its efficacy.

4.10.1.(iii).(i) Theme 9 – "To practice these principles in all our affairs"

This theme looks at how the participants dealt with some of the traumas they faced without relapsing. As mentioned earlier, there is a significant difference between living without alcohol and living sober.

Participant 17's life has not been a bed of roses. Her father died six years ago; two months later one of her cats died (she has no children); the following day her mother died; and two days later her other cat died. During these traumas she went to a 12-step meeting every day. Within a year, her husband also died after a long illness. Participant 17 had to nurse him almost 24 hours a day in the end. I asked her if she ever thought of drinking during this horrific period, and she said,
"*Not really, because it had nothing to do with that. It wouldn't solve the problems"* (19:5345). Participant 17 recently went through stem-cell therapy, leaving her unable to sleep and often waking at night, hourly, screaming in pain. I asked her how she coped, and she said, "*The programme helps me with everything, absolutely everything. You can have crazy-shaky moments...but your higher power is there 24-7"* (20;558-60). As one of her final comments Participant 17 remarked, *"The programme has helped me all along the*

way. I could not live my life if I did not have this programme. I would self-destruct in some way" (21:590-1). Participant 17 still believes "*I have more progress to make"* (19:550) and that "*I've got AA to get me through whatever comes next"* (26:747-8). [Since the commencement of this research, I have heard she developed terminal cancer but accepted it without rancor. Sadly, she has now passed away.]

Participant 18 exampled this theme by describing how he eventually made peace with his mother. He was unexpectedly speaking with his estranged mother and aunt for three hours, talking, laughing and general chit-chat one night. His mother died early the following day, and despite all that had happened to him, he is grateful that they parted on good terms.

Participant 19 gave a very moving example of how he helps his sister frequently with her vascular dementia. He ascribes this ability to his membership of the 12-step Group and his higher power. I asked Participant 19 directly whether he would recognise himself as he used to be if he were to meet himself today, and he said, "*No, I don't think so"* (16:417).
Rather than regarding his sobriety as a "daily reprieve", Participant 20 prefers to say to himself, *"I'm 12 steps away from taking a drink"* (17:470-1). His overall view of his 40 years of sobriety is that "*AA saved my life to start with and they gave me a totally different way of living"* (13-3545).
When recently asked what he wanted out of life, Participant 21 responded, *"...four things. I've achieved them four things that I wanted to do"* (17:502-3). He attends meetings almost daily and believes that *"I would go insane"* if he did not (18:544).

From this theme it is clear that during their 40 years of sobriety the participants have developed coping skills and a changed way of seeing, feeling and experiencing things.

4.11 Group 4 summary

While there may be considerable repetition, in general terms, between how these participants became dependent on alcohol and recovered and earlier groups, there is a major underlying factor – they have resumed living life just the same as the rest of the population. Like other people with life-threatening conditions such as heart or respiratory difficulties, they know they need to keep taking their "medication" to keep them well. For them, rather than taking a pill or using an inhaler, they need to attend 12-step meetings for the same

reason as mentioned in the conclusion of Group 3 – they believe that they only have a daily reprieve. These meetings also serve an additional purpose in that they become a social network of "fellow-travelers". There is existing literature on the question of AA being part of a new social network. Most of the participants attend meetings daily – the lowest being 3-4 meetings per week. Through the interviews, the participants only refer to their pre-recovery conditions briefly. As Participant 21 put it, "*I see my sober life as a separate one"* (10:260). Real and psychological life traumas occurred for some of them, and rather than dwell on a "why me" attitude they accepted the reality of "why not me" and got on with whatever was necessary.

Step 12 takes on a new importance for this group – the grateful transmission of a solution to a hopeless situation. This arises from the fact that they appreciate the programme not only works but also includes many perks, including leading an everyday life. Regarding the idealized life set out in the promises, the number of qualifications dropped to very few, and these few derive from an acknowledgement of their humanity.

4.12 Group 5 – Celebration of a sober life: Participants with > 50 years of sobriety and recovery

4.12.1 Introduction

It is rare to describe interviews as both informative and enjoyable during qualitative research studies into sensitive subjects. However, this was my experience with these two participants. Their openness, frankness and humor made the exploration of their experiences fascinating. They required little or no prompting or directive questioning – they grasped the research concept and spoke directly to it with enthusiasm. Despite their humor, they carried a message of how they have recovered from a potentially fatal malady for over 50 years – and how they continue to do so "on a daily basis" (their words) successfully.

Table 29: Group 5 – setting out participant number, age, gender, location over the majority of sobriety years, and sobriety length (n=2)

Participant ID	Age (years)	Gender	Location of residence for the majority of their sobriety	Length of sobriety (years)
Participant 22	93	Male	Europe*	54
Participant 23	82	Male	Europe*	50

(*For anonymity purposes, the participant's countries names have been changed to "Europe")

As with all the previous groups, a line-by-line analysis of each interview took place. The

interviews began with the same open-ended question as with the participants of previous groups. From the following superordinate theme, six discernible themes emerged.

Table 30: Group 5, superordinate theme, theme (n=1)

Superordinate theme	From being alcohol dependent to living an abstinent lifestyle

4.12.1.(i) Superordinate Theme: From being alcohol dependent to living an abstinent lifestyle

This superordinate theme may not seem difficult at this time, but the reality was, 50 years ago, being "… prepared to go to any lengths" (AA World Services Inc., 2001, p. 58) quite literally meant that. There were few meetings, and much effort and travel were involved getting to them and being involved in service. The participants wanted so much to recover and regain sobriety that they did *"...go to any lengths...*" to get it.

Table 31: Group 5, superordinate theme: themes (n=6)

Superordinate theme: From being alcohol dependent to living an abstinent lifestyle	
Themes	
1	The onset of dependency; first AA encounters, meetings and perceptions
2	Engaging with a sponsor; "doing the steps" and service
3	Emotional sobriety and quality of life improvements
4	Personal actions and outcomes
5	The messages of the 12-step fellowship as the participants understood them

4.12.1.(i).(a) . Theme 1 – The onset of dependency; first AA encounters, meetings and

perceptions

In this theme, how the individuals' dependencies developed is outlined, how they came to be involved in their 12-step groups, and what they thought of them.

Participant 22 came from a teetotal home and enjoyed a good family background despite the advent of the Second World War. His father died when he was 17. Six months later, he went drinking for the first time with friends and had four beers. He spent the next 21 years chasing the same buzz, drinking more and more in his quest to find it but never did. He lost control of his drinking some years later and almost burned the house down. His wife locked him out of the bedroom until he did something about his drinking. He never saw his son growing up until he joined AA – when he was 11-12 years old. Participant 22 was 12-stepped into his first sober meeting – he had been at one before, but he was too drunk to remember it. He has a vague recollection of it – that it was a mission house or religious sect. His "12- stepper" told him,

> *"...what I've never forgotten, he said do you know Participant 22, this programme of recovery in Alcoholics Anonymous can work for you if you want it. He said, but you must want it for yourself. Not for your wife and family and your relations, your friends, your employers, your employees. You get sober for Participant 22 and stay sober for Participant 22, and all these people will benefit through your sobriety"* (10:302-7).

A while later, he repeated that he felt "*something*" there for him that wanted him to stay sober – drawing him back all the time (12:394). When asked what messages (if any) he got from his first "real" meeting, he said, *"Well, it is hard to tell. There was something there that wanted me to stay sober* (11:362-3). While he remembers feeling welcomed, he cannot recall much of it. As he wanted sobriety so desperately, he had just gone through detoxification at home on his own before that meeting. This detox included experiencing *delirium tremens* and seeing non-existent rats and the like for 48 hours. He does, however, recall clearly the chairman speaking bluntly to him afterwards and saying, "*Take the cotton wool out of your ears and stuff them in your mouth and listen, and listen hard"* (11:354-5) and *"Keep coming back"* (11:356). Participant 22 hardly mentioned God/higher power/spirituality at all. Perhaps this was because he said he never lost his childhood faith and remained quite involved in it. Ironically, his sponsor was from a different faith.

Participant 23's mother died when he was three, and he saw little of his father. He was

always timid, "*This shyness and the low opinion I had of myself was unreal"* (2:52-3) – despite his apparent outward success in life. With his first drink, when he was 20, *"All the fears and all the shyness and everything just was wiped away"* (2:35-6). He drank excessively for 10 years. He behaved generally reasonably for the first two years, but for the final eight, *"... suddenly I changed. I became an obnoxious blaggard ... angry, badmouthing, violence, verbally attacking everybody"* (3:75-7). After a dreadful night, he met a member of AA and spoke to him for 15 hours. For the first time, he met someone who thought and felt like him. The primary advice he got from the man was to stay away from the *first* drink. He went to a meeting the following day but soon left as he felt he was too young to be there – they were all his father's age. The only message "*...I got from my first meeting. One day at a time, stay away from that first drink. If you don't have the first drink you can't get drunk, and go to meetings, keep in contact with AA members* (9:274-6). Raised as Catholic, he tried praying to God for help; he even *"went to monasteries, friaries, nunneries. I took pledges; I had green pins and blue pins and all kinds of pins"* (5:128-30). For six or seven months he was in and out of AA like a yo-yo, but after causing an awful lot of damage and after one dreadful night,

> *"When I woke up in the morning, again I hadn't a notion but whatever happened at whatever magical moment of whatever little splink of sanity came into my life, that following day I never drank again"* (11:323-5). *"I threw myself into AA, not having it as an aside in my life, now it became a priority. A focus in my life. I upped my meetings, and I got involved in service. I began, got a good sponsor again, the original man who brought me in"* (11:329-32), and he *"... began to accept really that I was powerless over alcohol. I took the first step. I'm powerless over alcohol and the tough part of it realizing that my life was totally unmanageable – totally unmanageable, and that I needed help. A very tough thing for me, because of the pride in me, asking for help"* (11:335-9).

Since then, he has never drunk alcohol again.

Table 32: (50 years) Name, first drink, dependency and main developmental issue (n=2)

Name	Age of first drink	Abuse/dependency	Developmental issue
Participant 22	17	21 years	Told he was a "mistake"
Participant 23	20	Immediate	Mother died early, fearful; shy

Index 5, Table 5 sets out in more detail early dysfunctionalities for this group.

This theme showed how both participants became dependent on alcohol in entirely different circumstances but shared the same desire to get sober and acted by joining a 12-step Group and learning what that fellowship believed to be a solution. All this occurred 50 years ago when conditions were very different. For example, there were only 6,000 members in Ireland in 1976, far fewer meetings, members, cars, no mobile phones, so a commitment to living sober through a group programme required real effort. Participant 23 described one incident where a member travelled over 320 miles to help another struggling member who had phoned him for help.

4.12.1.(i).(b) Theme 2 – Engaging with a sponsor; "doing the steps" and service

These concepts, explored in earlier sections, are still important from the current two participants' perspectives regarding longevity and continuity.

Participant 22's "12-stepper" was three years sober. He said, "*I was so impressed with what he had done, and he became my sponsor, and he was my sponsor for over 20 years"* (12:372-4). *"He became more or less a father as far as I was concerned"* (12:375-6). After a year,

> *"...he says now you're sober, I think it's time you were looking at the programme of recovery in Alcoholics Anonymous, the 12 steps of recovery. He says I'll go through them with you. He led me into the 12 steps of recovery. I found out that I was only staying dry, I was only staying sober, but that was all. I had to change my whole attitude in life to the person, the old life that didn't want to and the new life that does and carried on at the AA. I changed into a better person.... He and I had* 43 *years of life together in Alcoholics Anonymous"* (13:424-32).

Participant 22 found that "*The fourth step I think is one of the most important steps, taking*

a moral inventory of your life. I feel I've got to take that every day of my sobriety" (15:465-7). (The latter point is contained in the tenth step – taking a daily inventory.) Like most other participants before him, Participant 22 considers service a vital constituent of recovery – especially "prison service" (abv.) as it enhances his recovery experience.

Participant 23 began to understand the necessity that the programme became part of his life, including going through the 12 steps, practising them, and no longer putting himself first. He said:

> *"...the first time I did four and five, which are huge milestones in any alcoholic's life"* (13:385-6) "*was with another member. I told him a huge amount of stuff that I never, ever, ever shared or admitted to God, not to myself, not to any human being, I told him. I got tremendous relief"* (13:402-5).

He also got involved in continuous service and recounted the following example. He made a "12-step" (abv.) call on a man.

> *"I told him a good bit of my story and he listened away to me and that man died two years ago after 45 years' sobriety. Now, who delivered that message to that man?* [I replied, 'You did'.] *I didn't, anyway, let me tell you. I mean I was the bearer of the message, but I didn't deliver the message, that was done by God as I understand Him, no doubt about it"* (19:576-83).

Both Participant 22 and Participant 23, despite their ages, never say no to anything asked of them in their fellowship and have an absolute belief that the more you give it away, the more benefit you get.

This theme illustrates that the entire programme requires a commitment for life – and is not a temporary or short-term term "fix".

4.12.1.(i).(c) Theme 3 – Emotional sobriety and quality of life improvements

This theme showed how emotional sobriety is closely interlinked to quality of life, but still takes considerable time to be recognized and addressed. It was first accepted as a material factor by all Group 2 members (20 years of sobriety).

Participant 23 recalls its significance when he said:

> *"Well emotional sobriety, that's been the key to it all for me because my emotions were all over the place. Totally. I mean, first of all I didn't know what emotions were or I never gave much thought to emotions. Emotionally I was totally immature. Totally immature. I was a '15/16-year-old' when I came into*

> *AA at 30. Emotionally I hadn't developed at all. Coming to terms with a kind of a growth in that emotional stability has been a key factor in my sobriety"* (15:555-61)

Participant 23 described how it took many years before he could reach a level place in his life where he could live normally. He ascribed that to the last part of step 12, "*...practice these principles in all our affairs; I wasn't doing it"* (16:488). He heard about emotional development in AA and began to think about that. *"I was developing emotionally unbeknownst to myself and becoming more in tune with the inner Participant 23"* (16:498-9). He ascribes this growth of accepting a God of his understanding into his life – a spiritual awakening of the educational variety (Appendix 15).

Participant 22 described, when talking about emotions, that it

> *"Took me three years to relax in an AA meeting. I used to sit on the edge of the seat. I sat on the edge of the seat in a house and at a meeting, until one night I just sat back and relaxed. That was me working the programme to the best of my ability".*

This theme reiterates the earlier groups' experiences, with shorter sobriety, that emotional sobriety is a essential part of the recovery process and should be addressed earlier rather than later.

4.12.1.(i).(d) Theme 4 – Personal actions and outcomes

This theme examines, briefly, how the participants worked the programme successfully and the life it gave them.

Participant 23 was quite clear that his sponsor's advice to read and re-read Appendix 2 of the "Big Book" (Appendix 10) was fundamental because he gained absolute and contented sobriety and became in tune with the actual "inner Participant 23". It meant letting a God of his understanding into his life.

> "*Everything I have depends on my sobriety. Every single thing I have in my life is tacked on to my sobriety and every single morning I go down on my knees and I ask that God to help me for today, like I did this morning"* (17:514-8).

He enjoys life to its full now in every respect but realizes he can never forget how much he has to prioritize staying away from the first drink and not letting things slip. He said, "[My wife]

We have an unbelievable, incredible, partnership, loving life together" (23:707-8). He is

adamant about reading p. 59, line 7 (AA World Services Inc., 2001) exactly as it says: "*Here are the steps* we took *which are suggested as a programme of recovery".* Although nowhere does it refer in any of the literature of 12-step groups to the need to attend meetings, they seem to be essential to the participants' well-being. Participant 22 did not say much about his life after alcohol except that,

> *"I need to go to these meetings because that's where I stay sober and it helps me and it shows me how to stay sober and live a normal life without the aid of alcohol"* (20:630-2). *"I knew that it wouldn't happen overnight, and I had to work at it, work hard at it to get sober and stay sober"* (22:691-2).

He made the incisive comment, *"The thing is, the programme of Alcoholics Anonymous still remains the same as it was written in 1939, because* it is us that has to change, not the programme*. The programme remains the same because it's there for each and every one of us"* (26:809-12).

In this theme, two key points were adverted to by these long termers. The use of the phrase *"Here are the steps we took…"* (as that is a statement of actions taken), and the reality that it is the person who must change, not the programme.

4.12.1.(i).(d) Theme 5 – The messages of the 12-step fellowship as the participants understood them

This theme explores what these very long-term members of their 12-step fellowship believe the core elements of the message of their fellowship to be. Incredibly, and despite the everyday life it has given them, they are as vague as the first group members were about the messages they are passing on. Despite – or maybe because of – his public speaking ability, Participant 22 did not directly answer what he considered was the message(s) of the 12-step group. Instead, Participant 22 said

> *"...the good thing about Alcoholics Anonymous was that they said – they didn't say you'll never be able to drink again in your life, which would have been an impossibility. All they said to me was, all we want you to do is to stay away from one drink for* one day at a time, *and when you go to bed at night, when you go to sleep, when you wake up tomorrow morning it's not tomorrow, it's today, and you repeat the process. That was the way that I was told in the beginning. That registered with me. I kept that in the foremost of my mind as I was staying sober. But it was only done a day at a time*" (23:737-45).

Participant 23 had a clear view of what the message meant to him:

> *"The message of AA, for me anyway, the message of AA is the twelve steps, the programme that's built into those twelve steps whereby you're learning to live your life one day at a time – very important – and that encapsulated in that one day is the fact that you must learn. The biggest lesson that I've learned is that in that one day, that I must, by what I say by what I do or by what I fail to do, that I won't hurt any other human being within that day"* (18:539-45) and *"I have to do my service in the fellowship. That's a huge part of the message of AA, giving back. You have to give back"* (18:546-8).

This theme, in a way, brings to a conclusion the question of whether there is a specific message or messages within the 12-step programme. If anybody could be clear on whether there were any or what they were, I believe these two educated and erudite gentlemen would have been.

4.13 Group 5 summary

While academics may debate the underlying conceptual dynamics of an alcohol 12-step group, these two individuals have the lived experience to prove that such a programme works. They described how it worked for them in a real-world situation. "*If you are prepared to go to any lengths..."* (AA World Services Inc., 2001, p. 58) means precisely that, and they did. They also distinguish between being abstinent and recovering. The difference is that the former means simply staying off alcohol, whereas the latter means recovering. They believe recovery entails the actual practicing of all the 12 steps in all their affairs every day. They prioritize this attitude above all else, giving them the thoroughly enjoyable life that they have now. Their narratives, in general, followed those of many of the earlier participants but some significant points emerged. Participant 22 quoted his first sponsor, from 53 years ago, who told him, "*...you must want it for yourself. Not for your wife and family..."* (10:304-5). Another central point made by Participant 22 was that although the programme was written in 1939, it remains unchanged as it is the person who must change and not the programme.

Both participants were in complete agreement that their recovery devolved from living their lives one day at a time, and continuous involvement in service (abv.) is essential to that.

4.14 Overarching theme and themes common to all groups

4.14.1 Introduction

By analyzing all the participants' contributions in their various groups, some themes emerged that were significant to the individual "where they were at" and their relevant groups and in contexts beyond alcohol dependency recovery. These are presented through an overarching theme and then themes, because they are of equal significance at all stages of recovery. Table O1 lists these themes sequentially. Each one represents, in one way or another, a foundational stage critical to how an alcohol-dependent person can start or develop their alcohol dependence recovery.

4.14.2 Overarching Theme: Moving from alcohol dependence to living "happy, joyous and free"

This overarching theme describes, thematically, the alterations in attitude and behaviour that participants underwent as they learned to live sober.

Table 33: Table of themes deriving from overarching theme (n=8)

Overarching theme: Moving from alcohol dependence to living "happy, joyous and free"	
Themes	
1	Experiences at a first 12-step recovery meeting
2	Lack of clarity of recovery group's message
3	"I have an illness/disease" – no one volunteers for addiction
4	Nature of underlying/pre-existing conditions and remedial actions
5	Central role of God or a higher power – a necessary option
6	Twelve-step approach succeeds through members "giving back"
7	"One day at a time" is not just a slogan; it is a belief
8	"Alcohol Use Disorder" – more palatable than "alcoholic"

4.14.2.(i).(a) Theme 1 – Experiences at a first 12-step recovery meeting

Gaining hope through the non-judgmental welcome they received at their first meeting and their identification with others recovering from the same malady or illness was

fundamental to all the participants' success, and 12-step movements' purposes and intents. As such, it merits an in-depth exploration through four sub-themes.

Table 34: Theme 1, sub-themes (n=4)

Theme 1 – Experiences at a first 12-step recovery meeting	
Sub-themes	
1	Courage to change
2	Being welcomed
3	Identification
4	Gaining hope

4.14.2.(i).(a).(i) Sub-theme 1 – Courage to change

It took the participants great courage to attend their first meeting as they had almost no sense of self-worth whether through self-stigmatization, alcohol withdrawal, apprehension, fear, embarrassment from prior failed attempts, guilt, or shame. Participant 1 put it this way: *" It was the most nerve-wracking thing I ever did, but the greatest"* (3:61). Although each participant came from widely disparate backgrounds, they all reached the same point of almost fatal psychological distress or illness through alcohol abuse dependence. Twenty-two of the 23 participants went to the first 12-step meeting, on which their current sobriety is based, of their own volition as a last resort. Participant 19 described how "[It took] ...*courage and desperation, but I did it"* (12:356). The twenty-third, Participant 14, went at the insistence of his wife. Four had a prior (brief) experience of treatment centers (Index 2, p. 299) and some of the others had attended previous meetings but had not absorbed what was required of them to achieve the ability to live sober. This last time, the difference for them was that they had reached the point where they were *"...unable to imagine life either with alcohol or without it. Then he will know loneliness such as few do. He will be at the jumping-off place. He will wish for the end"* (AA World Services Inc., 2001, p. 152). Up to this point, no extrinsic motivation from any source had had any meaningful impact on their aberrational behaviour. However, this new intrinsic motive to change – deriving from whatever source it did – worked.

4.14.2.(i).(a).(ii) Sub-theme 2 – Being welcomed

The welcome a newcomer receives is possibly the most significant part of their initial encounter with a 12-step fellowship, whether through phone inquiries or physically showing up at a meeting. Many groups make a point of opening the meeting room 30 minutes before the scheduled time to afford the time to welcome a newcomer irrespective of the state they are in – these newcomers do not even have to be sober (tradition 3, Appendix 8). This vital element is perpetuated because the "greeter" was once in the same place as the newcomer. Many of the participants commented on this incredible experience and how it affected them. Participant 8 was emphatic about it. *"The welcome I got in that first time was one thing that I think – I still believe that in AA the welcome you get into the first meeting is very important"* (5:125-7). Participant 13 was equally unequivocal about the effect of his reception. "*They're the kind of words I never got. 'It's great to see you'. 'You're very welcome.' People were very welcoming, and I started to fit in. I've never fitted in any place, but I felt……at home, really, in Alcoholics Anonymous"* (26:742-7). As most meetings commence, it is an informal tradition to read out the first three pages of Chapter 5 of the "Big Book", a sentence of which reads, *"There are those, too, who suffer from grave emotional, mental disorders, but many of them do recover if they have the capacity to be honest"* (AA World Services Inc., 2001, p.59). This statement resonated with many newcomers as they had led themselves to believe they were crazy or insane – due to the consequential behaviour associated with their dependency – but they were now being welcomed, somewhere, with unconditional positive regard.

It is standard practice at AA meetings when a newcomer arrives to change the meeting nature to a discussion about step 1 – discussing how they, themselves, came to be there.

4.14.2.(i).(a).(iii) Sub-theme 3 – Identification

As the participants took part in their first meetings, there was a sense of amazement at the experiential similarities they heard when others shared how they came to acknowledge who they were, i.e. their alcoholic identity.

Participant 4 said, "*I'd be listening to 'the top table' and the tears would be running down my cheeks because I was identifying with the people"* (10:307-8). Some even believed that the meetings were told in advance of their proposed participation, so similar were the stories they heard compared to their own. For example, Participant 1 said, *"I thought, in*

my crazy, mad head, that my sister-in-law had told them I was going there and that they were talking about me, because she told them about me....because what they were saying was the way I was feeling, the way I was thinking. I could relate to everybody that shared that night" (3:74-9). Participant 10 expressed his "identification" as "*I do say you're the black sheep of the family and you've found your flock"* (15:531-2). In counselling terminology, their experience would be described as "congruence"; they found "identification" in their own words.

4.14.2.(i).(a).(iv) Sub-theme 4 – Gaining hope

Seeing and hearing the members present at their first meeting talking, laughing and interacting normally immediately gave the participants a glimmer of hope that developed during the meeting. They also experienced a complete lack of condemnation, rejection, or any judgementalism whatsoever towards them. Some found this difficult to absorb, having been the subject of negative interpersonal interaction for many years. They were openly welcomed and usually regarded as the most important person at the meeting, either a newcomer or a "returner".

Participant 12 said, " *I went into it a hopeless drunk, and I came out full of hope"* (17:472-3). As meeting attendance progressed, they realized that they were not alone with their "disease", that the other pleasant and happy individuals present were once like them and wanted to show them how a return to relative normality was possible. Participant 2 said, "*I found hope, I'd seen the hope right at the very start"* (4:100). This "climate of change" (empathy) enabled them to gain the first identifiable positive emotion – hope.

4.14.2.(i).(b) Theme 2 – Lack of clarity of recovery group's message

This theme describes the ambiguities within the conception of the message or messages of the 12-step group.

Table 35: Theme 2 and sub-themes (n=2)

Theme 2 – Lack of clarity of recovery group's message	
Sub-themes	
1	Participants' views of the 12-step messages
2	The 12-step fellowship's views on "the message"

4.14.2.(i).(b).(i) Sub-theme 1 – Participants' views of the 12-step messages

This sub-theme elucidates that none of the members interviewed had received any clear messages from their fellowship. The twelfth step (Appendix 7) states explicitly, *"...we tried to carry this message to the alcoholics and to practice these principles in all our affairs".* As part of every interview, each participant was asked what the message or messages were. Their combined responses are set out in Appendix 11 and reflect the participants' myriad meanings about the messages. All the responses varied – even with the > 50-year participants. There was, however, a predominant response for nine of the participants, and that one was one of "hope".

Even Bill Wilson's own story, *"Pass it On: The Story of Bill Wilson and how the AA message reached the world"* (AA World Services Inc., 1984), does not contain a specific message.

4.14.2.(i).(b).(ii) Sub-theme 2 – the 12-step fellowship's views on "the message"

This sub-theme elicited that there are no-clearly defined or stated messages by the organization

AA itself. Their principal publication states, *"Our book is meant to be suggestive only. We realize we know only a little"* (AA World Services Inc., 2001, p.164) and does not contain one.

4.14.2.(i).(c) Theme 3 – "I have an illness/disease" – no one volunteers for addiction

Although this third theme has already been explored in the findings for Group 1 and others as the analysis of interviews progressed, it became clear that the "illness/disease" concept plays, to this day, a major conceptual role for most of the other participants.

Hearing that they have an illness/disease, usually at their first meeting, had a profound effect on most alcohol-dependent people; it relieved their feelings of guilt and or shame. They realize that they did not opt for the misery they found themselves in, nor were they alone in their situation. Of the 23 participants, 12 specifically refer to their "illness/disease" (Appendix 17). Coupled with their initial welcome to their first meeting, something long missing from their social experiences, they felt accepted by like-minded people who shared similar experiences. As Participant 2 said, he found it "…*aww, amazing"* (7:184). Participant 15 recalled that *"AA took any of this mystique and all of that away. They said we're human beings who have an illness but never forget the fact that you're a human being"* (20:596-8).

This theme shows that explaining their condition for the newcomer relieves them of the guilt, shame and remorse they feel, and then it offers a way out.

4.14.2.(i).(d) Theme 4 – Nature of underlying pre-existing conditions and remedial actions

This theme showed that while a 12-step fellowship can help redress many psycho-social issues, it is not a "catch-all" cure for every psychological problem.

For example, Participant 7 used alcohol initially to overcome her introversion. "*Then alcohol allowed me to lose that self-consciousness and become – revert back to the person I thought I really was and liked to be"* (3:83-4), but now she no longer needs it. Participant 13 described, "*My story was that I always had something in my system that stopped me feeling the way I felt. I didn't know how I felt, to be honest. That was the thing"* (4:111-3). While both were able to deal with their social phobias through the 12-step fellowship, both required outside help. Participant 13 twice received professional help after 10 and 16 years of sobriety to help him with childhood issues that still troubled him.

A generalized list of all participants' underlying or pre-existing conditions appears in Index 5 (p. 298). They are wide-ranging and display a broad spectrum of psychosocial difficulties. They are either in the process of addressing or have addressed them at meetings, with sponsors or, where necessary, using outside professional help.

4.14.2.(i).(e) Theme 5 – Central role of God or a higher power – a necessary option

This fifth theme is another cornerstone in the recovery approach of 12-step groups: the need for intervention by God/higher power or another spiritual dimension in the recovery process.

(*"The spiritual life is not a theory.* We have to live it" (AA World Services Inc., 2001, p. 83).

References to God/higher power and atheism are mentioned many times in AA literature and several times by Group 1 members, but they begin to drop in the latter groups. Participant 14's statement, "*I haven't had to have a drink from that day to this. By the grace of God, I don't take credit for it, because it's been done for me"* (7:208-10)

exemplifies what many of the participants believe. The lessening of references to God/higher power in groups C and D, rather than reflecting a loss or diminution of its importance, reflects a much deeper acceptance of the impact of such a power as the participants understand it. This reduction in references to God and a higher power is particularly evident in the narratives within Group 4. Participant 20 described,

> *"I had great trouble in arriving at a concept of a higher power and the concept of God...and then I came to this conclusion myself that alcohol is a higher power. I thought maybe I'd try and replace that negative power with a positive power, and then I started to believe in the power of good through AA. Then, after a time, I did develop a concept of God after about 18 months that I've been quite comfortable with since."* (6:142-152)

Even those who espouse atheism begin to or now have an open, tolerant mind to the concept that some power greater than themselves has got them to where they are today – just as Carl Rogers went from atheist to agnostic and, shortly before his death, expressed regret at his choice to disregard the spiritual dimension to existence.

Through this theme, across the groups, it can be seen how the spiritual side of the programme becomes almost an unconscious part of the participants' re-directed way of thinking or believing.

4.14.2.(i).(f) Theme 6 – Twelve-step approach succeeds through members "giving back"

This theme describes how members give freely back to the organization in gratitude for the new lease of life they have been given and remains practiced even for those who have very lengthy sobriety.

The running joke within the AA organization is that the "steps" (Appendix 7) protect members from killing themselves and the "traditions" (Appendix 8) protect them from killing one another. However, it is fundamentally true – there are no bosses, just trusted servants (AA World Services Inc., 2012, p. 136; Appendix 8, tradition 2). As quoted earlier, Bob Smith simplified the entire programme into two words: "*love and service"* (Appendix 16). Participant 9 commented, *"If you can get into that regular habit of service,*

it frees you from that small ego. I'm just an employee of the universe" (4:822-3). Even after 50 years of sobriety, Participant 22 opines, *"It was my gratitude for being sober at Alcoholics Anonymous was part of being in service. I've always tried to emphasize to anyone get involved in service, whatever it is, get involved..."* (19:601-3).

An organization with over 2 million active members, frequently meeting in diverse locations globally, requires extensive organization. Bearing in mind the seventh tradition that "*Every AA group ought to be fully self-supporting, declining outside contributions"* (Appendix 8) means that, as well as the dissemination of the message to the still suffering alcoholic (step 12, Appendix 7), there is a large amount of background work to be done to keep the movement operational at a minimal cost. This work ranges from arranging meeting venues, getting secretaries to run meetings, appointing treasurers, having "meet and greeters" for newcomers, and cleaning. A structural system must be in place for overall smooth running while still subject to the maxim that "*Our leaders remain but trusted servants, they do not govern*" (tradition 2, Appendix 8). Above the meetings, there are intergroup meetings (to ensure equanimity of practices and procedures) who in turn report to Group Areas (covering countries and regions) who in turn report to the General Service Office (GSO; the headquarters). GSO is subject to "The AA Service Manual/12 Concepts of World Service" (AA Grapevine Inc. 1962) and deals with the organization globally. The members provide all these functions free of charge except for out-of-pocket vouched travel costs and miscellaneous expenses. There is a provision for payment for extraordinary items – such as a function carried out by a non-alcoholic professional.

As with the previous theme, "service" becomes a more ingrained habit the longer participants are members. With that practice, members derive accreting benefits in their day-to-day living.

4.14.2.(i).(g) Theme 7 – "One day at a time" is not just a slogan; it is a belief

The seventh theme refers to the concept that recovery is on a daily basis and, within the fellowship, enjoys virtually universal acceptance. This "slogan" (Appendix 13) has been put to music by Marijohn Wilson and Kris Kristofferson (1973), becoming a worldwide hit, so it is well-known outside of the Anonymous fellowships. In its alcohol context, the import is made clearer: *"We are not cured of alcoholism. What we really have is a daily*

reprieve contingent on the maintenance of our spiritual condition" (AA World Services Inc., 2001, p. 85). A daily reprieve is a fundamental concept for the participants, and 16 of the 23 interviewees expressly referred to it. It was fascinating to note the emphasis that the > 50 years participants placed on "the daily reprieve" concept. Participant 23 said, *"I mean, it's just chalk and cheese, that serenity that I have, thanks be to God. Again, that serenity is very, very fragile. I have to mind it and watch it. Everything is on a daily basis"* (22:670-3). I asked Participant 23, specifically, whether he still accepts that his sobriety was just on a daily basis, and he replied, *"Yes, on a daily basis"* (25:758). Participant 22, too, was quite clear: *"...all we want you to do is to stay away from one drink for one day at a time"* (23:740-1). Almost all participants remembered exactly their original "sobriety date". The origins of this "daily" approach can be traced back to the biblical reference in Matthew 6:34, *"Take therefore no thought for the morrow: for the morrow shall take thought for the things of itself. Sufficient unto the day is the evil thereof"* (King James Version, 1769/2008).

4.14.2.(i).(h) Theme 8 – "**Alcohol Use Disorder" – more palatable than "alcoholic"**

This theme explored the effects of using the term 'alcoholic' as a label. Well recognized in the literature as having compounding negative connotations, it exacerbates negative feelings among the active alcohol dependent. However, few participants across the groups mentioned it. Participant 6 (a counsellor) expressed the view that the use of the term "alcohol dependent" *"... seems softer doesn't it. It seems less judgmental*" (12:352) and was a more acceptable description thus the importance of using person-first language. Much work is needed to remove the term "alcoholic" from general public usage, with all its negative connotations.

4.15 Summary of Overarching Theme

The themes explored above described how the participants became members of the alcohol self-help Group and how they absorbed the group's recovery messages – helping them understand the necessary changes to be made in their lives to move from being alcohol dependent people to becoming decent, sober ones. Despite experiencing mental, emotional or physical nadirs, these themes and sub-themes discussed how the participants found the courage to attend a 12-step group meeting and seek help. They were surprised at the open

welcome they received and gained hope through their immediate identification, hearing existing members' stories who were also recovering from the same problems they were experiencing. They also heard that it is possible to conceptualize their AUD in the context of "having a disease"; there was a solution to it, which brought a profound sense of relief. Having been subject to direction, abuse and opprobrium for so long, they felt relieved that the remedy was a *suggested* programme whose only requirement for membership was having a *"desire"* to stop drinking. There were no pre-defined rules or bosses. While a spiritual dimension was an integral tenet, they were free to pick (or not) a God/higher power *as they understood* Him – they simply had to accept that there was a "power" or "force", of whatever form they wished, that they could turn to for help when they were facing psychological distress. They learned about the programme that, *"It works if you work it and it won't if you don't",* which is precisely what 22 of the 23 participants did.

4.16 Conclusion

For individuals with a severe alcohol use disorder, based on the fellowship's combined experience, there is no cure for their malady. However, a viable daily reprieve is available that costs nothing but a commitment to a new way of living. This reprieve is somewhat paradoxical; the more one helps in its organization and tries to give "it" away, the more they gain from it. When they join, they find a suggested programme that allows them the freedom to design their own sobriety – within the overall parameters suggested.

5. DISCUSSION

5.1 Introduction

This study aimed to explore the experiences of members of self-help groups in their attainment of lifelong abstinent recovery. The research took the form of a phenomenological exploration of the lived experiences of alcohol-dependent people who, through a 12-step group, are in recovery from their condition for durations of between 10 and 50 years.

The discussion has been organized according to the sampling units, in keeping with the aim of the research, to explore the developmental trajectory of a life lived sober across the life course. Thus, the discussion focuses initially on the findings from the 10 years sober, followed by 20 years and so forth. In this way, the structure of the discussion affords each group the necessary focus for their respective stage of recovery and or sobriety.

Although Smith, Flowers and Larkin (2009) originally suggested that, with large numbers, that a few exemplars be selected for in depth exploration. However, now (in their 2022) version they refer to the fact that larger numbers are expected at doctoral level and while the methodology section is written in the active or 'present' voice, they say

> *"Above we suggested IPA studies normally separate discussion from analysis, and we would definitely recommend this for new students. However, it is possible, once you are more experienced, to choose not to have a clear demarcation between these two sections and rather to relate themes to extant literature as you are going along. In this case results and discussion are merged into one section."* (p. 117)

Having lived with a possibly recurrent cancer for more than forty years, I am aware that developmental changes that occur through different decades such as the fear in the first "*Am I going to die while my children are very young?"* to the realization that as I continue to exist, my role in their education, upbringing and well being diminishes and I personally develop to the point now, that my death now is of no particular significance in their welfare and has lost its power over my living consciousness. Even though I developed another form of cancer circa 2013 at the age of 61 (and which I rather obviously have survived) rather than being disturbed/distraught/worried etcetera, I was most chagrined at the fact that it was unlikely I get to complete a PhD that I had commenced the previous year.

In this thesis, the apparent repetition of themes is unavoidable such as how or why AUDs

joined the 12-step fellowship – every case is different with different precursors. The 23 participants had a combined total of 617 years of sobriety.

The research focus was original in that it explored the developmental processes of a major self- help group on a cross-sectional basis (cross-sectional by reference to decades rather than years or months) through the lens of the personal accounts of participants with severe alcohol dependencies. All meet the DSM-V criteria for severe alcohol dependence (each participant was assessed under DSM-V criteria, Appendix 18). These participants had successfully addressed their addiction problem at their own pace and had returned, or are returning, to everyday living, having made *"the crooked straight, and the rough places plain"* (Handel, 1741). It also explored participants' perceptions of where they viewed themselves concerning attaining the 12 promises made by their 12-step programme (Kelly & Greene, 2013). No earlier literature can be located that explored the concept of whether and when those 12 promises come true. This study spanned five decades – the only more extended study, and in which the participants were continuously monitored for 60 years, was that conducted by Vaillant (2003). Further, the study attempted to identify the key message or messages underpinning the entire 12-step approach.

From the findings of this study, all the participants' perceptions indicated two significant points: firstly, that stable recovery is a long-drawn-out person driven process and may take more than five years as suggested by the Betty Forde Institute Consensus Panel (2007); and secondly, continuous total abstinence for all of them is a pre-requisite – despite the views expressed in Rosenberg et al. (2020) and Witkiewitz et al. (2020b). This discussion of the research findings is in three sections and follows the flow of the research objectives, which were:

1. To explore the experiences of people with AUD at the first meeting of their self-help group, on which their current sobriety is based.

2. To understand the core elements of the message from the self-help group for people with AUD in developing a lifetime of sobriety.

3. To understand how people with AUD interpret and develop these core elements

underpinning their recovery at 10 years, 20 years, 30 years, 40 years, and 50 years.

4. To understand the challenges of incorporating the core elements of the message from a self-help group into a lifetime of recovery from AUD.

5. To provide recommendations for self-help groups on supporting people with AUD in maintaining a lifetime of sobriety.

6: To provide recommendations for preventative services, and other professionals interested in addressing alcohol and or substance use disorder in the community

Section A below ("From Insanity to seeking Normality") explores and discusses the first research objective, i.e., experiences of new members at the first meeting on which their current sobriety is based and determines the core elements of the *message* of self-help groups in the area of AUD. Section B ("From Normality to Generativity/Transcendence") discusses objective two – how members adopt these key elements into living a life of recovery. Section C explores the suggested beneficial outcomes that may flow from adhering to the programme described in the form as the twelve promises. (AA World Services, 2001, p. 84)

Objectives three, four and five, focusing on how applying this research's findings can improve current treatment approaches and increase awareness of tackling the broader community's alcohol problem, are incorporated into the Conclusion chapter.

5.2 Part A: From Insanity to seeking Normality

5.2.1 Experiences of participants at the first meeting grounding their current sobriety and determining 'message' from self-help groups in the area of AUD

By exploring participants' experiences of the first meeting grounding their current sobriety, core elements constituting the "message" of AA underlying their initiation, participation in the group and ongoing sobriety can be determined and brought together. These core elements do not appear in sequence within any material issued by Alcoholics Anonymous

(AA) or other treatment approaches. They are, however, mentioned in different contexts and stages.

5.2.2 "Courage to change" – the decision to attend a 12-step group

During the development or onset of their alcohol dependency, the participants had manipulated the significant people in their lives with duplicity, prevarication, and ultimately downright dishonesty. This propensity for manipulation undermined the ability to satisfy some of their fundamental human needs of intimate relations, security, and safety (Maslow, 1943). They began to perceive themselves as "bad" people – isolated and alone. An alcohol dependent person drinks to celebrate, "drown their sorrows", relieve boredom or other uncomfortable feelings, start the day, end the day, and even just get through the day. On all occasions and in all circumstances, alcohol presents support in some form or other. "*This relationship with alcohol becomes all-embracing, all-encompassing to the exclusion of all other meaningful attachments"* (Murphy, 2011a, p. 11). Bowlby (1973, p. 292) defined attachment as "*any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, usually conceived as stronger and/or wiser*". This attachment may also apply to objects (Keefer et al., 2012). In severe dependency, alcohol gives a clear example of object satisfaction of emotional succor. Loos (2002) described this point as being one of *"depraved loneliness"* (p. 199). Through a diversity of routes, the participants attended a 12-step meeting that changed their entire perception of life for the better. Despite a mixture of fear, apprehension, resentment, reluctance and trepidation, they found the courage to face up to the fact that their whole way of thinking and being may be under threat.

5.2.3 The reception and reaction to the participant's attendance

Surprisingly, there is limited literature on the profound effect that the welcome received by newcomers to meetings may have (Right, 1997; Lofland & Lejune, 1960). Hedges (2007) suggested that a recovering alcohol-dependent person is the living evidence of the program's effectiveness and a better promoter of change than enticement or inducement of family, friends or professionals. The best example of this self-deprecation being overcome is given by Basil, who, after drinking his way through 17 years of therapy and psychoanalysis to no effect, joined AA in desperation, voluntarily and without inducement, and said he regained his emotions after five years (10:286). All the participants commented that they

were overwhelmed by the acceptance shown to them by the group, a quality understood in Rogerian terms as unconditional positive regard.

Nine of the participants expressly referred to gaining hope that they, too, could recover. Frings et al. (2019), in exploring “tales of hope”, found that social identity may underpin addiction recovery via such contextualization. However, that study was limited to written material supplied to participants. Wnuk (2017) explored the subject of hope as an essential factor for mental health in patients attending AA and found *"Hope was correlated with two out of the three indicators of mental health, i.e., with the up till now evaluation of one's life and stress levels"* (p. 184). The third item referred to the correlation between "*time spent attending AA with the duration of alcohol abstinence and the level of hope"*. Surprisingly, Wnuk's (2017) finding gave an indeterminate outcome regarding extended hope, as nine of the participants in this research mentioned hope in terms of the future – even Participant 23, with >50 years of sobriety. Bradshaw et al. (2017) also proved that hope plays a role in recovery and relapse prevention by examining the dorsomedial prefrontal cortex dysfunction changes. Magura et al. (2003) had earlier established that hope and spirituality play a role in health promotion behaviour. AA itself says that "*Hope is the key that unlocks the door of discouragement. The programme promises me that if I do not pick up the first drink today, I will always have hope"* (AA World Services Inc., 1990, p.70). However, in the context of this study the “hope” expressed by participants changes in nature over time, from being a fundamental aspiration (as expressed by Group A participants) to a genuine belief in a better future in later years.

5.2.4 Rogerian principles of person-centred counselling apply to first interactions

Phenomenology underpins aspects of Carl Rogers’ original client-centered therapy (Rogers, 1951). Three of the six core conditions of counselling Rogers identified in 1957 – empathy, congruence and unconditional regard – were experienced by the participants at their first meeting. Concerning these core conditions, Rogers (1957) stated, *"No other conditions are necessary. If these six conditions exist and continue over a period of time, this is sufficient. The process of constructive personality change will follow"* (pp. 95–6). The three other conditions are also met for participants, except through the group rather than attending a counsellor. However, Rogers (1957) did not develop his theories until after establishing the first 12-step movement – Alcoholics Anonymous – in 1937.

Furthermore, the fellowship can only be partly considered in the context of his person-centred approach to therapy due to his disavowal of any role for God/spirituality – he, being an atheist, later an agnostic – only acknowledging the possibility of "*the mystical spiritual and transcendental"* 10 years before he died (Thorne, 1992).

5.2.5 The effect of the "God" word

One of the aspects of 12-step recovery that appears unexplored in literature is the effect of the initial sighting of the word "God", prominently displayed in the 12-steps scrolls hung at all meetings. It can be a significant "turn-off" for new members and may account, partly, for the same rate of drop-out of 80% as to other treatment approaches reported by Emrick & Beresford (2016). When speaking to Public Information Officers while recruiting participants, most confirmed that they had the experience of new members having adverse reactions to the word "God" and always ensured that, during the meeting, some members pointed out the word "God" is always qualified by the phrase "*as you understand Him".* Of the participants, 12 initially had a problem with the "God" aspect, 11 were ambivalent, unsure, or atheistic. In an informal discussion with me after an open meeting, one member stated that AA is just like the Christian faith insofar as they have one principle in common that is mentioned in the bible (KJV, Matthew 18:20) *"For where two or three are gathered together in my name, there am I in the midst of them."* He was referring to a God/higher power always being present at AA meetings.

Details of the participants' initial reactions, distilled from interviews, are set out in Appendix 19.

It is noteworthy that, although the AA 12-step fellowship places significant importance on the report of a meeting between Carl Jung and Roland H. regarding the need for a spiritual awakening, there is little or no reference to Jung's comment in his letter of 30 January 1961 to Bill Wilson on the subject when he (Jung) stated *"An ordinary man, not protected by an action from above and isolated in society, cannot resist the power of evil, which is called very aptly the Devil".*(Appendix 21) Jung, however, goes on to suggest that the general use of such terms is unwise and that an aloofness to its usage is appropriate.

5.3 The elements that make up the "message" of 12-step groups

Although the medical profession and the psychological fields remain some distance apart, recent research is beginning to close the gap. Examples include genome exploration (Frank et al., 2012; Sanchez-Roige et al., 2019); MRI studies distinguishing alcohol-related brain effects that are permanent from those that are reversible with abstention (Zahr and Pfefferbaum, 2017); the elucidation of profound changes in cellular physiology and molecular markers in crucial brain regions during the development of dependency in animals by Crowley et al. (2019); genetic studies of alcohol dependence in the context of the addiction cycle (Reilly et al., 2017); and other allied studies. Although lending more credence to the disease modelling of AUD, this has little or no influence on 12-step approaches to addiction treatment now. The participants' belief that they have an "allergy/disease" and that there is a "cure", evidenced by sober/clean members, significantly impacted new participants. Five of the 10-year group, two of the 20-year group, three of the 30-year group, four of the 40-year group and one of the two 50-year group participants specifically refer to their condition as a disease or illness. Irrespective of the argument's merit or strength, it gave them a sense of relief to hear that they had something wrong with them, an illness for which they did not volunteer, and which meant they were not crazy or maladjusted people. While nowhere in its texts is stated what *the message* of the fellowships is, it is possible to determine five core elements that go towards understanding what they wish to convey.

5.3.(i) The first core element – exploring the AA's concept of illness

From their first publishing of "The Big Book", AA include an undated open letter written to them by Dr. William D. Silkworth wherein he states, *"The inevitable conclusion is that true alcoholism is an allergic state, the result of gradually increasing sensitization by alcohol over a more or less extended period of time"* (cited in AA World Services, 2001, p. xxv and xxx) and they treat his "allergy" reference as being to a medical condition – an illness.

Even though participants may have tried meetings before, they were not then open to conceding defeat to alcohol, nor receptive to the help being freely and unconditionally offered to them. As participant Amy said about those earlier meetings, she wondered what their angle was (7:219-20). Now, utterly defeated, and really seeing other sober and happy members at the first meeting upon which their current sobriety is based, they were able to

hear and accept that their alcohol dependence was not their own fault – that they had an "illness", relieving them of their feelings of guilt, shame, remorse and self-loathing.
This is the first core element that the participants picked up was "I have an illness".

5.3.(ii) The second core element – *"We have found a common solution"*

Chapter 2 of the "Big Book" (AA World Services Inc., 2001) states,

> *"The tremendous fact for every one of us is that we have discovered a common solution. We have a way out on which we can absolutely agree and upon which we can join in brotherly and harmonious action. This is the great news this book carries to those who suffer from alcoholism"* (p.17).

Despite this statement's clarity and optimism, only one participant – Denise – directly referred to it, and even then, she did not recall the wording. However, the import endured for all the participants, evidenced by the progression in their quality-of-life experiences. While these changes may have had slow beginnings in the first 10 years where the hope of a continuation of such life improvements played a significant role, the accounts of the participants show how they developed from angry, bitter and resentful, self-centered alcohol-dependent individuals to being sober, considerate, reasonable and tolerant without changing their innate personalities.

This is the second core element, "*...we have discovered a common solution. We have a way out on which we can absolutely agree*".

5.3 (iii) The third core element – "do" the 12 steps of the fellowship

The Big Book recounts how the original members did recover in the late 1930s/early 1940s by clearly stating, *"Here are the steps we took, which are suggested as a programme of recovery"* (AA World Services Inc., 2001, p.59). Experienced members suggest that new members divide the 12 steps into three parts – steps 1-3 are the "Acceptance or trust" steps; 4-9 are the "self- examination/redemption" steps, and 10-12 are the "maintenance" steps. McCabe (2015) equates this, on a step-by-step basis, to the Jungian process of "individuation".

1. The first three steps – *"Acceptance and trusting in a power greater than themselves"*

These three steps require an individual to admit that they are alcohol dependent, that their lives have become unmanageable, that a power greater than themselves can restore them to sanity, and that they should make a decision to turn their will and lives over to the care of God or any Higher Power as they comprehend such an entity.

In the first step of the programme, new members are obliged to accept that they are human and are not in control of their own lives and drinking. "*Drinking alcoholics often believe they are empowered by it when in fact they are victims of it. Recovering alcoholics acknowledge that they have no power over alcohol and are, in turn, empowered by the truth and their acceptance of it"* (Brown, 1993, p. 138). Kurtz (1991) suggested that through the lack of control over their drinking, alcoholics realize "*...they are not infinite, not absolute, not God"* (p. 3). Kurtz argued that within this "not-God"-ness lies the beginning of recovery – the alcoholic's acceptance of their humanness and the need for fellowship. Bateson (1971) suggested that implicit in the first step of AA is " *...the experience of defeat not only serves to convince the alcoholic that change is necessary, it is the first step in that change*" (p. 4)

Whether through experience with group fellowship, a "*psychic change"* (AA World Services Inc., 2001, p. 21) or a *"A Spiritual Experience of the Educational Variety"* (AA World Services Inc., 2001, p. 567; Appendix 15), the participants came to understand that adding a spiritual dimension to the "recover package" is a vital element. For some participants, this conversion or reversion came to pass similarly to Bill Wilson's description of his spiritual awakening (see 2.4.6 (i) above). For participants Anne, Amy, Breda, Ben, Carl, Denise and Participant 23, it happened after they had been attending meetings for some time in the form of "moments of clarity" – when they could see themselves as who they really were. Only Participant 23 and Breda describe how this "rock bottom" or, in Jungian terms, "ego deflation in depth" occurred before they attended their first meeting. For the others, it took many years, and a few remained atheistic – but became more open-minded on the God/spirituality concept. Recovery took longer for those who remained atheist/agnostic, impacting how they developed in their sobriety. One way or another, it could not be ignored – it is a tenet of the programme. New participants, who are put off by the "God" word, are encouraged to see the word as standing for "group of drunks" (Breda, 7: 847-8) or "good order and discipline" or, if that does not work, to regard the

group itself as a power greater than themselves – as they have kept the person sober for that day.

While Kelly (2017) suggests that *"AA's beneficial effects seem to be carried predominantly by social, cognitive, and affective mechanisms"* and that *"...studies on MOBC* [Methods of Behavioral Change] *suggest this* [spirituality] *may be true only for a minority of participants with high addiction severity"* (p. 929), in general the current participants who are the longest sober would disagree with his view. Tonigan et al. (2013) suggested that spiritual change, as reflected in increased religious behaviour, was predictive of increased abstinence and decreased drinking intensity but varied across levels of spiritual practices. Tusa and Burgholzer (2103) reviewed the literature on spirituality as a mechanism of change in AA between 1992 and 2012 and concluded that

> *"The complex nature of 12-step recovery and issues surrounding the measurement of concepts like spirituality have proven challenging. Initial studies have indicated that spirituality, as practiced in AA, affects change through common pathways present in other treatment modalities"* (p. 244).

Timmons et al. (2019) reviewed spirituality and locus of control and found, "*Our exploration certainly supports interest in the relationship between spiritual beliefs and behaviours but* [found] *limited research that examines the concept of spirituality per se*" (p.98).

Professional approaches have, until recently, been skeptical regarding the "spiritual" dimension of AA studies. For example, Day et al. (2015) demonstrated that the apparently "religious" nature is a significant factor in skepticism about 12-step mutual aid amongst professionals and their clients. However, this view changed when Kelly (2017) identified that spirituality was the "scaffold" that mobilized the other mechanisms of change: those of a social, cognitive and affective nature. Dermatis and Galanter (2016) also suggested that, as recovery was "*nothing short of a miracle from God"* (p. 517), greater spirituality levels would be found among those sober longer and the current study bears their suggestion out. The further point is that the concept of spirituality is endemic to its success. AA state: *"The spiritual life is not a theory.* We have to life it*"* (AA World Services 2001, p. 83) This "spirituality" – no matter how broad an interpretation a participant gives it – requires the

practicing of discipline and repetition, just as all the other change mechanisms do.

Step 10 of the programme suggests explicitly taking a daily inventory, and when a wrong comes to light, promptly admitting it and then righting it as soon as possible. In AA's third step prayer is the line "*Relieve me of the bondage of self ...*" (Appendix 14), and all participants reflect this desire and behaviour. What is evident from the current study is that the longer the participants were in the programme, the more a spiritual dimension became a vital element of their recovery – but simply less spoken about except at meetings. This practice reinforces one of the findings by Dermatis and Galanter (2016) that more extended sobriety is linked to increased spirituality and lends further credence to Vaillant's statement, "*I believe that AA provides a concrete example of spirituality being made safe for human consumption*" (Vaillant, 2014, p. 215). The participants who chose to remain agnostic derived fewer and slower benefits from the programme – despite there being a chapter in the main text specifically addressed to agnostics (AA World Services Inc., 2001, Chapter 4 *"We Agnostics"* pp. 44-57) about how to circumvent the dilemma this presented to them. The advocation of trusting in a God/higher power, if not conceded at this early stage, undermines the rest of the steps. This "acceptance" becomes apparent in the following subparagraph.

2. Steps 4-9 – the "self-examination" and "redemption" steps

In order to work their way properly through steps 4-9, AA recommends that a member engages with a sponsor. Numerous studies support this contention, including Kelly et al. (2016), Tonigan and Rice (2010) and Pagano et al. (2004). Stevens and Jason (2015a; 2015b) found a good sponsor's characteristics to be those currently engaged in the programme, trustworthy, available, respectful of confidentiality, and with the necessary knowledge and experience. McCabe's (2015, p. 86) Jungian description of them is "…*the epitome of the archetypal wounded healer*". Bowlby (1973) would see the sponsor taking the role of a new attachment figure – someone conceived as stronger and or wiser, and with whom the newcomer could form a secure attachment.

The participants indicated that they felt apprehension and difficulty concerning tackling these steps. Anne, who took three years to address them, demonstrated this reluctance.

Even then, she did not engage fully due to trust issues and, as she related, she had to repeat the process two years later after nearly relapsing. Amy, too, took three years to address the steps but had to repeat the process after eight years for the same reason – lack of unconditional trust in a higher power or another human being. Alan, who never went beyond step 1, and Adam, who never went through the steps, have reaped the minimum benefit from the programme but remain sober. Brian, Charlie, Cathy, Declan and David never had a sponsor but, apart from Cathy, have acted as sponsors.

It is usual practice for the sponsee to write out everything about themselves in a suggested format under three headings: *"I'm resentful at", "The cause",* and *"Affects my"* (AA World Services Inc., 2001, p. 65), before speaking with the sponsor about their step work. Quite often, a column *"My part"* is added by a sponsor. While there are advantages of using a sponsor over a practicing counsellor or therapist in terms of availability and being free of charge, there are some potential pitfalls, such as the harm that may arise from unqualified people in dealing with childhood abuse or other sensitive issues (Wilsnack, 1973; Beckman, 1994; Schwandt et al., 2013).

The third entity mentioned in step five ("*Admitted to God, to ourselves* and to another human being, *the exact nature of our wrongs")* presented a major stumbling block, and some of the participants did this with a distant priest or in a monastery, rather than their sponsor. This need to "confess" to another human being, and the consequences arising therefrom, were identified by Jung (1954). *"Confessions made to one's secret self generally have little or no effect, whereas confessions made to another are much more promising"* (p. 292) and "*The goal of the cathartic method is full confession – not merely the intellectual recognition of the facts with the head, but their confirmation heart and the actual release of suppressed emotion"* (Jung, 1954, p. 68). More recently, in writing about Jung's views on confession, Todd suggests that *"Confession and forgiveness, then, are twin elements of a process frequently encountered in basic human relationships. The idea of confession and forgiveness is located in that place where psychology and religion meet – guilt"* (Todd, 1985, p. 39). Based on her study of Jung's work, Todd also states that *"It is essential that the confession involves another human being who accepts, and pardons. The penitent is no longer alone. His burden of shame guilt is now shared and lessened. The isolation and alienation are lessened, moral exile has ended"* (Todd, 1985, p.42).

Using regression analysis, Gomes and Hart (2009) found that going through steps 4 and 5 with a sponsor had a significant effect regarding remaining sober and improved emotional and existential well-being. Failing to have completed step 5 properly makes step 9 virtually impossible to address fully. Step 9 reads, *"Made direct amends to such people except where to do so would injure them or others"* (AA World Services Inc., 2001, p. 59). This step, being the first part of bringing the programme into the public domain (out of the meeting rooms), when appropriately done, proves cathartic and liberating. It does not, however, refer directly to making amends or to forgiving oneself.

While dealing with *"guilt"* plays an integral part in recovery, so too does addressing *"shame."*(Erikson, 1997). As Kim et al. (2011) point out, the person perceives their behaviours as "bad", and thus the self is negatively evaluated. Scheff (2000) refers to shame as a "social emotion" interfering with others and their social worlds. Sawer et al. (2020) found that alcohol served as a means of artificially relieving these feelings of worthlessness and a means of connecting with others, concluding that addressing shame was an important component in recovery. In this context of negative self-evaluation, Krentzman et al. (2018) examined the longitudinal relationship of the forgiveness of self and others. They found that participants were more forgiving of others than themselves, while each type of "forgiveness" increased over time, the effect on forgiveness of others compared with self was twice as strong as the reverse effect.

3.Steps 10-12 – the "maintenance" steps

Steps 10, 11 and 12, the "maintenance" steps, describe continuing and improving recovery behaviors. Practiced daily, they require taking a daily inventory and the prompt admission of any wrongdoing, trying to improve a conscious contact with "God" through prayer and meditation, trying to help still suffering alcoholics, and practicing all the fellowship principles in all their affairs.

Step 12 embraces a considerable part of the programme. The Step begins with the statement *"Having had a spiritual awakening..."*. This *"spiritual awakening",* or "*Spiritus contra spiritum"* (Jung, 1961), has been discussed above in earlier paragraphs. Although some participants said they remain atheistic – the majority being in the 10-year group –

Segal (2020, p. 2) suggested a broader conception of spirituality *"...consistent with both theistic interpretations and naturalistic ones that centre on such things as unselfishness and healthy emotional connectedness to other conscious beings and the rest of nature*", which he refers to as N-spirituality. This broader interpretation has no metaphysical commitments and would bring those who proclaim remaining atheistic/agnostic or "anti-God" within a spiritual awakening concept.

On the other hand, Segal accepts that his "*...complex hypothesis* [is] *yet to be scientifically validated"* (2020, p. 2). As mentioned earlier, AA devotes an entire chapter to the subject, *"We Agnostics"* (AA World Services Inc., 2001, pp. 44-57). Hearing the changed behaviors and attitudes of the "agnostic participants" tends to suggest that "agnostic" is a label to which the participant wishes to cling on, based on undisclosed childhood or other issues, rather than being a factual statement of belief or non-belief, and is belied to an extent by how they do try to "*... practice the programme in all our affairs*". Notwithstanding these comments, those who still proclaim agnosticism do reflect a slower rate of recovery.

A further part of this step is "*...we tried to carry this message to still suffering alcoholics...".* This action is a vital part of the programme. Most of the participants have acted as a sponsor at some stage or another. Borrowing a phrase from the legal community, *"Noscitur a sociis"* (its associates shall know it), is highly applicable to recovery and behaviour and 12-step membership. Thus, the third core element is, "do" the 12 steps of the fellowship.

5.3.(iv) The fourth core element – "*What we have is a daily reprieve contingent on the maintenance of our spiritual condition "*

Section B of this discussion ("From Normality to Generativity /Transcendence") elaborates on the importance, absorption and acceptance of the statement, *"We are not cured of alcoholism. What we really have is a daily reprieve contingent on the maintenance of our spiritual condition"* (AA World Services, 2001, p. 85). This message is referenced by 16 of the 23 participants and has two essential points. The first one is that of not being cured of AUD. There are many analogous examples used by AA; the necessity to take daily medication such as insulin, an allergy to peanuts, and similar examples – for all of which there are no "days off". Recent literature suggests otherwise that AUD recovery can include

some heavy drinking (Witkiewitz et al., 2020a; Witkiewitz et al., 2020b; Fan et al., 2019). However, this is, as yet a developing area of research. Some alcohol consumption may be possible for people with mild or moderate AUD as defined by the then DSM-IV (Vaillant 1988), However, those who frequently attend frequently 12-step meetings generally have severe AUD –the third and highest category defined by the DSM-V- and a return to social drinking is simply not an option. The participants of this research give multiple examples about how they tried this approach with no success. None of the participants would consider such a course as being viable.

Thus, the fourth core element is "*We are not cured of alcoholism. What we really have is a daily reprieve contingent on the maintenance of our spiritual condition".*

5.3.(v) The fifth core element – the attainable idealised life

The Big Book (abv.) describes an idealised life achievable in several specific details – sometimes referred to as "the promises of AA". They are set out in Appendix 9 and the realization of attaining these promises is discussed in detail in part 5 C of this thesis. These promises or outcomes are the fifth and final core element of AA's "message".

These five core elements described in the preceding paragraphs constitute the core of AA's "*message"* .

5.4 Summary of core elements constituting the "message" of AA

Throughout history, alcohol-related mutual self-help groups have not met with much success. However, as Emerick and Beresford (2016) suggested, it would better demonstrate AA's efficacy by assessing those who have had an adequate "dose" of the programme. They opined

that treating all dropouts and one-time attendees as failures led to a gross underestimation of AA's effectiveness. Indeed, in my initial meeting with a Public Information Officer in Lanzarote, she stated she knew every English-speaking member (or former member) permanently living on the island, and their outcome rate since inception was over 80% – despite the absence of any licensing laws or special taxes or duties on liquor.

While some of the other early groups enjoyed rapid growth, they usually disintegrated through internecine difficulties. AA found that "directions" led to problems; hence, they only made their entire programme suggestive. Notwithstanding the absence of mandating in any aspect, certain parts of their programme are fundamental necessities. These "core elements", as enumerated 1- 5 above, are essential elements of its 'message' and underpin its success – both for the organization and the individual alcoholic.

They are summarized as follows together with their source reference:

Core Element 1 is *"The inevitable conclusion is that true AUD is an allergic state, the result of gradually increasing sensitization by alcohol over a more or less extended period of time"* (Silkworth, 1937).

Core Element 2 is that *"The tremendous fact for every one of us is that we have discovered a common solution. We have a way out on which we can absolutely agree, and upon which we can join in brotherly and harmonious action. This is the great news this book carries to those who suffer from AUD"* (AA World Services Inc., 2001, p. 17).

Core Element 3 is about working the suggested programme: *"Here are the steps we took, which are suggested as a programme of recovery"* (AA World Services Inc., 2001, p.59).

Core Element 4 is *"We are not cured of alcoholism. What we really have is a daily reprieve contingent on the maintenance of our spiritual condition"* (AA World Services Inc., 2001, p. 85).

Core Element 5 is the "promised outcomes" outlined in AA World Services Inc.(2001, pp. 83- 4) but are only achievable on continuously working the programme.

This summary identifies the core elements that constitute the message of the 12-step group. From the earlier accounts of participants, those core elements remain unchanged in their minds. They had, however, learned that they must change their thinking if they wished to live an enjoyable quality of life while remaining sober.

While according to the third tradition of AA "*The only requirement for membership is a desire to stop drinking"* (AA World Services Inc., 2012, p. 143) – membership can include pedophiles, murderers and other less than desirable elements – what is less evident is that it also opens a recovery path to illiterate, impoverished and disadvantaged people, without limitation, and those who otherwise would fall between the cracks in society's services.

From a developmental perspective, these participants in Groups A are currently in the residual stages of '*breaking the chains'* of their dysfunctional attachment styles but have not yet completed this task. They have also resolved some of Erikson's "Psychosocial Crises" of *Basic Mistrust; Shame & Doubt; Guilt and sense of Inferiority.* They are also working their way through Maslow's hierarchy of needs in a free manner at their own pace with their sponsors.

If considered from a psychoanalytic perspective, Giffney (2017)'s statement that

> *"To seek to remove a symptom without addressing the underlying dynamics that gave rise to that symptom serves only to activate the unconscious to produce another symptom in its place. To attempt to weaken a psychical defense before the person has the psychical space to experience whatever the defense has been protecting them against results in the shoring up and strengthening of the defense to deflect the persecutory experience that is too much for the person to bear. It is delicate work that cannot be rushed. Instead of taking away clients' experience of pain, which is impossible, they are offered an opportunity to develop a capacity to suffer their pain rather than self-medicating"* (para. 27).

This is borne out by how individual members of this group have changed within the first ten years and demonstrates the merit of "*doing steps 4-9*", properly and comprehensively with a sponsor as they have to revisit how negative self- perspectives had developed and face them. Those who did not follow this course, showed lower progress. However, there are no time constraints on any of AA's programme of suggestions or recommendations; and, as the participant Carl stated, "*You can design your own sobriety"* (23:593

5.5 Part B: From Normality to Generativity/Transcendence

This section explores the progression of recovery of members at 10 years, 20 years, 30 years, 40 years and 50 years of recovery, and the challenges experienced in incorporating recovery messages into living life of sobriety.

5.5.1 Ten-year group – dependency and developmental issues

In the Findings chapter, Table 5 described each participant's age and time from their first drink to severe dependency along with one of their primary underlying developmental issues.

Almost from the very beginning, alcohol was problematic.

Four participants (Participant 1, Participant 3, Participant 5 and Participant 6) described how it released pent-up anger in them almost immediately once they started drinking. Alcohol enabled the participants to express their reactive feelings to suppressed emotions. It also shows the very early age and how quickly they became alcohol abusing/reliant/dependent. They used alcohol to change or block out how they were truly feeling. According to Schwandt et al. (2013), *"Childhood trauma was significantly more prevalent and more severe in the alcohol-dependent subjects. In addition, childhood trauma was found to influence A.D. severity, an effect that was mediated by neuroticism"*(reaffirmed by De Bellis et al., 2019). However, Participant 23 made the telling comment about the emotional developmental aspect of working the AA programme when he said, *"Emotionally I was totally immature. Totally immature. I was a 15/16-year-old when I came into AA at 30. Emotionally I hadn't developed at all. Coming to terms with a kind of a growth in that emotional stability has been a key factor in my sobriety."* (15:459-61) As this research was about recovery, childhood issues could not be directly explored. The participants themselves made references to information relating to such issues. Those childhood psychological states are set out in Index 5, in tables according to each group. What is clear from these tables is that all the participants suffered difficulties involving multiple harmful psychological conditions. There are ample comments to suggest that none of the participants had formed secure attachments – *"lasting psychological connectedness between human beings"* (Bowlby, 1969, p. 194). In the context of Erikson's (1959) stages of psychosocial development, all the participants reflected mistrust, shame, inferiority, role confusion and isolation at the time of their first meeting, implying they may not have previously or adequately resolved these developmental crises or had regressed. Concerning the present study, the consequences of this, starting at approximately 10 years of sobriety or recovery, is that the nature of the participants' original attachment style could only be

postulated. Such conjecture is further compromised by the participants' earlier dysfunctional apparent transfer of attachment to alcohol.

Comments from all the participants in the findings section showed that mistrust was one of the main factors in their slowness in fully embracing the entire 12-step programme from the beginning. Examples are Anne, who took five to six years to come to terms with *"rigorous honesty"* (AA World Services Inc., 2001, p. 58) and Amy, who was eight years in recovery when she said that re-learning how to trust brought her back to how she felt at the age of four.

The developmental nature of the 12-step programme becomes evident when comparisons are made between how each group felt when joining the programme and how they felt about the realisation of the idealised life as constituent parts of that "new life" materialised.

From Table 3 (Group 1), many substantial changes can be seen for the better for the participants. Some have qualifications on these 'AA promises' in one way or another, and some are rejected as the research concerned long-term recovery processes, it was impossible to determine the role of traumagenics in negative responses without re-visiting sensitive issues. The three promises with the highest qualifications were the first, third and tenth. Regarding the first, the participants all carried some hangover from their past, so they could only occasionally experience a new freedom and a new happiness.

Interestingly, the third promise is not an experience per se; it simply refers to *comprehending* the word "*serenity"* and directly bears on the fourth – which is about knowing "peace" – which had only one qualification. The tenth promise relates to "*Fear of people and economic uncertainty will leave us"* and an appreciably remaining negativity for all of them. Alan showed a minimal gain. His difficulty with this promise may relate to the fact that he has never gone through the 12 steps with a sponsor, remains an atheist, and may still have underlying traumagenic issues. The participant with the slightest reservations was Aidan, and that referred to personal financial insecurity. Three participants – Arthur, Amy and Adam – who admitted to remaining selfish from time to time, felt the eighth promise eluded them.

As this was an IPA study, my personal view of the members of this group was that while sober and doing their best to follow the AA programme, they were still somewhat

"fragile". Their sobriety was built on hope and belief that they could maintain their newfound freedom. They began to explore other quasi-spiritual/mystical approaches. Arthur had become somewhat fixated on a total reliance on being a "born-again" Christian, promulgating that as much as the programme of AA. I would not regard this group yet as being in "stable recovery". Rather than having a secure attachment to another person, their sponsor/group/God/higher power, I felt that there is still a sense of insecurity or uncertainty as evidenced by their dabbling in mystical and other non-mainstream spiritual approaches. Most had repaired or were in the process of addressing broken familial links. This finding goes against the conceptualization of being in "stable recovery" after five years had elapsed, as suggested by the Betty Ford Consensus Panel (2007).

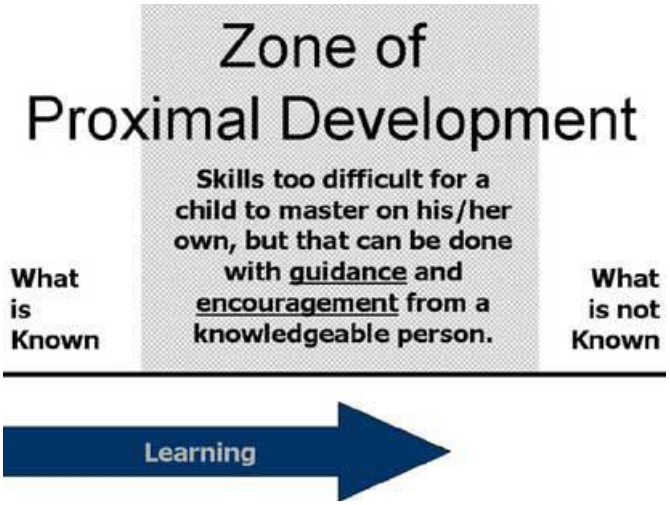
Regarding how the participants of this 10-year group interpreted the message or messages of the 12-step group, Anne's view was, "*Stick with it, give it your best shot and see how it goes; the door swings both ways. I would say give it your all, go with the flow and see what's ahead of you*" (15:424-7). Anne's view still contains an element of ambivalence, and this may well relate to the trust issues she experienced (earlier recounted after five years of sobriety that almost led to a relapse) – lacking a total commitment to the tenets of the programme regarding underlying issues. This omission may well indicate one of the weaknesses of the 12-step programme – where traumagenics are not the member's fault, and external professional help is required. Arthur's view of the message was, *"I'd seen the hope right at the very start"* (4:100). [The programme gives me the ability] "... *to be the best version of me"* (14:409-11). *"We only know but just a little"*(10:284). While this view may seem quite positive, it masks that this participant has transferred his attachment or trust to a particular religion – a "born-again" Christian. Alan's view is more balanced and in keeping with the programme – recognizing that he has more work to do on himself. "*It is a day at a time. Big time, it's a work in progress"* (17:535-6). Aidan commented that "*If you don't pick up that first drink, you can't get drunk.*(15:445-6). *That's a constant message that stays basic and straightforward* (15: 450-451). *"What AA has taught me to take life on a day-to-day basis. Not to worry too much of the future, and not to fret about things that went wrong in the past"* (16:482-3). Aidan's comments appear straightforward. However, as he had declined to talk about his childhood – even though he had not been asked to – except his reference to alcohol making *"...all my feelings, despair, worry, insecurities, they all started to disappear"* (1:20-21). It follows that while he had progressed significantly during his current period of sobriety in several ways, his dependency's progenitors remained

unaddressed. Amy described her views of the 12-step message as being "*Hope* (6:176), *love* (8:242), *kindness* (14:425)… *Service has been the root of my growth"* (30:948). However, interpreting facets of her story showed she did not move through Erikson's (1958; 1963) stages of *mistrust, shame, guilt* (misplaced), *role confusion and isolation* until she was eight years into the programme. Adam said: "*What I took from that was I have to keep growing. I don't have to, but it's important I keep growing"* (9:262-3). Adam, as a counsellor, would have learned the theories relating to his dysfunctional childhood and upbringing but, surprisingly, reflects the least gains in terms of the promised outcomes of the fellowship (Index 3, Table 1).

Through this discussion there is an underlying correlation with how all of the stages of the transtheoretical model of behavioral change (TTM) described by Prochaska and DiClemente (1984); Prochaska et al. (1992); Prochaska and Velicer (1997); DiClemente et al. (1999) apply accurately despite Sutton (2001) and Manoj and Ashutosh's (2006) caveats. Furthermore, how other approaches to psychological problems that are incorporated within the AA program are also described. The TTM's important difference to standard treatment centre's approach is that if a client relapses, it does not mean they have to 'go back to square one' and start all over again

Vygotsky (1978, p. 86) described the concept of an area or 'zone of proximal development' that has been defined as *"...the distance between the actual development level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers."*. (Cited by McCleod, 2012, p. 1). McCleod's graphic clearly explains this process:

Figure 5: Graphic of Zone of Proximal Development (McCleod, 2012, p. 1)

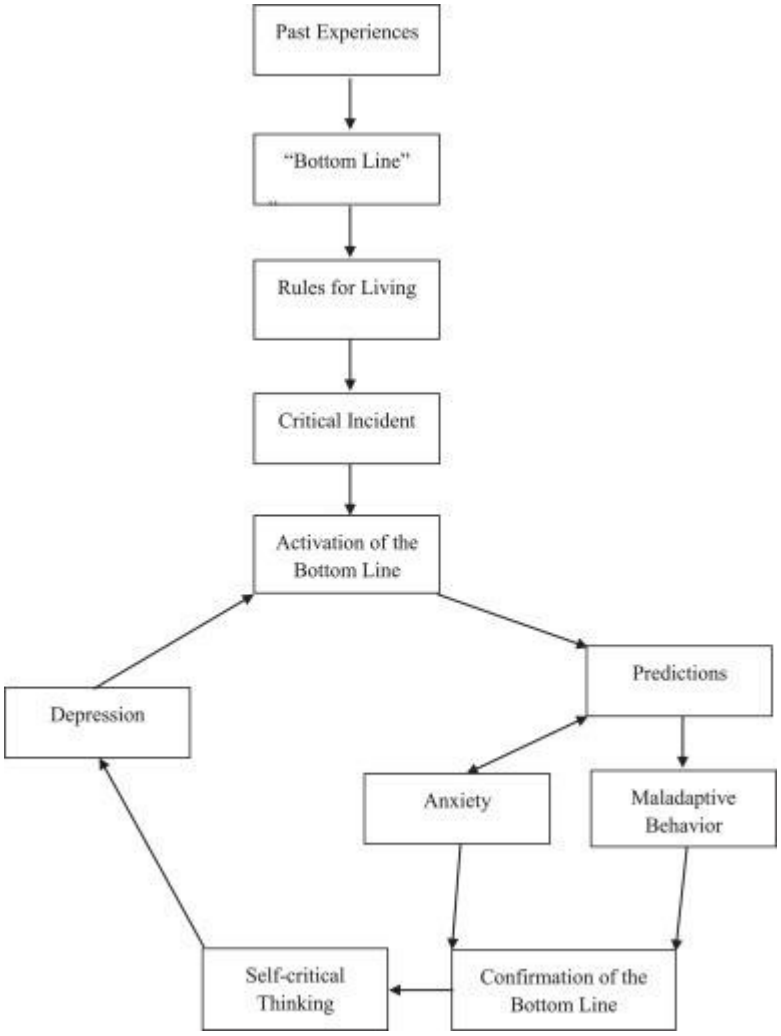


Generically applied, this diagram describes precisely what happens at first and later AA meetings. The new member has tried unsuccessfully to quit drinking on their own in the past, and these failures increased their feelings of low self-worth to the point of their arriving "… *at the jumping-off place. He will wish for the end"* (AA World Services Inc., 2001, p. 152). The new member then encounters others who had also previously failed on their own to overcome their alcohol dependence but have now done so through the group. In the early stages, other group members, through their sharing of their experiences, strengths and hopes provide "*scaffolding*" (Wood et al. 1976) to support the new member in understanding their dilemma and how to cope with the difficulties of getting and staying sober. The 'scaffolding' can also be viewed as underpinning "doing the steps" of the AA program. Regarding the efficacy of the 'scaffolding' approach to learning, Freund (1990) found it more effective than (self) discovery-based learning. In an AA context, this is quite understandable as new members, at the beginning, have no real appreciation of how they got where they were or what to do to get out of their situation.

In terms of Vygotsky's theory, the meetings of the 12-step fellowship form "*zones of proximal development"* (Landry et al., 1996; Rogoff, 1990), and facilitate the normalization of thinking and feeling processes. However, by year 10, while the "scaffolding" may be in place through meetings, peer suggestions and assistance, the reconstruction is not always completed. Between this group of participants, they experienced nine highly emotive incidents that brought them close to relapsing.

Fennell's 1999 modelling (p. 66; Figure 6) illustrates the self-perpetuating cyclical nature of depression caused by low self-esteem, self-worth, unhelpful behaviour and negative self-critical thinking that continues until the circle is broken and the underlying precursors are addressed.

Figure 6: Fennell's modelling of self-perpetuating of negative automatic thoughts (1999, p. 66, Fig. 6)



AUD and depression are causally linked (e.g., Briere, 2014; Petrakis, et al. 2002). Briere et al.'s study describes *"…the relation between disorders across periods (adolescence, early adulthood, adulthood) and cumulative impairments by age 30*" (p. 526) and Fennel's diagram equally applies to those in the throes of severe active alcohol dependence.

5.5.2 Twenty-year group – dependency and developmental issues

Table 12 in the Findings described each group member's age and time from their first drink to severe dependency, along with one of their primary underlying developmental

issues. They are described in greater detail in Index 5, Table 2.

Due to the passage of time, reference can only be made to specific psychological factors mentioned by participants during their interviews. However, again the time from first drink to alcohol dependence was either immediate or relatively short.

This group's members placed a importance of emotional sobriety and how they brought it into their lives. Emotional dysregulation has been associated with attachment problems in early adulthood (Morris et al., 2007; Fraley et al., 2006; Gross, 1998) and into adulthood (Zimmermann & Iwanski, 2014). Guilbaud et al. (2002) determined that the level of alexithymia (an inability to describe and interpret feelings) in active alcohol-dependent people was 63% compared with a level of 21% in controls – an outcome confirmed by Chambert et al. (2007) and Chaudhury et al. (2010). Thorberg et al.'s (2011) research suggested that alexithymia and alcohol dependence were mediated in two out of three cases through alcohol expectancy of assertion and affective change. The linkage between attachment styles, emotions and alcohol dependency was further developed in a Lebanese study by Zakhour et al. (2019). That study suggested that alexithymia, combined with abnormal attachment styles, was directly linked to higher alcohol use disorder rates. In a dependency recovery context, there is a division in the literature on the impact of alexithymia. Bochand and Nandrino (2010) and Maurage et al. (2011) suggest that it is significant - that abstinent subjects' levels of emotional awareness become once again comparable to those of control subjects, - whereas Zaplana et al. (2010) and Stasiewicz et al. (2012) do not. Regardless of these differing findings, none of these participants now had any difficulty in describing their feelings.

While the "Big Book" and some of AA's other publications frequently refer to emotional sobriety, it seems from this research that it takes more than 10 years before its significance is perceived and explored in a non-professional recovery context. This is remarkable as the interoperability of alcohol dependency and negative emotions, experiences and loneliness have been acknowledged in literature for some time – but the latter has been given scant attention until more recently. *"The feeling of loneliness appears to be connected with a general negative perception about oneself and one's relations to other people"* (Åkerlind & Hörnquist, 1992, p .405). Sinha et al. (2009) found that "*stress and cue exposure induce a*

persistent negative emotion-related alcohol craving state in abstinent alcoholics accompanied by dysregulated HPA and physiological arousal responses" (p. 1198).

However, recently more attention is being paid to the importance of emotions. "*Emotional and social-cognitive functions affected in AUD can potentially compromise efforts to initiate and maintain abstinence by hampering efficacy of clinical treatment. Such dysfunction can obstruct efforts to enable or reinstate higher-order abilities such as emotional self-regulation, motivation to change, success in interpersonal/social interactions, and emotional insight and awareness of social dysfunctions (i.e., accurate metacognition)"* (Le Berre, 2019, p. 808). Koob et al. (2020, p. 177) suggested that "*Over time, neuroadaptations reduce the relief that is provided by alcohol and increase emotional misery between episodes of use"*. Only one person in Group A referred to emotions relating to his sobriety, i.e., Adam, a practicing counsellor.

Four of the five have sponsors to help them go through the steps and with ongoing life problems. Basil has the same sponsor today as he did when he started over 20 years ago. Brian never had a sponsor but has been going to daily meetings for many years (he was 59 years old when he joined AA). Those who had sponsors had overcome any residual mistrust and formed stable relationships with sponsors or intimate partnerships. By this stage, all these participants would appear to have formed secure attachments in one way or another. This "attachment" enhanced their ability to remain abstinent by improving social networking (Groh et al., 2008), improved self-efficacy, and increased belief or hope that life will continue to improve (Kelly & Yetarian 2011; Kaskutas et al., 2002; Humphreys & Noke, 1997). These participants also seem to have gone through a social identity transition (Best et al., 2016) and improved security through recovery-based social networks built around their meeting attendance. Notwithstanding that, two experienced periods when they were close to relapsing but did not. Index 4 sets out a table of "near misses" by the participants.

By the twentieth year of sobriety, participants would have experienced several severe events in their lives. Brian had lost two partners to cancer, yet he did not drink. Their ability to cope with these types of problems points to appreciably improved coping skills, as suggested in the literature (Timko et al., 2000; Morgenstern et al., 1997; Humphreys, K. and Moos, R, 1996; Timko et al., 1995; Humphreys et al., 1994) and a reduction in

impulsivity (Blonigan et al., 2011). Herman and Duka (2019) prove the corollary – through brain imaging – that alcohol abuse is directly related to increased impulsivity.

In interpreting how participants make sense of their recovery process, I suggested a certain fragility in the first (10-year) group. With this group (Group 2), I discerned a marked change. They were more settled in their lifestyles, spoke with more confidence and were reasonably happy with how they were getting on. They also seemed to treat meeting attendance as more of a "living routine" than a necessary chore and had constructed a good life around their recovery network as well as into extended areas of interest. To get participants' perceptions of their 12-step group's messages, in a more focused way, probing their responses gave a clearer picture of how they viewed them.

Breda said, "*life would be barren, dry and joyless*". She felt that she could not survive indefinitely without it. While this does not refer to any of the core elements of the message, it suggests that her well-being depends on following the programme, and she said she loves the fact that her development journey will continue. Brian's interpretation that *"I would say it's been a gradual process how I've adapted my way of life to AA way of living the 12 steps on a daily basis"* adverts to two of the core elements – that recovery is on a daily basis, based on the program's steps. Ben opined that he has a disease or allergy to alcohol, and if he picks it up again, he will revert to where he was at on his last relapse – drawing on the "disease" concept. Bart's view mentioned two core elements of the message – that of AUD as an illness, and that there was a way out. Basil identified four messages that he believed were key ones for him: 1. Keep coming back; 2. You don't get well and do the steps; you do the steps and get well; 3. Get a sponsor and go through the steps with them; and 4. Get involved in service. Although their views are somewhat mixed, Appendix 12 sets out their perceptions of where the participants felt they are now concerning the promises, and the contrast between this group and the previous group's (Group A) responses are remarkable. The first significant point is that Brian feels all the promises have come true for him – even though he never had a sponsor. He formed three stable relationships in his recovery. The second point is that there are no denials on fulfilling any of the promises, just some qualifications. The third main point is that the two with the most "qualifications", Breda and Ben, work as counsellors or therapists. While Ben had six reservations to his agreement, a re-reading of his interview showed that they were based

more on a pedantic approach than on major reservations or repudiations.

5.5.3. Thirty-year group – dependency and developmental issues

Table 21 in the Findings describes each group member's age and time from their first drink to severe dependency, along with one of their primary underlying developmental issues.

Index 5, Table 3 sets out in more detail early dysfunctionalities for this group.

Again, all the participants had dysfunctionalities in their childhood but had come to terms with them. Probably the most significant appreciable change with this group was that their "recovery behaviors" had become part of their lives. They know they are alcohol dependent and do whatever is necessary to avoid taking the first drink. They have adopted interpretations of "God" as they do or do not understand Him; they are comfortable with that and feel no need to explain their view. They do their best, accepting their humanity, to practice the programme in all their affairs. They attend meetings almost daily and accept the need for them without question. Cyril's story about how he coped with the events surrounding his nephew's death is a perfect example of the cognitive restructuring "in action" that the programme can imbue into its members. When viewed as a thought disorder, Steigerwald and Stone (1999) showed that cognitive restructuring was an effective treatment model for alcohol addiction.

Earlier groups believe that their 12-step group works for them. Now, 30 years on, these participants know it works, and their "identification" with newer members works in reverse. It keeps what is in store for them at the forefront of their mind if they drink again. They know there is no actual recovery; they accept entirely that *"We are not cured of AUD. What we really have is a daily reprieve contingent on the maintenance of our spiritual condition"* (AA World Services Inc., 2001, p. 85). However, Cathy's story did not portray the actual ambivalence I sensed in her during the interview. She is sporadic in her meeting attendance and only calls on the programme when she struggles with some aspect of her life. She seems to retain still, subconsciously, the need to be the best at whatever she does. Regarding total immersion in the program's concepts and spirit, I felt that she "dips in" when she feels she needs to. The need to admit total failure regarding alcohol use still goes against her "need to succeed" despite her words to the contrary.

Again, comprehension of the core elements of the message by members of this group was

somewhat convoluted. Charlie believes the message is threefold: first of all, to get him well; to get him out of where he was; that "*love and service"* are essential ingredients and that the programme helped him to become the person he was born to be and not the one he had become through its slogans and everything else that they promulgate. Colm's view of the message(s) was that there's a tranquil, comfortable life out there. He feels now that life happens, and people (sober alcoholics) just have to go along with it. Carl was clear that the messages were those stated in AA World Services Inc. (2001 p.60) – that he is alcoholic and cannot manage his own life; that no human power could relieve him of his AUD, and that God could and did if His aid was sought – the whole purpose of the AA programme was to find God as he understood Him. Cyril did not explicitly identify any message but stated that his life had turned around 360 degrees, and the most significant thing for him was that he was coping on a daily basis without lifting a drink. Cathy had to think for a few minutes and suggested that the programme is a solution for anybody prepared to give it an honest effort and an honest chance.

When exploring the promises with these participants, some of the doubts expressed by the earlier group had disappeared. Appendix 12 sets out their comments and reservations.

5.5.4 Forty-year group – dependency and developmental issues

As with the previous groups, Table 28 of the Findings chapter sets out the age and time from their first drink to severe dependency and describes (where available) a primary underlying developmental issue for each participant. Index 5, Table 28 sets out in more detail early dysfunctionalities for this group.

Again, alcohol consumption commenced at an early age, but there were wider divergencies in how long it took to recognise and address the problem. That may well relate to the lower recognition of AUD and the availability of AA meetings at the time. In 1959, the then Minister for Health told the Irish Parliament:

> *"I think we are admitting that there is a number of alcoholics in the country if we give way on this business of giving special facilities for drinking on Sunday, because a man who cannot forego a drink on one day of the week, if he is not an alcoholic, is fairly addicted to drink."*

Coincidentally, in 1958, there were over 20,000 people in hospitals and asylums (Walsh et

al., 2016). This apparent attempt to cover up the extent of alcoholism reflects the broader sociopolitical context of Ireland at the time, which involved denial of widespread societal ills, including mental health concerns, suicidality, institutional abuse, and so forth. This directly impacted on the availability of support for people in need with alcohol-related or other concerns. Those issues notwithstanding, Butler (2010) points out that although the Irish Republic was ruled with an iron fist by the then Catholic Archbishop of Dublin, Charles McQuaid, he turned a blind eye to the formation of the Evangelical Christian-based organization Alcoholics Anonymous. Butler suggests this was possibly because a family member was benefiting from the organization's programme.

Within this group, the participants were entirely at ease during the interviews. Two participants avoided mentioning their childhood – this seemed more because they considered their sobriety a new life and that the past lay in the past. They had come to terms with any old issues and did not see the relevance to their lives now. They were able to talk freely and frankly about all

aspects of their recovery without discomfort or reticence. In summary, they reacted and spoke just as anyone who never had an addiction would converse. However, their stories describe how this "new normal" had been well earned. As explored in the Chapter 4, alcohol cessation did not mean an end to life problems. However, they had learned to cognitively restructure problems through their programme rather than rely on their prior dysfunctional emotional responses (Petit et al., 2015). This link between craving and relapse was highlighted through imaging studies that showed the same neural circuits as those associated with regulating other emotions (Kober et al., 2010; Seo et al., 2013); thus, this change in emotional understanding and processing is a fundamental aspect. It is not learned through formal cognitive behavioural therapy but through steps 4 and 5, with the oversight of a sponsor or confidante. While some doubts may remain in the broader academic arena regarding the effect of the "spiritual dimension" of recovery (Kelly and Greene 2014), for these participants it is a core tenet upon which they draw, as they genuinely believe the fourth key message – that they only have a daily reprieve from their disease.

Segal (2020) suggested that factors important for new members staying sober in their first "run through the steps" may significantly differ from those with years and decades of sobriety. As step 10 requires carrying out a daily inventory, that would appear to be a self-

fulfilling prophesy. Having cleared the wreckage from their past and made amends wherever possible, the participants are free to move on. They can now handle new or different aspects of personal development or life difficulties as they occur. These participants prove that this is true.

These participants' views of the message were as follows: Denise said, "*The phrase that comes to my mind is there is a solution, which is in the Big Book. I did not feel like there was a solution before I came in the programme and then I found that there was a solution for the drugs and the alcohol. Then I thought there was no solution with sugar, and then I found that there was a solution there"* (17:470-4). Dan had no clear view of the group messages but feels they have changed as new people join with other addictions. He believes that within the 12-step group there is a solution to alcohol dependency – a new way of life. Dan is sure that if he drinks again, he will not be able to stop. He attends meetings every day because he believes he needs them. He also expresses gratitude for how his life and children turned out, which forms a significant part of his sobriety. David believes the message of the 12-step group is "*That there was hope. A new life for an old life, there was a way out of the misery and that I could maybe pass on what was passed on to me, to somebody else, continue the chain"* (6:149-51). Gratitude also plays a big part in David's day-to-day outlook – knowing how many others have "not made it". He believes that AA's approach is holistic in its defence against the disease – that it is the future and the past that break a man. He appreciates his recovery "*...it's always today*" (18:467). Declan's interpretation of the group's message was, "*Well, there's hope to start with. That's the whole message of AA, and it's a different way of life. It's a new way of living. It's adopting a new way of living and then working on what needs to be worked on from your previous life. I see my sober life as a separate life"*. Des picked up the message that *"The feeling I got was hope and it was possible"* [to live sober] but found it was like a drip, very slow going. To this day, he still finds it a challenge to trust himself every day.

5.5.5 Fifty-year group – dependency and developmental issues

Table 34 of the Findings chapter sets out the age and time from their first drink to severe dependency and describes each participant's primary underlying developmental issue. Index 5, Table 5 sets out in more detail early dysfunctionalities for this group.

With > 50 years of sobriety for this group, their first drink was comparatively late in life compared with the previous participants.

Encapsulating Participant 22's account of his descent into utter alcoholic chaos is his comment that he did not notice his son growing up until 11-12 years of age. He had a second son four years younger. He did not address his AUD until he nearly burned the house down while drunk. After another accident, a stranger approached him and introduced him to his first 12-step meeting. He brought him to a meeting and told him that he must get sober for himself and nobody else, but that others would benefit from his recovery. He said he found something there that wanted him to keep sober. He got a sponsor who was to remain so for 20 years. He described him as a "father figure". He feels that step 4 (taking a moral inventory) is vital and does it every day (step 10). Gomes and Hart (2009) have pointed out that adherence to recovery practices prescribed by Alcoholics Anonymous, particularly steps 4 and 5, leads to greater abstinence, lower depression, and life meaning and purpose. Even to this day he gets involved in service, including "prison service". He felt that service reflects gratitude for his sobriety. Every aspect of his life improved as he got more involved in service. He is adamant that recovery is only achieved one day at a time. He opined that the programme, written in 1939, does not have to change – it is the individual that has to. He felt the program's personal development part took many years, that it did not happen overnight. He rebuilt all his family relationships and has, since joining the fellowship, a thoroughly rewarding life.

Participant 23, despite an apparent decent upbringing by his grandparents, had several negative underlying emotions. He went to third-level education at a time when that was rare enough. Once he had his first drink, it seemed to "kill them off" entirely – until the next day. He related that he had been the party's life and soul for 10 years of drinking until suddenly he turned into an obnoxious drunk. His initial introductions to the 12-step group were unsuccessful for six months until something happened for him – he underwent a form of spiritual awakening. From then on, he immersed himself in the programme. Like Participant 22, he found steps 4 and 5 had a profound effect on him – especially telling another human being the exact nature of his wrongs. Again, like Participant 22, he found it took years to recover to his conception of normality and that emotional sobriety was the key for him. He also emphasized that it took many years for him to become in tune with the

"real" Participant 23. He enjoys every aspect of life these days but never forgets that it is a daily reprieve. Participant 23 described how, 45 years ago, he told a man his story, and that man remained sober until he died. He made the point that while he was the bearer of the fellowship's message, that it was God, as he understood Him, who delivered it. Regarding the (outcomes)/promises, they have all come true for him long ago. He enjoys an active life to the full. In terms of psychosocial development, both these participants demonstrated ego integrity/wisdom (Erikson, 1997) and transcendence (Maslow, 1964).

When asked directly what the message or messages of the 12-step group were, they were unclear but had their own opinion. Their views have been quoted verbatim in 4.13.5, Theme 5 above already.

In an IPA study of three AA members, average age 69, with > 20 years of sobriety, McInerney and Cross (2021) explored how they experienced ageing. They found five main concepts were applicable – spirituality, being in the present, acceptance, self-esteem and fellowship, and a

support network. They concluded that AA helps transition to later life that includes coping with poorer health while still having a purpose and meaning in their lives, just as these two members say but in a slightly different way.

Notwithstanding that, the main points of both > 50 years participants are worth part

repeating: Participant 23 said *"...the good thing about Alcoholics Anonymous was that they said – they didn't say you'll never be able to drink again in your life, which would have been*

an impossibility. All they said to me was, all we want you to do is to stay away from one drink for one day at a time... I kept that in the foremost of my mind as I was staying sober. But it was only done a day at a time." (23:737-45

and for Participant 22,

"The message of AA, for me anyway, the message of AA is the 12 steps, the programme that's built into those 12 steps whereby you're learning to live your life one day at a time... and *"I have to do my service in the fellowship. That's a huge part of the message of AA. Giving back. You have to give back."* (18: 546-8)

In this section, B, the developmental nature of the 12-step programme is quite evident from the maturing attitudes and behaviors of the participants as the years go by, once they move on from their previously ingrained, mistrustful (and probably dysfunctional) attachment style. They began to gain the primary virtue of hope almost from the beginning but retained some mistrust elements. By year 10, they had dealt with or were in the process of addressing the psychological crises of shame, guilt and isolation through the Rogerian principles found at all meetings – congruence, empathy and unconditional positive regard, together with a new "take" on the concept of a beneficial spiritual dimension being in their lives. By the general nature of their recovery process, it is virtually impossible to say when dysfunctional emotional reactions changed to positive cognitive processing and their ways of living, feeling and behaving towards themselves and others. However, among these participants it appears to happen between the tenth and twentieth years. At that stage, too, they had dealt with feelings of inferiority and role confusion and were in stable relationships – even if they were new ones, different from those they had been in while drinking. While not in the order that Erikson (1958; 1963) described, they had regained or were regaining the virtues he described. This growth is evident through the evolving rate at which the promises come true for them. Indeed, by then, feelings of mistrust, shame and guilt were waning or gone.

The interviews show that the 23 participants' perceptions of the 12-step groups' key messages vary. However, there were three recurrent themes within their responses: hope, having a specific illness, and getting a daily reprieve. Strangely, "gratitude" was only mentioned by eight of the participants, although it is generally recognised to play a significant role in the recovery process (LaBelle & Edelstein, 2018; Krentzman, 2017; Chen, 2017) and has been acknowledged in psychology, philosophy, theology and sociology. Indeed, many groups within AA use the name of their group as "*Attitude of Gratitude",* and most sponsors require their sponsee to write out "gratitude lists" as a reminder of what they have gained, as a positive reinforcer of remaining abstinent, and as an incentive (LaBelle & Edelstein, 2018; Laudet et al., 2006).

As one participant pointed out, the message does not have to change – it is the person who must, which has been happening with these individuals. Initially, they developed more secure attachment styles (Jordan, 2019; Smith & Tonigan, 2009), then addressed emotional dysregulation (Goldstein et al., 2019). The 20-year group live their everyday lives through

new social networks and new social identities (Frings et al., 2019). However, this "good life" is predicated on ongoing meetings and practicing its principles in all their affairs. Those with 30 years or more of AA-based sobriety appear to become more involved in the generativity process and more in keeping with their natural ageing. Frings et al.'s (2021) suggestion *that "*

...those with more long-standing attendance reported social identification unrelated to involvement" (p. 1) is indirectly confirmed by the fact that participants have resumed normalized lives entailing involvement in a wider range of activities. However, this research would not support that a decline in group involvement occurs while the 'active ingredient' - being their social identity – endures (Frings, et al. 2021, p. 7). By their fortieth year, the participants begin to move into the transcendence phase (Maslow, 1978). They also begin to attend meetings almost daily – on the premise that if they allow their commitment to that power that gave them such a wonderful life to fade, they could fall back into irritability, restlessness and discontent, leading to relapse at any age. Jin et al., 1998 estimated that there is a lifetime 3% risk of relapse – although this figure is an unsubstantiated conjecture by the authors

5.6 Part C – The Twelve Promises of AA; Participants views and experience

Although attributed to having been written by Bill Wilson in 1939, the Big Book of AA is in fact a collaboration of the experiences of his co-founder and physician Dr. Bob Smith and many of the first 100 alcohol dependent persons who created AA.

However, Wilson, had a predominant input into the actual writing of the book and that has been widely acknowledged through his use of language; non-repetition of terms/words and general tenor of writing. Wilson, after the end of World War one, became a very successful stockbroker introducing innovative and lucrative approaches to that work. He was, in fact, a good 'salesman'. However, based on the lack of success of previous movements aimed at addressing excessive alcohol consumption since the Washingtonians in the 1850's, and the underlying disenfranchisement of the value of an individual as a person over their time-construct as an economical commodity, it seemed that that, other than offering abstinence or sobriety and living nebulously "*happy, joyous and free*" (AA World Services Inc., 2001, p. 133) or existing in accordance with some religious theosophy, that a much more cohesive and understandable set of encouragements or life enhancements of what

‘recovery’ had to offer was needed. He, (Wilson) therefore, wrote about what one could expect while they were completing the hardest part of the programme – step 9 – (*“Made direct amends to such people wherever possible, except when to do so would injure them or others”* - AA World Services Inc., 2001, p.60). by adding in possible highly desirable outcomes which have become widely known as the “12 Promises”

Never formally acknowledged by AA, the organization does not endorse these “promises” and their view is that

> *"We are aware that some groups and members make reference to 'twelve promises'— however, that did not originate from the collective group conscience of AA as a whole"* (AA World Services Inc., 2008, p. 6).

The Big Book poses the question :

> “*Are these extravagant promises? We think not. They are being fulfilled amongst us – sometimes quickly, sometime slowly. They will always materialize if we work for them”* (AA World Services, 2001, p. 84).

Although making such aspirational promises, this specific area of the AA programme has received little or no academic attention regarding achievability or timeliness. This thesis attempts to address this lacuna of how realistic it is in that section of the Big Book describing the rewards deriving from fully following their 12-step programme, known as the '12 Promises'. While set in a non-numeric manner in Alcoholics Anonymous key text (A.A., 2001, pp. 83-4), they are an integral part of the AA programme - first written in 1939 - and have remained unchanged since that date. These twelve promises describe an idealized life quality available to anybody who fully embraces the A.A. programme into their daily living. But, as stated earlier, they do make the promises in the context of working their way through the difficult ninth of the 12 steps. The words preceded their recitation: "*If we are painstaking about this phase of our development, we will be surprised before we are halfway through....* (A.A., 2001. p. 83).

Kelly & Greene (2013) suggested that the Promises are apt descriptions of the cognitive, affective and behavioral benefits that may accrue from being an active member of the fellowship, apart, of course, from the benefit of being abstinent from alcohol. They, Kelly & Greene (2013) designed a psychometric scale - the Twelve Promises Scale (TPS) that might elucidate the extent to which the Twelve Promises emerge for participants over time as an independent benefit of participation. Kelly & Green (2014) also refer to their occurrence as part of an explication of the "spiritual awakening *"of the educational variety*"

(A.A. 2001, p. 567) coming after completion of the trust and action steps of the A.A. The 'trust' Steps are numbers 1–3 and 'action' ones, numbers 4-9 (A.A., 2001, p. 59). They suggested that they were "*... a potentially important, more broadly defined, "spiritual mechanism" of AA-assisted recovery*" (Kelly & Greene, 2013, p. 311).

Kelly et al. (2013) constructed the TPS in consultation with several clinicians working in 12-step oriented treatment facilities and members of AA and NA (Narcotics Anonymous) with varying lengths of sobriety. The result was a 26-item self-report measure designed to capture the essence and elements of A.A.'s original Twelve Promises (A.A., 2001, p. 83-4) and was stated to be a conceptually relevant and psychometrically sound measure that may be helpful to elucidate the extent to which the Twelve Promises emerge as an independent benefit of 12-step participation and help explain AUD remission and recovery. Their study's participants (n=320) took part in an interview at intake and 3, 6, and 9-month intervals. Their study concluded that only two factors were positively affected – "Psychological Wellbeing" and "Freedom from Craving." However, several limitations were identified to the TPS and, on follow up after one year, they found participants had a high attrition rate. Apart from these findings, their study seems wholly compromised by the meta-analysis by Stavro et al. (2013) concerning the extended dissipation of multiple cognitive impairments in severely alcohol disordered persons – showing that for those particular individuals, normalizing of cognitive functioning can take up to one year to abate. More recently, Stavros et al.'s (2013) findings have been corroborated by other studies such as Rupp (2021), Nixon & Lewis (2020), and L.E. Berre (2017; 2019).

The 12 Promises as utilized by Kelly & Green (2013) were:
First: "*We are going to know a new freedom and a new happiness".*
Second: "*We will not regret the past nor wish to shut the door on it".*
Third: "*We will comprehend the word serenity".*
Fourth: "*We will know peace".*
Fifth: "*No matter how far down the scale we have gone, we will see how our experience can benefit others".*
Sixth: "*The feeling of uselessness and self-pity will disappear".*
Seventh: "*We will lose interest in selfish things and gain interest in our fellows:*
Eighth: "*Self-seeking will slip away".*
Ninth: "*Our whole attitude and outlook upon life will change".*

Tenth: "*Fear of people and economic insecurity will leave us".*

Eleventh: "*We will intuitively know how to handle situations which used to baffle us".*

Twelfth: "*We will suddenly realize that God is doing for us what we could not do for ourselves".*

While Kelly & Greene's (2013) may not have achieved the desired results for diverse reasons, this study, because of its timeframe facilitates the understanding that the '12-Promises' are realistic and can and do come true - with the caveat that the duration to realization is down to the client's working of the programme. Their comments are set out in Group sequence.

5.6.1 Group 1.

The participants of group 1 had been abstinent and sober for ten years; overall they disclosed many uncertainties and non-realization of some Promises.

Only two of the 10-year group claimed Promise 1 – "*We are going to know a new freedom and a new happiness"* had materialized for them. They were Participants 2 and 3. The other participants said about Promise 1, "*No. Maybe I got a glimpse of it* (Participant 1 16:478-81), and that is clear enough. Participant 5 was also fairly clear in saying, *"Yes, because now I have freedom of mind. Do I have it fully every day, all day? No. But I do experience pockets of it. I do experience happiness. All day, every day? No. But I am experiencing it. That has come into fruition for me."* (Participant 5 42:1188-91) but Participant 6 negatively opined, "*I've experienced that at different times beyond – very fleeting actually because of the nature of our mind."* (22: 643-644). Bearing in mind that all these participants had serious attachment and or emotional issues prior to beginning their sobriety journey (Index 5) and Rutter's (1971; 1981) and Bowlby (1988) comments regarding the difficulty in changing dysfunctional attachment styles, it is not problematic in understanding that re-framing perceptions would impact well into the first decade of sobriety. Participants 1, 3, 5 and 6 show just how time-consuming these changes can be and when they began to feel a "*... new freedom and a new happiness".* (Promise 1.) Their early recovery would also have been impacted by cognitive impairments in early recovery (e.g., Rupp, 2021; Nixon & Lewis, 2020; Le Berre, 2019 & 2017).

With Promise 2, Participant 2 was the only one not agreeing that he gained the benefit in full "*I don't regret the past. I have disappointments in the past, but I don't regret the past because of what I do now.* (12:365-7).

Regarding Promise 3, five of the six participants expressed reservations about having gained this benefit. However, my impression was that understanding the concept of "*serenity*" eluded the participants. As Participant 3 said, "*I didn't even know what serenity meant when I came in; it wasn't in my language". Participant* 5 said it took eight years of sobriety before she grasped it *"I have it now - so, I understand what it is. Serenity. Peace."* (42:1205).

Regarding Promise 4, Participant 4 admitted that not all suicidal thoughts had left him. The others all confirmed that they had peace in their lives.

All confirmed the following two Promises as having come to pass. Participant 5's comment on Promise five was, *"Today I know that to be true. Back then, I would have said no, because I was only a thing. I know today I'm not a thing, I'm a person, and it is in - I hear in somebody's story, and I share my story with them."* (42:1215-1217). This reflects the views of the other participants of this group. Participant 6 said: *"It scares me that sometimes my life has gone so quiet that that scares me. That I'm not used to it on that level, and you think there's something wrong"* (25: 717-9)

About half of the of participants missed out on the seventh Promise, "*We will lose interest in selfish things and gain interest in our fellows",* while three participants said it was now true for them. Of the other three, Participant 2's comment was, *"I do still have an attachment to a lot of earthly goods and earthly things. That's a work in progress."* (15:401-3). Participant 5 said, "*Yes, but that would be one that I would have to work on every day*." (43:1224). Participant 6's view on where he stood was, *"I'm being honest. I struggle with that one. That's not one that's fully - I think that one I struggle with."* (26:754-5)

Only three claimed that the eight Promise had materialized "*Self-seeking will slip away".* Participant 2 commented, *"Yes, a bit of it - it can be there. I say a bit, you know what, there are certain days the bit's fairly big, it's all self-seeking. I suppose I'm aware that this is something I'm aware of, and I can go and take it to God*" (15; 405-7). Participant 5's qualification has been mitigated recently as she said, "*Yes. That took time as well because I truly believed that I wasn't me unless I had material stuff around me. Now I know the most precious thing is what we are doing here this evening."* (42:1228-30). Participant 6 felt that it applied *"At times, yes, but at times no"* (27:761)

All participants endorsed the ninth Promise – a change in attitude and outlook on life.

All participants qualified their response to Promise ten "*Fear of people, and economic insecurity will leave us"* in one way or another. Participant 2 commented. *"That's the devil putting temptation in my life; he wants to take my eyes off my God"* (14:416-9). The others tended to advert to economic insecurity, which is more of a life than a recovery trait. Participant 3's comment was amusing "*In eight years, sobriety I've been stopped and breathalyzed three times, and I've absolutely shat myself when the old bill pulled me in."* (28:828-9).

Promise 11, which refers to having adequate coping skills in life, generally was confirmed by all to have come true.

Regarding Promise 12, except for Participant 6, who remains atheistic, they were happy enough that it had come to pass.

The tabulation of the participants' perceptions of the realization of AA's 12 promises was developed to offer some interesting insights into whether their programme is working or not at this stage of their recovery process. It raises interesting questions such as why the 10th promise was only meeting one with limited success. However, exploring this facet is beyond the focus of this thesis.

Table 36. Group 1 Fulfilment of 12 Promises:

Promises	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
Participant 1	✓(q)	y(q)	✓	✓	✓	✓	✓	✓	✓	✓(q)	✓	✓
Participant 2	✓	✓	✓(q)	✓	✓	✓	✓(q)	**x**	✓	✓(q)	✓	✓
Participant 3	**x**	✓	(✓q)	✓	✓	✓	✓	✓(q)	✓	✓(q)	✓	**x/a**
Participant 4	✓	✓	✓	**x**	✓	✓	✓	✓	✓	✓(q)	✓	✓
Participant 5	✓(q)	✓	✓(q)	✓	✓	✓	✓(q)	**x**	✓	✓(q)	✓	✓
Participant 6	✓(q)	✓	✓(q)	✓	✓	✓	**x**	**x**	✓	✓(q)	✓	✓

Index to Table 1: ✓ =yes; ✓ (q)=qualified; x=no and x/a=no, while still atheistic

[However, the only thing certain about AA is its uncertainty. The same form of enquiry as with Group 1 regarding the 12-Promises was also carried out with other groups – on a time increasing basis and their views are quite illuminating regarding the increasing and acceptance levels of subconscious psychological changes taking place on an ongoing basis.]

5.5.2 Group 2.

The 'Promises' Fulfilment' pattern changes considerably within this group. Rather than a Promise proving elusive for most of a group, individuals have problems with differing promises – although the fulfilment rate increases.

For the first Promise, only one participant had a problem. Participant 9 said *", I don't have that all the time, but I had that experience, and I continue to have those experiences from time to time. The way I look at it is my higher power, in a sense, has given me that experience. But I don't have it automatically."* (24:724-7)

For the second Promise, he (9) also had a reservation about **"***Now, I sometimes do regret the past, especially the harm I've done to others. I can't say that I wouldn't want to change that…."*

Participant 10 also had a reservation on this; as he put it, *"No, I think it's my best asset. Everything that I've done, everything - every dirty stuff."* (28; 879-91) Participant 7 was slightly unclear on the application of Promise 3 "*Yes, absolutely." "I find that it comes and goes."* (23: 680 & 683). Participant 9 also had a reservation to Promise 4 was, *"Yeah, I've had peaceful moments at times. It's not like I say, it's not a constant thing".* (25:754-5).

There were no reservations to Promise 5.

In that next following (Promise 6), Participant 9 said, *"I see it as a kind of a poison to me. Sometimes, when I feel self-pity, I try to do something about it right away."* (25:765-7).

Participant 7's interpretation of Promise 7 for her was, "*I don't think I'm self-centered anymore. I think I'm still selfish. By that, I mean selfish, in that I will often put myself first over other people."* (25:724-5). She was the only participant with a caveat to Promise 8 *"Yeah, I still get it sometimes"* (26:776).

Promise 9 had only one qualification, and this was by Participant 11 - "*I try and cut people slack. I can still be judgmental in meetings and think, God, what's that guy sharing?* (12:349-351).

With promise 10, Participant 9 has some reservations *"Yeah, I get that from time to time. I feel like I can let that go. I do actually experience it now. Sometimes, it can come back in. It can kind of creep in."* (26:788-90) and Promise 11, dealing with personal and economic insecurity, he felt, *"Yeah, that's one that comes true quite often. I've noticed that in the last few years"* (27; 807-8).

The 12th and final Promise had no qualification. However, two participants – 7 and 9, both

remain atheistic. Ironically, they are also professional counsellors or therapists. Participants 7's view was that "*If I take God to be the power greater than myself, yes, yes".* (28:841) .... *"It is thanks to this Group Of Drunks, or thanks to this God… It's G-O-D. Absolutely."* (29: 847-50). *"There's no way I would have become this person without this guidance. I mean, it's just ridiculous to think that I could have done it on my own.* (29:854-856). Participant 9's response was to put it in Jungian terms and *concluded, "… it frees you from that small ego. I'm just an employee of the universe."* (27:822) and "*…" a Christian perspective, we have a new employer."* (27:826). What may come across from the text and quotes above regarding the numerous reservations by participant 9 is that they are relatively pedantic and based on whatever form of psychotherapy he practices. During the interview, they, rather than being denials were more pedantic discussions.

In this group, Participant 8 – who joined in his late 50's – is the first to say he enjoys the benefits of all the promises unconditionally.

Table 37. Group 2: Fulfilment of 12 Promises

Promises	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
Participant 7	✓	✓	✓(q)	✓	✓	✓	✓	✓(q)	✓	✓	✓	✓/a
Participant 8	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participant 9	✓(q)	✓(q)	✓	✓(q)	✓	✓(q)	✓	✓	✓	✓(q)	✓	✓/a
Participant 10	✓	✓(q)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participant 11	✓	✓	✓	✓	✓	✓	✓	✓	✓(q)	✓	✓	✓

Index to Table 1: ✓=yes; ✓(q)=qualified yes; x=no and ✓/a=yes while still atheistic

5.6.3 Group 3

None of this group's participants had any argument with Promise 1.

For the second one, Participant 13 said, *"One of the things with that one, and people will argue with that point with you, I do regret the past. I hate the fact that I had my mother down on her knees, begging me not to go out on one particular day."* (33:930-2) and *"Laying a hand in anger on my wife, and I will always regret that."* (33:941) Participant 15's view was that *"I describe it as the pot of shame. I don't. I did it, but I'm not shutting the door on it.* (22:671-2).

For Promise 7, Participant 15's view on his progress was *"Up to a point like you know. Yeah, I'd have to say."* (23:704). Participant 16's response reflects an ambivalence when she says, "*First half of it, I'd say yes. The second half, no not yet."* (16:490).

Participant 12 said about the eighth Promise that it only came through *"After a long time, yes."* (29:808).

Participant 16 had a problem with the ninth and said, "*Mm, no, I don't think has happened for me yet, no."* (17:496).

The 10th Promise proved the most elusive for this group. Participant 12 said*, "I have something to say on that. I believe yes is the answer, but with economic insecurity, it's only the fear that leaves."* (29:812-3). Participant 15 humorously said, "*Majority - most of the time, and now I'm retired, and I have a pension… I mean, I was a postman who was afraid of post."* (24:742-4). Participant 14 commented, "*Yeah, well, one of the things I always had trouble with was finances and – one of the things - one of the things that was most difficult was working on financial insecurity and freedom on that."* and *"They haven't quite left me, and I can still get days when they baffle me."* (21:633-4).

The changing nature of the conversations with participants did not lead to specific Yes/No answers from participants regarding whether promises were coming true. However, the quality of their lives, the natural and worked changes that they had made over the years lend credence to the merit of the 'promises' as coming to pass rather than 'happening.

Table 38. Group 3: Fulfilment of 12 Promises.

Promise	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
Participant 12	✓	✓	✓	✓	✓	✓	✓	✓(q)	✓	✓(q)	✓	✓
Participant 13	✓	✓(q)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participant 15	✓	✓(q)	✓	✓	✓	✓	✓(q)	✓	✓	✓(q)	✓	✓
Participant 14	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓(q)	✓(q)	✓
Participant 16	✓	✓	✓	✓	✓	✓	X	✓	x	x	✓	✓

Index to table 3: ✓=yes; ✓ (q)=qualified yes and x=no

5.6.4 Group 4

There are very few reservations in this group. With Promise 5, Participant 21 said, "*Mumm... That's a difficulty…. When I say difficult, part of my disease or illness, if I'm not at ease and serenity and things like that, and because of my low self-esteem - would be, I don't have much to offer."* (20:591-598). For the sixth Promise, Participant 17 said, *"Once in a while if I do something, I can get this old useless feeling and then I go into self-pity: poor me. I'm not doing it right."* (24:667-8). Participant 21 was the only one to comment on the 12th Promise when he said, *"See, that's the 64 million $ question… I find it very hard to answer that…. It's hard to believe that there is a God. It's a terrible thing to say. And it's hard to believe that there isn't."* (24:647-653).

Through the lengthy interviews with these participants on all aspects of their long-term recovery, it is obvious that the promises do come true for them – not in any sudden fashion but in a gradual and cumulative way.

Table 39: Group 4 – Fulfilment of 12 Promises

Promise	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
Participant 17	✓	✓	✓	✓	✓	✓(q)	✓	✓(q)	✓	✓	✓	✓
Participant 18	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participant 19	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participant 20	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participant 21	✓	✓	✓	✓	✓(q)	✓	n	✓	✓	✓	✓	✓

Index to table D: y=yes; y(q)=qualified yes and n=no

This theme discloses far fewer uncertainties for group D about the promises, and only two express any reservations based solely on normal human frailties

5.6.5 Group 5

Both these participants, despite their ages, live as complete a life as they can. However, they still live by the adage that they only have a daily reprieve from their alcohol addiction

- that it is one day at a time.

Table 40. Group 5: Fulfilment of 12 Promises

Promise	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
Participant 22	✓	✓	✓	✓	✓	✓*	✓	✓	✓	✓	✓	✓
Participant 23	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Index to table L: ✓=yes; y (*) = delegated to wife (!)

5.7 The correlation between long-term recovery and realization of 12-step promises

During the first ten years of recovery, most participants had become involved in new activities that they believed would help them with their recovery. One had started following massage therapy, Reiki, holistic and other approaches at the expense of missing A.A. meetings until she nearly relapsed after five years and returned to them. Another participant had become involved with 'Angels' and similar quasi eastern philosophies. A third participant became immersed in A.A./Church work that focused on Jesus Christ and fundamentalist Christianity. Participant 6 had become a counsellor – running after-care therapeutic groups. Ironically, he was the least certain of all the participants of where he was at in life. He has doggedly stuck with his atheistic beliefs, and this may reflect in the progress of his recovery.

In the second decade, participants began to bring emotional sobriety into their lives. While the first group had been hopeful about continuing to live sober, this group had lived through some serious life events in their second decade. Participant 7 mentioned two events that brought her close to drinking, but she did not because of the programme and support from other members.

A further ten years later, even more of the promises had come true. However, an immeasurable quality in how they spoke and interacted with the researcher was apparent. They had come to terms, totally, with their alcohol addiction. Only one, participant 16, who only goes to meetings *"...when I really need to"* had any reservations. While she accepts, unconditionally, that she has a severe alcohol dependency, she puts minimal effort into her membership of A.A. – as a participant, sponsor or organizer.

After 40 years, there remained almost no qualifications to receipt of the benefits of the promises. Participant 21's caveat suggests that there are still some unresolved or underlying issues for him. However, his comment about believing in God (or not) seems just a normal human reaction to attempting to rationalize the impossible.

For the 50-year group, both participants, despite their ages, enjoy living life to the full as best they can. However, they still live by the adage that they only have a daily reprieve from their alcohol addiction - that it is always one day at a time.

Only in the first category (10-year of sobriety) is there a consensus on some of the Promises that had failed to materialize. They were the 3rd and the 10th. The first refers to *"... knowing a new freedom and a new happiness."* and yet 5 of the 6 participants did not feel that had come true for them.

In the 1st, the limitations may well be understood if viewed from the perspective set out in the original Doctors Opinion. He said, *"They* [alcoholics] *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"* (A.A. 2001, p. xxvii-xviii).

Regarding the difficulty with the 3rd Promise, this failure to "*... comprehend the word serenity"* may be understood if viewed in the context of being misunderstood or confused with the following Promise (4) – "*We will know peace."*

The 10th Promise, "*Fear of people and economic insecurity*", has two elements - people and economic insecurity. The former will have been dealt with through Steps 4, 5 and 9th. However, the latter still troubled the participants and the 20 and 30-year groups.

Participant 9 had the most reservations, amounting to eight. Participant 6 and Participant 7 (both counsellors) had reservations on Promise 5. On an individual basis, both Participant 6 and Participant 9 had the most reservations. There is no discernible pattern to the remaining refutations or qualifications. (Table 2.)

5.8 Conclusion:

Considering the diversity of the participants and lengths of sobriety time it took for the Promises to be generally fulfilled (20-40 years), the Promises may not provide a practical

basis for developing yet another method of measuring developing levels of sobriety. They do, however, provide a picture of how life *may* develop through following the A.A. programme in its stated form. Measurement scales already in existence, such as Millar and Del Boka (1994), Morgenstern et al. (2003) and Kelly and Greene (2013), do not appear to serve any direct purpose in encouraging or promoting recovery through a programme that works for persons with severe AUDs. As only 6 of 23 participants confirmed that all the Promises had come true for them, the results of this study could well be off-putting to new members regarding the viability or timeframe involved in attaining all the Promises. It may serve better to advocate the supremacy of the self-interpretative nature of this organization, as stated in p. 164 when the authors accept that *"Our book is meant to be suggestive only. We realize we know only a little"* (A.A., 2001).

The conclusion of this section of this thesis on whether the 'Promises' are extravagant wishes or predictive outcomes is that they are.

For those who have a commercially based interest in the subject, the tables do give indication of where weaknesses in the system may lie.

All tables are set out together in Table 6 of the Appendices to provide an "at a glance" perspective of how the 12-Promises evolve in real life situations.

5.9 Summary of Chapter 5 – parts A, B and C

The preceding paragraphs describe how the research met the overall aim of exploring the experiences of people with alcohol use disorder (AUD) using self-help groups in maintaining a lifetime of sobriety using Alcoholics Anonymous (AA) as an exemplar. It also discussed the pitfalls encountered along the way, such as dogmatically maintaining agnosticism – although the particular participant's behaviours may undermine that assertion – and, in one case, how "paying lip service" to the programme can impact and seriously delay enjoyment of abstinent based recovery.

Although AA frequently refers to "*passing the message",* what the message is is never clearly stated. However, through AA's Big Book and participants' interviews it was possible to identify five clear core elements constituting *"the message"* that underpin the programme and endure unchanged for members for their entire sobriety period. What does

change is how the members personally develop through their continuous working, practicing and interpreting the steps mentioned in the third core message.

The study illuminated the stages participants had to go through, the barriers they encountered, their experiences of how the programme worked incrementally for them, how their interpretations of the program's steps evolved, and the varying time frame it took for changes in some fundamental aspects of their attitudes and ways of thinking and feeling.

This study also showed that full alcohol dependency recovery takes many years – and that it may be unsafe to regard stabilized recovery or normalcy as having been achieved by any specific year.

From the individual accounts, it became apparent that the realization of the AA 12 promises also took many years and occurred in tandem with an individual's affect and emotional development. This finding calls into question the merit of Kelly and Greene's (2013) construction of a psychometric measure of the promises' attainment developed with people at three, six and nine months of sobriety.

Although a misquote from an original AA slogan, *"It works if you work it, so work it 'cause you're worth it"* the open meetings I attended as an interested party finished with members holding hands and reciting after their Serenity Prayer *"It works if you work it and it won't if you don't"* – a highly accurate truism.

6. CONCLUSION

6.1 Introduction

This study explored how alcohol-dependent members of a self-help group developed their group's recovery message into living enjoyable everyday lives without using alcohol again. For the first time, it illuminated on an individual and time-related basis how unmonitored 12- step programmes can change an individual life from one with a severe alcohol dependency into a lifetime of sobriety.

As 22 of the 23 participants had come into their 12-step groups directly and not via a treatment centre, the research gives a fair representation of how the programme can work for any severely alcohol-dependent person who simply walks in from the street to join such a 12-step group.

6.2 Research Outcome -key findings

Four key findings emerged through this study of the experiences of how people with alcohol use disorder (AUD) use self-help groups to gain an enjoyable abstinent lifetime of sobriety.
They are discussed below.

6.2.(i) It takes up to 12 months for cognitive processes to normalize before complete recovery can begin and then possibly many years to achieve

It took the participants almost a year before they could "clear-headedly" embark on all the changes they had to make. Recovery from the psychological pathologies of an AUD is a long, drawn-out process taking many years but, critically, is completed at participant's own rate in their return to sober living. Twenty-two of the twenty-three participants had to address dysfunctional attachment styles (Bowlby, 1969;1972;1982), resolve or get the benefit of differing needs identified by Maslow (2014) and regain their appropriate locus in Erikson's (1997) description of the stages of the life cycle. One participant reported wanting to leave the past in the past and not re-visit any of it. Until their second decade, participants

did not address a different but immediately related major factor – emotional sobriety (Maurage et al. 2011; Zimmermann & Iwanski, 2014; Le Berre, 2019). Once they had resolved that issue, their priority became the building of their psychological well-being further through continued affiliation with their 12-step group. Based on the findings of this research, it could take up to twenty years to achieve true normalized absent sobriety. This research highlights that there is no "quick fix" to severe alcohol use disorder, and that genuinely stabilized recovery may take many years to achieve. The evidence is quite clear regarding enduring severe cognitive impairment post-cessation of alcohol consumption (Powell et al. 2021; Nixon & Lewis, 2020; Le Berre, 2019; Le Berre et al., 2017; Stavro et al., 2013; Gorsky, 1989). Those findings call into question the ability of treatment centres to "cure" or "treat" patients just after they have conceded the existence of their addiction. This facet of recovery may well account for their unpublished but suggested success rate of 5% or less. At best, treatment centres may open the door to possible ways of recovering and form bridges between old ways and new ways of living in addressing what is going to be a lifelong condition.

6.2.(ii) The core elements of the unstated message of Alcoholics Anonymous

Rather than allow a munificent, self-funding, self-perpetuating benign organization be regarded as a form of 'Pyramid or Ponzi Scheme', the organization of AA was developed from a non-academic and wide range of social, spiritual psychological and religious sources without compartmentalization or within any theoretical boundaries. The organization works and has been doing so for over 80 years saving countless lives, dissipating misery and giving life to many who never had one or understood what ordinary life meant.

However, unlike the mythical 'goose that lays the golden egg', AA must have core elements (equivalent to a multiple DNA helices) essential to its functioning. Despite being a totally 'suggested only' programme (AA World Services 2001, p. 164) these essential unformalized elements underpin its continuity and success as without them, it would disappear and fade in the way many of its forebearers did.

Although the AA constitution may be described as cosmopolitan, their focus is on the 'human' and 'spiritual' side of the psychologically disturbed severe AUDs, maladjusted through a multiplicity of processes.

There are five core elements to AA's existence without which it could fail or not endure. While referenced in detail in the thesis, they are summarize here - with appropriate referencing to participant comments as appropriate.

1. *"The inevitable conclusion is that true alcoholism is an allergic state, the result of gradually increasing sensitization by alcohol over a more or less extended period of time"* Silkworth (1938, undated but cited in AA World Services, 2001, p.xxv and xxx)
AA treats this developed "allergy" reference as being like an illness/disease (Kurtz, 2002). Although at that time, medical knowledge regarding allergies was somewhat limited, a recent publication by Australasian society of Clinical Immunology and Allergy (ASCIA, 2019) clearly describes the origin and development of different allergies. They include medications (such as alcohol) and refer to the life-threatening nature of untreated allergic occurrences.
2. The second core element has no direct academic rationale or underpinning – it is, however, an example of Bill Wilson's expertise as a salesman. Immediately after telling members hear that they have a lifelong and possibly terminal condition, he offers them hope by stating:
"The tremendous fact for every one of us is that we have discovered a common solution. We have a way out on which we can absolutely agree and upon which we can join in brotherly and harmonious action. This is the great news this book carries to those who suffer from alcoholism" (AA World Services Inc., 2001, p. 17; Big Book).
Notwithstanding, the lack of any scientific merit, this resonates with many new members in that, once having learned that they have an 'illness' they hear that, despite their abjectly dismal self-perception condition, there may be way out or cure for them.

3. The third core element is going through each the 12 steps (and necessary follow up actions) which are set out in pages 59-60 of the Big Book. This is usually done under the aegis of a sponsor (see 'General abbreviations pp. 20 and actual working with sponsors in section 2.4.7.
(The whole process of going through the steps is explored in pages 182-187 of this thesis.)

4. The fourth core element – *"What we have is a daily reprieve contingent on the maintenance of our spiritual condition".* This is the most fundamental element of all – the concept of a daily reprieve from alcohol dependence and is discussed in page 221. It is the

one comment repeated specifically by both 50 yr sober persons. Just as a person with a peanut allergy cannot try 'just one' to see if they still have the allergy, neither can an AUD ever 'try' an alcoholic drink.

5. The fifth core element is the attainable idealized life achievable through the '12 Promises of AA (Big Book p. 83-4). It evolves rather than happens - in line with developing sobriety over many years.

The participants individual comprehensions of '*the message'* are set out in appendix 11.

The participants' narratives across all groups show that, while their recovery followed a generally progressive and consistent pattern, their level of recovery varied at relatively unpredictable and individually different points. However, the underlying five core elements of the AA message became more ingrained as their sobriety time increased. Already mentioned in the previous sub-section, two factors that impeded the rate of recovery for the participants in their programmes emerged – how long it took to (i) learn to trust in some power greater than themselves (in whatever form they chose), and (ii) the attainment of emotional sobriety (Wilson, 1958). Once these difficulties were ameliorated, that enabled the continuing development of their sobriety, the formation of secure attachments in one form or another through beneficial social networks and social identity transition (Martinelli et al., 2020; Frings et al. 2019 & Best et al. 2016) and "…*lasting psychological connectedness between human beings"* (Bowlby, 1969, p. 194). In the later years, the participants continued to build on their established sobriety by gaining a deeper understanding of their groups' message. By year thirty, they had unconsciously automated how to replace instinctual responses to unpleasant things or events through cognitive restructuring deriving from their changed and developed secure attachment styles, emotional responses (Le Berre, 2019) and affect processing. Despite the efforts put in by the participants, there were a few occasions where they came near to the point of relapsing (Index 4). The significant point about these near relapses was that the participants had become self-alert to danger signals, and they did something about them before they came to the point of picking up a drink.

6.2.(iii) The 12 Promises of Alcoholics Anonymous are realistic objectives that may be achieved but may take very many years.

For the first time, the research also shows how the AA fellowship's 12 promises can all come true - but usually in tandem with how a member's sobriety is developing over the years. The 12 promises of Alcoholics Anonymous are realistic objectives that can be achieved but can take many years to come to full fruition. This "new life" is one to which anyone currently going through AUD could aspire to but may be either unaware of or not yet "ready" to undertake the very first step – admission or acceptance of their condition.

6.2.(iv) Non-abstinent recovery is not an option for people with a severe AUD.

The findings of this research indicate that there is no merit in DSM-V diagnosed severe alcohol use disordered people seeking to adopt a "non-abstinence as an outcome" goal. The participants were quite adamant that they disagree with the idea of non-abstinent recovery and that they cannot consider it an option for anyone with severe AUD recovering within the 12-step ethos. They would regard this as ‘Epsilon alcoholism’ (a condition described by Jellinek (1960) who characterized it as being composed of periodic drinking episodes or binges interspersed with dry periods lasting weeks or months.)

6.3. Limitations

There are limitations to this research, and the first is a potential bias in the study cohort. As the study participants had all recovered for quite some time from alcohol dependence through their 12-step group, therapeutic allegiance may have influenced their responses. Alcohol-dependent people were selected as a purposive group to represent recovery development through AA 12- step group methodology because 1. that is the only group that confines itself to one substance dependence only while advocating the avoidance of any other non-prescribed mind-altering substance or behaviour, and 2. there is an overwhelmingly more significant amount of literature on the subject. The participants were residents of five different countries – Ireland (5), Scotland (4), England (5), Wales (3), and Spain (6) for most of their sobriety periods.

To resolve a query raised by the University's Research Ethics Committee (REC/19/0029) regarding participants ability to identify one another through any publication deriving from this research, the Research Protocol was amended to include an additional condition on

participant inclusion - that a minimum separation of 150 miles be observed between individual participants or their home groups. This ‘distancing’ also ensured the negation of any suggestion of participant collusive narratives.

Another limitation is the potential interpretative nature of interviews and researcher or participant bias. Interpretative phenomenological analysis requires that a researcher makes sense of how an individual makes sense of a particular phenomenon. This double hermeneutic may induce bias by either or both parties. Neither applied in this study. AA members, through their preamble, adhere to the statement *"... 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"* (AA Grapevine Inc., 2017). However, as the participants were interviewed as recovering alcoholics and not as members of AA, they spoke freely about difficulties experienced along the way, including doubting the merit of some parts of the programme. As a counsellor/therapist, the researcher is very familiar with different forms of therapy and has no allegiance to any approach in particular – applying the most appropriate to each client who may seek assistance

A further limitation is the absence of detailed knowledge of the pre-dependency stages. As the participants had been advised that the study would concern their recovery process, precursor behavioural patterns and traumagenics could not be explored. However, most did advert to such incidents. Only one participant declined to refer to his childhood at all. When a participant did speak of childhood issues, they were allowed do so without interruption, but no follow-up questions were put to them. Thus, the impact or influence of severe issues such as child abuse may be understated or missed.

6.4 Cultural differences between participants

Room (2004) had argued that alcoholism was culture-based, and this point was used by Heather (2021) as one of his critiques of Kelly et al.'s (2020a) Cochrane Database Systematic Review, when he suggested that AA was primarily a US phenomenon. Kelly and Abry's response (2021) were that AA had international significance, but they accepted this caveat – and had previously mentioned in their review that it merited further study (Kelly et al., 2020a, p. 36). Therefore, culture was another potential limitation in this study. For nuances, expressions, body language, and other non-verbal cues not to be missed, all the

participants had to have English as their primary language, although a number were multi-lingual. As participants gained their sobriety in five different countries, localized cultural factors did not apply. Interestingly, no macro cultural differences were discernable either, when considered in the context of literature – which is predominantly of US origin. All participants were "singing from the same hymn sheet", differing only in individuality or in personality.

Furthermore, as their ages ranged from 35 to >90, cultural differences might be expected to emerge in interpretation, management, or other differing practices. Quite extraordinarily, there were almost none save for the use of local colloquialisms. Once the names were anonymized, it becomes almost impossible to tell where the participants are from – such is the unity of purpose and the practicing of the programme. All participants differed only in individuality or in personality. Possibly that was because I, as the researcher, was following an AA slogan which says, "*Stick with the winners*".

6.5 Contribution to literature

Despite the vast amount of literature existing on most aspects of alcohol use disorder and other addictions, this is the first research that presents a phenomenological view of the experiences of people with alcohol use disorder (AUD) using self-help groups from the commencement of recovery and maintenance of a lifetime of sobriety.

The participants in this study did this by frequently remembering their conception of the core elements of the recovery message as they perceive it and applying that perception to how they have to "work" the programme on a daily basis. Every participant believed in the concept that they only had a daily reprieve and that their recovery could fade, leading to relapse, unless they kept it to the forefront of their minds. The majority of early research on AUD has tended to focus on abstinence rather than sobriety. While abstinence exclusively refers to abstaining from alcohol and ignores the dependency disorder's symptomology, recovery goes much deeper – referring to its emotional, psychological and mental dimensions (Helm, 2019). The participants had, through adhering to their programme, become increasingly aware of that fact in their recovery progression.

The research also contributes significantly to knowledge in that it explored with all participants a relatively ignored facet in the literature of the Alcoholics Anonymous 12-step programme –

the 12 promises they make if their programme is painstakingly followed. Those promises, while not numerically enumerated in AA World Services Inc. (2001), but as used in Kelly and Greene's (2013) when read objectively for the first time, seem to list an unrealistic, idealized lifestyle. Nevertheless, they do come true. At present, the only literature on the subject is a measurement scale designed by Kelly and Greene (2013), and that was limited to people who were 3-, 6- and 12-months post-treatment. This research showed that, in practice, they do not occur in the short term but can take very many years. However, compared with the different decades of sobriety, a clear, unique and invaluable insight emerges into how the 12 promises of the 12-step fellowships evolve in line with lived sobriety.

Attachment issues play a role in the traumagenics of substance dependency, and numerous papers acknowledge that in the addiction and alcoholism field (Liese and Hodgins 2020; Flores, 2004). This research also suggests that 22 of 23 participants reported sufficient information from childhood that may classify them as having "insecure attachment styles" (Bowlby, 1973) and, concerning development, lacking b-values (Maslow, 2014). (One participant refused to revisit the past at all – wanting to leave it where it was – past.) Rather than being a coincidence, the random nature of participant selection and location, this aspect of the findings suggests that attachment and early developmental issues play a much more significant role in the development of addictions than is currently suggested.

6.6 Practical recommendations deriving from findings

This section provides a set of four recommendations. They have in mind alcohol 12-step mutual aid groups and others that emulate or promote the approach to harmful dependency- related behaviors. The also contain illuminated generalizable factors, that are informative for spin-off organizations and educational and preventative services in the wider community, which encounter alcohol dependency.

6.6.1 To promote a greater awareness of the contents of the "message" of 12-step fellowships

The AA 12-step programme seemed to work best with those with the mildest and most severe alcohol dependency (Vaillant, 1988). Kelly et al. (2020b) suggests that well-articulated Twelve- Step Facilitation organizations' (TSFs') manualized interventions,

intended to increase AA participation during and following alcohol use disorder treatment, can lead to enhanced abstinence outcomes over the following months and years – more so than any other professional approaches. Kelly et al. (2020b) also points out, "*The results … also indicate that clinicians who have prejudged AA should give it another look. In a study of NHS workers, Day and colleagues (Day et al., 2005) found that clinicians were highly confident they understand what happens at AA meetings but had never actually visited one*" (p. 649).

During the extensive travel involved in this research, I used the spare time between interviews to attend, anonymously, at open meetings of Alcoholics Anonymous, Gamblers Anonymous, Narcotics Anonymous, Overeaters Anonymous, and Al-Anon. As Kelly et al. (2020b) and Day et al. (2005) suggested, it gave me, a qualified counsellor/psychotherapist, a new and enlightened perception of them from being informal, disorganized, and somewhat weak on efficacy or effectiveness, to realizing that they are focused and effective for those who give them a chance. It is highly recommended that attendance at several different open "Anonymous" meetings becomes a mandatory part of the training of any professional that will encounter alcohol, substance or behavior dependency, or excessiveness's during their practice.

6.6.2 To highlight, and the need for, early identification of underlying psychopathologies

If 12-step groups and TSFs followed this research's findings, they could appreciably improve their outcome rates. Through early emphasizing of the third core element of the "message" – the importance of the first three steps of the 12-step programme (trusting in any power they wish that is greater than themselves) – they could zero in on one of the fundamental problems that all new members have: a deep-rooted lack of trust in anybody or anything. Indeed, a review of their drinking or "using" histories, displayed a "need to fail" – to prove their worthlessness.

6.6.3 To explain, in general and at an early stage, the advantages for new members in undertaking the rigorous self-examination process and the admission of wrongdoings as described in steps 4 and 5 of their fellowships

Steps 4 and 5 of the 12-step programme are "*Made a searching and fearless moral*

inventory of ourselves" and "*Admitted to God, to ourselves and to another human being the exact nature of our wrongs."*

Following the learning of trusting another human being, if the concept of the damage and effect of having had insecure attachments is raised and discussed in general with a sponsor, it may provide grounds for a comprehensive exploration of steps 4 and 5 and the potential beneficial consequences that could flow from that course. The use of Todd's (1985) references to Jungian quotations on confession may well give a more incentivizing perspective for those with a severe alcohol use disorder to start or continue to engage with a sponsor. Discussing the powerful effect of secure attachments, whether with a fellow-traveler or 12-step sponsor, would enable their processing of steps 4 and 5 of the 12 steps to be addressed more openly and honestly – avoiding the need to repeat them at a later date as some of the participants had to do.

Establishing a secure attachment while within a treatment facility may possibly not be beneficial as (a) a power dynamic may lie in such a scenario between the therapist and client, negating its value, and (b) such a relationship would be time-limited – possibly being treated as yet another abandonment by the client.

6.6.4 To ensure that clients attending treatment centres are aware that Severe Alcohol Use Disorder (DSM-V), in particular, is a lifetime condition and will require ongoing support to be coped with, best given through mutual aid.

Clients need to understand that their DSM-V Severe Alcohol Use Disorder malaise is a lifelong condition, and this needs re-emphasis to clients on leaving treatment centers. A more focused idea of how to hold on to any benefits that may have resulted from their treatment may be to advise them to join an abstinence-based fellowship. They are freely and readily available for the duration of their condition – that is, the rest of their lives – if they wish to retain the benefits that sobriety brings and could bring to them.

6.7 Future research directions

Other groups such as Narcotics Anonymous, Overeaters Anonymous, and Cocaine Anonymous have adopted the broad-spectrum approach of the 12-step movement to address other dysfunctional behaviours. Kelly and colleagues (2020b) have shown that the 12-step approach has better long-term effects than other approaches, particularly where alcohol dependency is involved. "*AA/TSF interventions produce similar benefits to other treatments on all drinking- related outcomes except for continuous abstinence and remission, where AA/TSF is superior"* (p. 641).

This research gives insights into the critical core elements of 12-step groups' "message" that drive that recovery, through the 12-step format, from "day one" to periods greater than 50 years, and highlights issues that cause hesitancy and delay in the process.

1. Further studies that would enhance this knowledge could explore the actual prevalence of attachment issues in alcohol-dependent people generally – having regard to the fact that all the participants' narratives in this study suggested severe developmental and or insecure attachment issues leading to early mistrust and identity foreclosure (Erikson, 1997) that endure for quite some time into recovery.

2. Studies at the beginning and end of the first level of education, in line with Ainsworth et al.'s Strange Situation (1971, 1978) and a modification of the Adult Attachment Interview (George et al., 1996; Hesse, 2008), could identify those at risk of developing severe dysfunctional behaviors and then make appropriate referrals to professionals. The age profiles of participants' alcohol abuse in the current study suggest that by the mid-secondary school/post-puberty stage, any such intervention may be too late – in all probability, those prone to addictive behaviors would already have started down that road. If primary school curricula were to include a module on attitudes to life, self and others, it could well avoid the development of what AA World Services Inc. postulate (2001, p. 62) *"So our troubles, we think, are basically of our own making"*.

3. Many of the participants found steps 4, 5 and 9 of the program difficult as they required them to write out and then discuss with their sponsor or other trusted person the nature of all their resentments, the causes and the effects on them, acknowledging the part they

themselves played in the problems, and what had to be done about them. Those who did not go through this process showed more delayed recovery and negativity towards the fulfilment of the promises. However, those who had gone through all the steps felt a tremendous sense of relief and liberation. The necessity of comprehensively addressing these steps after the first year of living sober requires attention by treatment centers. Although challenging to arrange, phenomenological research into the processes involved in addressing these specific steps with participants would add considerably to the knowledge of how the whole 12-step process works.

4. At present, treatment centers – mainly commercially based ones – do not seem to do enough to promulgate the fact that ongoing treatment for life is necessary for severely alcohol-dependent people. Of the four participants who had been in treatment, only one directly joined the 12-step fellowship – and that was because his Employee Assistance Programme insisted that he do it. There is literature on the role of Twelve-Step Facilitation facilities (TSFs), and some do run pre-set weekly or monthly aftercare meetings. However, there is a severe problem attaching to the reliance on their suggestion of attending aftercare or 12-step meetings. Their clients go from the protected environment of the facility straight back to their place of origin. The alcohol-dependent person may have worked on changing themselves, but their family and friends have not. Creating a link between the treatment and returning home should become part of the process, so that the client attends a meeting adjacent to their home *on the day* they leave and *before* they go to their homes. This practice would create a bridge for them – meeting locals who have the same problem, establishing new contacts and knowledge of a nearby safety net, engendering a more reassuring feeling of security and ability to maintain their newfound sobriety. Reviews of long-term outcomes for rehabilitation treatment centers' effectiveness could be enhanced if they ensured their clients are not considered as having completed their programme until they attend such a self-help group meeting adjacent to their homes. This course could be discreetly arranged by bringing the client to such a meeting and waiting until it is over before the client is "signed off". Manca & Lewsey (2021) suggest ‘discharge locations’ (home settings and environment where the individual resides) are significant psychosocial risk factors and should be considered by clinicians when discharge planning from AUD treatment centres.

6.8 Academic dissemination: Conference presentations

- Ulster University Festival of Research: April 2019 – poster presentation.
- British Association of Counselling and Psychotherapy (BACP) Annual Research Conference: 17/18 May 2019 – "Having lived sober – a developmental perspective of recovery: Literature Review" (see note 1 below)
- This thesis will be published via Open Access.
- Written recommendations based on the findings will be sent to the Irish Strategic Task Force on Alcohol and interested major sporting bodies.
- I am a member of The UK-Ireland Alcohol Research Network and will, on completion of studies, actively participate in their research and information dissemination activities.
- Presentations may be made to international conferences: 1. August 28-31, 2022, the 23rd International Council on Alcohol, Drugs and Traffic Safety Conference (ICADTS) takes place in Rotterdam, The Netherlands. 2. European Conference on Addictive Behaviours and Dependencies, Lisbon Conference Centre, 23-25 November 2022
- Planned Publications:
  1. Alcohol dependence: *An exploration of unmonitored 12-step recovery from alcohol dependency from day 1 to 50 years later.* (Journal: Alcoholism: Clinical & Experimental Research) – submission stage for publication
  2. Alcoholics Anonymous 12 promises: Extravagant thinking or achievable objectives? (Journal: Drug and Alcohol Dependence) – submission stage for publication
  3. Self-help groups: *What are the core elements of the messages that drive ongoing recovery in 12-step self-help groups?* (Journal: Alcohol and AUD) – in course of preparation
  4. Alcohol dependence and insecure attachments: *Prevalence in AUD and how 12-step group membership may help redress them*. (Journal: Journal of Social Work and Practice in the Addictions) – in course of preparation
- Presentations may be made when regular conferences are resumed (post-Covid-19 pandemic) to the Irish Association for Counselling and Psychotherapy (IACP -14 October 2022), the BACP, and, as requested by them, to the Irish Addiction Counsellors Association once my studies are completed.

Note 1: Email reply to my application to include a poster for the BACP Conference 17/18 May 2019, Hilton Hotel, Belfast

> "*I am delighted to let you know that your submission to present at the BACP Research Conference 2019 has been accepted by the peer review panel with no amendments necessary. Indeed, the panel thought very highly of the submission and suggest that it would be more appropriate to present as a Paper"*
>
> andy.boyle@bacp.co.uk

6.9 Summary

Based on the participants' accounts, full recovery can take many years for people with severe Alcohol Use Disorders; there is no quick fix to their addiction and or dependency-based behaviours. Despite the lukewarm reports in the literature, this research indicates that 12-step programmes can and do work very well for those who can embrace their ethos. The tradition of recruiting only by "attraction rather than promotion" (eleventh tradition, AA World Services Inc., 2001, p.562) is an appreciable constraint. However, that only applies to members and there is no limitation to non-members advocating its approach and potential to help someone with a severe AUD. Lack of awareness of the merit and strengths of 12-step programmes among the medical profession at the GP level is worthy of investigation; material findings could then form part of their medical education on alcohol and other addictions.

For professionals in the addiction counselling field, it should be a mandatory part of their training that they attend at least three "open" meetings so they understand how SHG/MHGs can help and what they are about – as suggested by Day et al. in 2005 and proposed by Breuninger et al. (2020) on the complementing use of cognitive behavioural therapy associated with AA attendance.

This research illuminated how those participants who are genuinely attempting to "live the 12 steps" have learned how to enjoy a significantly better quality of life than others – based on their experiences of engaging, in a lifelong capacity, with this 12-step programme.

This study showed how its participants with severe alcohol use disorder (AUD) use self-help groups in their developing a lifetime of sobriety through the 12-step program's "message". The core elements of the "message" remain unchanged as participants continue their personal development while living sober – despite variations in the 23 participants' perceptions of what they believed those elements were. Their responses contained three main recurrent themes:

gaining hope, having a specific illness and getting a daily reprieve. The five core elements that constitute AA's "message" incorporate these themes. One participant pointed out that the message does not have to change; it is the person who must change, which has been happening with these participants. Those with 30 years of sobriety and more appear to become more involved in the generativity process, more in keeping with the typical developmental processes of their stage in the life course. They also begin to attend meetings almost daily, based on gratitude to whatever power that led them to receive freely and unconditionally such a happy, fulfilling, sober life that only a tiny minority of people with AUD have been able to achieve. Those with 50 years' sobriety exhibit "transcendence" as described by Maslow (1978) and Erikson (1997), fully embracing their growing physical limitations and serenely accepting the inevitability of dying in the relatively near future.

The "take-home" message of this research is that 12-step self-help groups can empower members in attaining lifetime enjoyable abstinent sobriety, and, through their words, actions and deeds, can pass the "message" on to someone else so that they, too, learn to live "… *happy, joyous and free".*

REFERENCES

Ainsworth, M. D. S., Bell, S. M., & Stayton, D. J. (1971) Individual differences in strange-sation behavior of one-year-olds. In H. R. Schaffer (Ed.) *The origins of human social relations*. London and New York: Academic Press. Pp. 17-58.

Ainsworth, M.D.S., Blehar, M.C., Waters, E. & Wall, S. (1978) *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Åkerlind*,* I. & Hörnquist*,* J.O. (1992). Loneliness and alcohol abuse: A review of evidences of an interplay. *Social Science & Medicine*, 34(4), 405-414.

AA Grapevine Inc. (1962) *The A.A. Service Manual/Twelve Concepts for World Service Short Form* Rev. 6/14, SM F-114. New York, AA World Services Inc.

AA Grapevine Inc. (2017) *Preamble* AA-literature, SMF-92_en_AA, Alcoholics Anonymous General Service Office,

AA World Services Inc. (1984) *"Pass it On": The story of Bill Wilson and how the AA message reached the world.* New York: AA World Services Inc.

AA World Services Inc. (1990) *Daily reflections.* New York: AA World Services Inc.

AA World Services Inc. (2001) *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism,* 4th Ed, New York: AA World Services Inc.

AA World Services Inc. (2005) *Living Sober* New York: AA World Services Inc.

AA World Services Inc. (2008) *News and notes from the General Service Office of AA*. Box 459 (Summer Issue p.6). [web resource, n.d. http://www.aa.org/newsletters/en_US/en_box459_holiday08.pdf last accessed 13/2/21]

AA World Services Inc. (2010) *Service material from the General Service Office (S.M. F-143).*
New York: AA World Services Inc.

AA World Services Inc. (2012) *Twelve Steps and Twelve Traditions.* NewYork: AA World Services Inc.

Alcoholics Anonymous World Services, Inc. (2021) (https://www.aa.org/pages/en_US/aa- around-the-world; Web resource, n.d. last accessed 7/11/1/21).

AA World Services Inc. (2019) *Service material from the General Service Office (S.M. F-132 Rev 12/19).* New York: AA World Services Inc.

Addiction Counsellors of Ireland, Code of Ethics for Counsellors, [web resource, n. d. https://addictioncounsellors.ie/forms-2 /Code of Ethics for Counsellors.docx Ver.2 June2013 Last accessed 27/2/22]

Akhouri, S., Kuhn, J. & Newton, E.J. (2021) Wernicke-Korsakoff Syndrome. [Updated 2021 Jul 18]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK430729/

Allen, J.P., Mattson, M.E., Miller, W.R., Tonigan, J.S., Connors, G.J., Rychtarik, R.G.,
Randall, C.L., Anton, R.F., Kadden, R.M., Litt, M., Cooney, N.L., DiClemente, C.C., Carbonari, J., Zweben, A., Longabaugh, R.H., Stout, R.L., Donovan, D., Babor, T.F., Del Boca, F.K., Rounsaville, B.J., Carroll, K.M., Wirtz, P.W., Bailey, S., Brady, K., Cisler, R., Hester, R.K., Kivlahan, D.R., Nirenberg, T.D., Pate, L.A. & Sturgis, E. (1997) Matching alcoholism treatments to client heterogeneity. *Journal of studies on alcohol,* 58(1), 7-29.

Allen, J., Anton, R.F., Babor, T.F., Carbonari, J., Carroll, K.M., Connors, G.J., Cooney, N.L., Del Boca, F.K., DiClemente, C.C., Donovan, D., Kadden, R.M., Litt, M., Longabaugh, R., Mattson, M., Miller, W.R., Randall, C.L., Rounsaville, B.J., Rychtarik, R.G., Stout, R.L., Tonigan, J.S., Wirtz, P.W. & Zweben, A. (1998) Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research,* 22(6), 1300-1311.

Amended NIH Policy and Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research, (2017) Notice Number: NOT-OD-18-014 [web resource, dated 28 November 2017, https://grants.nih.gov/grants/guide/notice-files/NOT-OD-18-014.html last accessed 22/2/22]

American Psychiatric Association (2013) *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA.

Anderson, M.L. (2003) Embodied cognition: A field guide. *Artificial Intelligence,* 149, pp.91- 130.

Angermeyer M.C. & Matschinger H. (1992) Mentally ill patients: Viewed from 2 perspectives. A methodological contribution on attitudinal research in psychiatry. *Soz Praventivmed,* 37(2), 96-102.

Arksey, H. & O'Malley, L. (2005) Scoping studies: Towards a methodological framework.
International Journal of Social Research Methodology, 8(1), 19-32.

Aten, J.D. & Hernandez, B.C. (2005) A 25-year review of qualitative research published in spiritually and psychologically oriented journals. *Journal of Psychology and Christianity,* 24, 266-277.

Australian Psychological Society (2010). *Evidence-based psychological interventions in the treatment of mental disorders: a literature review*. Melbourne: APS [no longer

available as a web resource 21/1/21]

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.*
Englewood Cliffs, NJ: Prentice-Hall.

Barnett, A.I., Hall, W., Fry, C.L., Dilkes-Frayne, E. & Carter, A. (2018) Drug and alcohol treatment providers' views about the disease model of addiction and its impact on clinical practice: A systematic review. *Drug Alcohol Rev,* 37, 697–720.

Bakermans-Kranenburg, M. J. & van IJzendoorn, M. H. (2016). Attachment, Parenting, and Genetics. In J. Cassidy and P. R. Shaver (Eds.), *Handbook of Attachment*, 3rd Edition (pp. 155-179). Guilford Press

Bateson (1971) The cybernetics of "self": A theory of alcoholism. *Psychiatry*, 34(1), 1-18.

Beatty, W.W., Tivis, R., Stott, H.D., Nixon, S.J. & Parsons, O.A. (2000) Neuropsychological deficits in sober alcoholics: Influences of chronicity and recent alcohol consumption. *Alcohol Clin Exp Res,* 24, 149–154.

Bebbington, P.E. (1976) The efficacy of Alcoholics Anonymous: The elusiveness of hard data.
The British Journal of Psychiatry, 128, 572-580.

Beck, M., Dietrich, S., Matschinger, H. & Angermeyer, M.C. (2003) Alcoholism: Low standing with the public? Attitudes towards spending financial resources on medical care and research on alcoholism. *Alcohol Alcohol*. 38(6), 602-605.

Beck, A.K., Forbes, E., Baker, A.L., Kelly, P.J., Deane, F.P., Shakeshaft, A., Hunt, D. & Kelly,
J.F. (2017) Systematic review of SMART Recovery: Outcomes, process variables, and implications for research. *Psychology of Addictive Behaviors,* 31(1), 1-20.

Beckman, L.J (1979) Reported effects of alcohol on the sexual feelings and behavior of women alcoholics and non-alcoholics. *Journal of Studies on Alcohol*, 40, 272-282.

Beckman L.J. (1994) Treatment needs for women with alcohol problems. *Alcohol Health and Research World*, 18(3), 206–211.

Beckman, L.J. & Amaro, H. (1984) Patterns of women's use of alcohol treatment agencies. In Wilsnack, S.C. & Beckman, L.J. (Eds.), *Alcohol problems in women*. New York: The Guilford Press, pp.319-348.

Bernard, H.R. (2000) *Social research methods, qualitative and quantitative approaches.*
Thousand Oaks, CA: Sage Publications

Best, D., Albertson, K., Irving, J., Lightowlers, C., Mama-Rudd, A. & Chaggar, A. (2015). *The*
U.K. Life in Recovery Survey 2015: The first national U.K. survey of addiction recovery

experiences. Project Report. Sheffield: Helena Kennedy Centre for International Justice, Sheffield Hallam University.

Best, D., Beckwith, M., Haslam, C., Alexander Haslam, S., Jetten, J., Mawson, E. & Lubman,
D.I. (2016) Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR). *Addiction Research & Theory,* 24(2), 111-123.

Betty Ford Institute Consensus Panel (2007) What is recovery? A working definition from the Betty Ford Institute. *J Subst Abuse Treat,* 33

Biernacki, P. (1986). *Pathways from heroin addiction*: *Recovery without treatment*. Philadelphia, PA: Temple University Press.

Blaine S.K., Wemm, S., Fogelman, N., et al. (2020) Association of prefrontal-striatal functional pathology with alcohol abstinence days at treatment initiation and heavy drinking after treatment initiation. *Am J Psychiatry,* 177, 1048–1059.

Blay, S.L. & Peluso, E.T.P. (2010) Public stigma: The community's tolerance of Alzheimer disease. *Am J Geriatr Psychiatry,* 18, 163–171.

Blizard, P. J. (1970). The social rejection of the alcoholic and the mentally ill in New Zealand.
Social Science & Medicine, 4(5), 513–525.

Blonigen, D.M., Timko, C., Finney, J.W., Moos, B.S. & Moos, R.H. (2011) Alcoholics Anonymous attendance, decreases in impulsivity and drinking and psychosocial outcomes over 16 years: Moderated-mediation from a developmental perspective. *Addiction,* 106(12), 2167- 2177.

Blume, S.B. (1982) Psychiatric problems of alcoholic women. In Solomon, J. (Ed.), *Alcoholism and clinical psychiatry.* New York: Plenum. pp.179-193.

Bochand, L. & Nandrino, J.L, (2010) Levels of emotional awareness in alcohol-dependent patients and abstinent alcoholics. *L'Encephale: Revue de psychiatrie clinique biologique et therapeutique,* 36(4), 334-339.

Bogart, C.J. and Pearce, C.E. (2003) "13th-stepping:" Why Alcoholics Anonymous is not always a safe place for women. *Journal of Addictions Nursing,* 14(1), 43-47.

Bond, J., Kaskutas, L.A. & Weisner, C. (2003) The persistent influence of social networks and Alcoholics Anonymous on abstinence. *J Stud Alcohol,* 64, 579–588.

Bowlby, J. (1956) *Mother-child separation.* In Soddy, K. (Ed.) *Mental health and infant development. Vol. 1. Papers and discussions*. New York: Basic Books, Inc. pp.117-112.

Bowlby, J. (1958) The nature of the child's tie to his mother. *International Journal of Psychoanalysis,* 39, 350-371.

Bowlby, J. (1959) Separation anxiety. *International Journal of Psycho-Analysis,* XLI, 1-25.

Bowlby, J. (1960) Grief and mourning in infancy and early childhood. *The Psychoanalytic Study of the Child,* VX, 3-39.

Bowlby J. (1969) *Attachment and loss: Vol. 1. Loss*. New York: Basic Books.

Bowlby, J. (1973) *Attachment and loss: Vol. 2. Separation: Anxiety and anger*. New York: Basic Books; Revised in Bowlby, J. (*1982*). Attachment and loss: Retrospect and prospect. *American Journal of Orthopsychiatry*, 52(4), 664–678

Bowlby J (1980) *Loss: Sadness & Depression. Attachment and Loss* (vol. 3) London: Hogarth Press.

Bowlby, J. (1988) *A secure base: Clinical applications of attachment theory.* London: Routledge.

Bradshaw, S.D., Shumway, S.T., Dsauza, C.M., Morris, N. & Hayes, N.D. (2017) Hope, coping skills, and the prefrontal cortex in alcohol use disorder recovery. *Am.J.Drug Alcohol Abuse,* 43(5), 591-601.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101

Braun, V. & Clarke V. (2013) *Successful qualitative research: A practical guide for beginners.*
London: Sage.

Bravo, F., Gual, A., Lligona, A. & Colom, J. (2013) Gender differences in the long-term outcome of alcohol dependence treatments: An analysis of twenty-year prospective follow up. *Drug & Alcohol Review,* 32(4), 381-388.

Breggin, P. (1994) *Toxic psychiatry: Why therapy, empathy and love must replace the drugs, electroshock, and biochemical theories of the "new psychiatry"* (1st Ed.). New York: St. Martin's Press.

Brett, P., Graham, K. & Smythe, C. (1995). An analysis of speciality journals on alcohol, drugs and addictive behaviors for sex bias in research methods and reporting. *Journal in Studies on Alcohol,* 56, 24–34.

Breuninger, M.M., Grosso, J.A., Hunter, W. & Dolan, S.L. (2020). Treatment of alcohol use disorder: Integration of Alcoholics Anonymous and cognitive behavioral therapy. *Training and Education in Professional Psychology,* 14(1), 19–26. https://doi.org/10.1037/tep0000265

Brière, F. N., Rohde, P., Seeley, J. R., Klein, D., & Lewinsohn, P. M. (2014). Comorbidity between major depression and alcohol use disorder from adolescence to adulthood. *Comprehensive psychiatry*, *55*(3), 526–533. https://doi.org/10.1016/j.comppsych.2013.10.007

Brorson, H., Arnevik, E.A., Rand-Hendriksen, K. & Duckert, F. (2013) Drop-out from addiction treatment: A systematic review of risk factors. *Clinical Psychology Review,* 33(8), 1010-1024.

Brown, S. (1993) *Therapeutic processes in Alcoholics Anonymous.* In McCrady, B.S. & Miller,
W.R. (Eds.), Research on Alcoholics Anonymous. New Brunswick, NJ: Rutgers Centre of Alcohol Studies pp. 113-135.

Bufe, C. (1991) *Alcoholics Anonymous: Cult or cure?* San Francisco: Sharp Press.

Burns, V.F. (2021) The Sober Professor: Reflections on the Sober Paradox, Sober Phobia, and Disclosing an Alcohol Recovery Identity in Academia. *Contemporary Drug Problems*. 48(3):223-240. doi:10.1177/00914509211031092

Butler, S. (2010) *Benign anarchy: Alcoholics Anonymous in Ireland.* Dublin: Irish Academic Press.

Caldwell, P.E. & Cutter, H.S.G. (1998) Alcoholics Anonymous affiliation during early recovery. *Journal of Substance Abuse Treatment*, 15(3), 221-228.

Canadian Medical Association (2008) *8th annual national report card on health care.*
Available at:
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwic6
-jg2_jvAhVMyhoKHSk8DqYQFjABegQIAhAD&url=http%3A%2F%2Fwww.bc-psychologist.com%2Fdownloads%2Fother%2FNational_Report_Card_EN.pdf&usg=AOvVa w0D_wHYwrX-fbR6Ee6UY_RH [last accessed 12/4/2021]

The Centre Against Sexual Abuse (2006) web resource:
http://www.casahouse.com.au/index.php?page_id=154 [last accessed 16/11/21]

Centre for Reviews and Dissemination (2001). *Undertaking systematic reviews of research on effectiveness: CRD's guidance for those carrying out or commissioning reviews*. C.R.D. Report 4 (2nd edition). York: University of York.

Chambert, A., Bayard, S. & Carton, S. (2007) Self-assessment of alexithymia: Influence of mandatory treatment in alcohol-dependent subjects. *Alcoologie et Addictologie,* 29(3), 227- 232.

Chappel, J.N. (1993) Long-term recovery from alcoholism. *Psychiatric Clinics of North America,* 16(1), 177-187.

Chappel, J.N. & DuPont, R.L. (1999) Twelve-step and mutual-help programs for addictive disorders. *Psychiatric Clinics of North America,* 22(2), 425-446.

Charmaz, K. & Bryant, A. (2011) Grounded theory and credibility. In Silverman, D. (Ed.), *Qualitative research: Issues of theory, method and practice* (3rd ed.). London: Sage.

pp.291- 309.

Charmaz, K. (2015) Grounded theory. In Smith, J.A. (Ed.), *Qualitative psychology: A practical guide to research methods* (3rd Ed.) London, Sage. pp.53-85.

Chaudhury, S., Prakash, J., Walia, T.S., Seby, K., Sukumaran, S. & Kumari, D. (2010) Psychological distress in alcohol dependence syndrome. *Journal of Projective Psychology & Mental Health,* 17(1), 38-44.

Chen, G. (2017) Does gratitude promote recovery from substance misuse? *Addiction Research & Theory*, 25:2, 121-128.

Chenhall, R.D. & Oka, T. (2006) An initial view of self-help groups for Japanese alcoholics: Danshukai in its historical, social, and cultural contexts. *International Journal of Self Help & Self Care,* 5(2), 111-152

Cleland, C., Magura, S., Foote, J., Rosenblum, A. & Kosanke, N. (2005) Psychometric properties of the Toronto Alexithymia Scale (TAS-20) for substance users. *Journal of Psychosomatic Research,* 58(3), 299-306.

Cloud, W. & Granfield, R. (2001) Natural recovery from substance dependency. *Journal of Social Work Practice in the Addictions,* 1(1), 83-104.

Cobb, S. & Jones, J.M. (1984) Social support, support groups, and marital relationships. In Duck, S. (Ed.), *Personal relationships: Vol. 5. Repairing personal relationships*. London: Academic Press. pp.47-66.

Cohen, P. (2000) Is the addiction doctor the voodoo doctor or the western man? *Addiction Research and Theory,* 8, 589-598

Cohen, S. & Wills, T.A. (1985) Stress, social support, and the buffering hypothesis.
Psychological Bulletin, 98, 310-357.

Condron, I., Carew, A.M. & Lyons, S. (2020) *Drug treatment in Ireland 2013-2019.* Dublin: Health Research Board. Available at https://www.drugsandalcohol.ie/32093 [accessed 7/9/2021].

Connor, S. & Caswell, S. (2012) Alcohol-related harm to others in New Zealand: Evidence of the burden and gaps in knowledge. *New Zealand Medical Journal,* 125(1360).

Connors, G.J. & Dermen, K.H. (1996) Characteristics of participants in Secular Organizations for Sobriety (S.O.S.). *The American Journal of Drug and Alcohol Abuse,* 22(2), 281-295.

Connors G.J., Walitzer K.S. & Tonigan J.S. (2008) Spiritual change in recovery. In Kaskutas,
L. & Galanter, M. (Eds). *Recent Developments in Alcoholism*, vol 18. New York: Springer.

Corrigan, P., Schomerus, G and Smelson, D. (2017) Are some of the stigmas of addictions

culturally sanctioned? The British Journal of Psychiatry, 210, 180–181.
doi: 10.1192/bjp.bp.116.185421

Coyle, A., (2007) Discourse analysis. In Breakwell, G.M., Hammond, S., Fife-Schaw, C. & Smith, J.A. (Eds.) *Research methods in psychology* (3rd Ed.) London: Sage. pp.366-388.

Craparo G, Ardino V, Gori A, and Caretti, V. (2014) The relationships between early trauma, dissociation, and alexithymia in alcohol addiction. *Psychiatry Investig*. 11(3):330-335 https://doi.org/10.4306/pi.2014.11.3.330

Creswell, J.W. & Miller, D.L. (2000) Determining Validity in Qualitative Inquiry *Theory Into Practice,* Volume 39, Number 3*,* pp. 124-130.

Crisp, A.H., Gelder, M.G., Rix, S., Meltzer, H.I. & Rowlands, O.J. (2000) Stigmatisation of people with mental illnesses. *Br J Psychiatry*.,177, 4-7.

Crisp, A., Gelder, M., Goddard, E. & Meltzer, H. (2005) Stigmatization of people with mental illnesses: A follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry*., 4(2), 106-113

Crocker, A.F. & Smith, S.N. (2019) Person-first language: are we practicing what we preach? *J Multidiscip Healthc*. (12) 125-129. doi: 10.2147/JMDH.S140067. PMID: 30799931.

Crowley, N.A., Dao, N.C., Magee, S.N., Bourcier, A.J. & Lowery-Gionta, E. (2019) Animal models of alcohol use disorder and the brain: From casual drinking to dependence. *Translational Issues in Psychological Science,* 5(3), 222-242.

Davidson, R. (1998) The transtheoretical model: A critical review. In Miller, W. & Heather,
N. (Eds.) *Treating addictive behaviours* (2nd Ed.) New York: Plenum. pp. 25-38

Davies, S.J.C, Pandit, S.A., Feeney, A., Stevenson, B.J., Kerwin, R.W., Nutt, D.J., Marshall, E.J., Boddington, S. & Lingford-Hughes, A. (2005) Is there cognitive impairment in clinically 'healthy' abstinent alcohol dependence? *Alcohol and Alcoholism,* 40, 498–503.

Davis, S.J., Benshoff, J.J. & Koch, D.S. (2006) Attitudes toward spirituality and the core principles of Alcoholics Anonymous. *Journal of Teaching in the Addictions,* 5(1), 19-30.

Dawson, D.A. (1996) Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States. *Alcoholism*: *Clinical and Experimental Research*, 20, 771-779.

Day, E., Gaston, R.L., Furlong, E., et al. (2005) The United Kingdom substance misuse treatment workers' attitudes toward 12-step self-help groups. *J Subst Abuse Treat,* 29, 321-327.

Day, E., Wall, R., Chohan, G. & Seddon, J. (2015) Perceptions of professional drug treatment staff in England about client barriers to narcotics anonymous attendance

ADDICTION RESEARCH AND THEORY, 23(3), 223-230.

De Bellis, M.D., Morey, R.A., Nooner, K.B., Woolley, D.P., Haswell, C.C. & Hooper, S.R. (2019) A pilot study of neurocognitive function and brain structures in adolescents with alcohol use disorders: Does maltreatment history matter? *Child Maltreatment*, 24(4), 374–388.

Dennis, M.L., Scott, C.K. & Funk, R. (2003) An experimental evaluation of recovery management checkups (R.M.C.) for people with chronic substance use disorders. *Evaluation and Program Planning,* 26(3), 339–352.

Dermatis, H. & Galanter, M. (2016) The role of twelve-step-related spirituality in addiction recovery. *Journal of Religion & Health,* 55(2), 510-521.

Deurzen, V. (2015) *Passion and paradox in psychotherapy: An existential approach.* (2nd Ed.). London: Sage.

DiClemente, C.C., Bellino, L.E. & Neavins, T.M. (1999) Motivation for change and alcoholism treatment. *Alcohol Research & Health: The Journal of the National Institute on Alcohol Abuse & Alcoholism,* 2 (2), 86-92.

Di Sclafani, V., Finn, P. & Fein, G. (2007) Psychiatric comorbidity in long-term abstinent alcoholic individuals. *Alcoholism: Clinical and Experimental Research*, 31, 795-803

Dodes, L. & Dodes, Z. (2014) *The sober truth: Debunking the bad science behind 12-Step programs and the rehab industry*. Boston, MA: Beacon Press.

Domínguez-Salas., S., Díaz-Batanero, C., Lozano-Rojas, O.M. & Verdejo-García, A. (2016) Impact of general cognition and executive function deficits on addiction treatment outcomes: Systematic review and discussion of neurocognitive pathways. *Neurosci Biobehav Rev*., 71, 772-801.

Downing, C. (1991) Sex role setups and alcoholism. In Van Den Bergh, N. (Ed.), *Feminist perspectives on addictions.* New York: Springer. pp. 47-60.

Dunne, C. (2015) *Wounded Healer of the Soul an illustrated biography Carl Jung,* Shelly Rubin Foundation, NY, Watkins

Dunn, K.E., Harrison, J.E., Participant 22utsakos, J.M. Han, D. & Strain, E.C. (2017) Continuous abstinence during early alcohol treatment is significantly associated with positive treatment outcomes, independent of duration of abstinence. *Alcohol Alcohol.* 52(1), 72-79.

Edmonds, C. (2020) The entwined narratives of the wounded healer. *Social Work with Groups*, 43(1-2), 126-130. DOI: 10.1080/01609513.2019.1639102

Edwards, E. & King, J.A. (2009) *Stress Response: Genetic Consequences* Ed. Encyclopedia of Neuroscience, p. 495-503.

El-Guebaly, N. (2012) The meanings of recovery from addiction: Evolution and promises.
Journal of Addiction Medicine, 6(1), pp. 1-9.

Elms, E., Savic, M., Bathish, R,. Best, D., Manning V. & Lubman, D. (2018) Multiple pathways to recovery, multiple roads to well-being: an analysis of recovery pathways in the Australian Life in Recovery survey. *Alcoholism Treatment Quarterly*, 36(4), 482-498.

Emrick, C.D. (1974) A review of psychologically oriented treatment of alcoholism: I. The use and interrelationships of outcome criteria and drinking behavior following treatment. *Quarterly Journal of Studies on Alcohol,* 35(2), 523-549 .

Emrick, C.D., Tonigan, J.S., Montgomery, H. & Little, L. (1993) Alcoholics Anonymous: What is currently known? In McCrady, B. S. & Miller, W. R. (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives*. New Brunswick, NJ: Rutgers Center of Alcoholic Studies, Publication Division. pp.41–76.

Emrick, C.D. & Beresford, T.P. (2016) Contemporary negative assessments of Alcoholics Anonymous: A response. *Alcoholism Treatment Quarterly,* 34(4), 463-471.

Epstein, E.E. & Menges, D. (2013) Women and addiction. In: McCrady, B.S. & Epstein, E.E. (Eds.), *Addictions: A Comprehensive guidebook.* New York, NY: Oxford University Press. 788-818.

Erikson, E.H. (1958) *Young man Luther: A study in psychoanalysis and history*. New York: Norton.

Erikson, E.H. (1959) *Identity and the life cycle: Selected papers.* New York, International Universities Press.

Erikson, E.H. (1963) *Youth: Change and challenge*. New York: Basic books.

Erikson, E.H. (1997) *The life cycle completed: Extended version with new chapters on the ninth stage of development by Joan M. Erikson.* New York: Norton.

Estévez, A., Jáuregui, P., Sánchez-Marcos, I., López-González, H. & Griffiths, M.D. (2017) Attachment and emotion regulation in substance addictions and behavioral addictions. *Journal of Behavioral Addictions*, 6(4), 534-544.

Etheridge, R.M., Craddock, S.G., Hubbard, R.L. & Rounds-Bryant, J.L. (1999) The relationship of counselling and self-help participation to patient outcomes in DATOS. *Drug Alcohol Dependence*, 57(2), 99–112.

EVS (2020) *European Values Study 2017: Integrated Dataset.* GESIS Data Archive, Cologne. ZA7500 Data file Version 4.0.0, doi:10.4232/1.13560.

Eysenck, H.J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16(5), 319–324.

Eysenck, H.J. (1964) The outcome problem in psychotherapy: A reply. *Psychotherapy:*

Theory, Research & Practice, 2, 97–100.

Fama, R., LeBerre, A. P. and Sullivan E.V. (2020) Alcohol's Unique Effects on Cognition in Women: A 2020 (Re)view to Envision Future Research and Treatment *Alcohol Research Current Reviews* https://doi.org/10.35946/arcr.v40.2.03

Fan, A.Z., Chou, S.P., Zhang, H., Jung, J. & Grant B.F. (2019) Prevalence and correlates of past year recovery from DSM-V alcohol use disorder: Results from a national epidemiologic survey on alcohol and related conditions-III. *Alcohol Clin Exp Res,* 43, 2406–2420.

Fairbairn, C.E., Briley, D.A., Kang, D., Fraley, R.C., Hankin, B.L. & Ariss, T. (2018) A meta- analysis of longitudinal associations between substance use and interpersonal attachment security. *Psychological Bulletin*, 144(5), 532–555. https://doi.org/10.1037/bul0000141

Fein, G., Landman, B., Tran, H., McGillivray, S., Finn, P., Barakos, J. & Moon, K. (2006) Brain atrophy in long-term abstinent alcoholics who demonstrate impairment on a simulated gambling task. *NeuroImage,* 32(3), 1465-1471.

Ferri, M., Amato, L. & Davoli, M. (2006) Alcoholics Anonymous and other 12-step programmes for alcohol dependence. Cochrane Database Syst Rev. 2006 Jul 19;(3):CD005032. doi: 10.1002/14651858.CD005032.pub2. PMID: 16856072.

Fillmore, K.M., Bacon, S.D. & Hyman, M.M. (1979) *The 27-year longitudinal panel study of drinking by students in college, 1949-1976*. Berkeley, CA*:* Social Research Group, University of California.

Fingarette, H. (1989) *Heavy drinking: The myth of alcoholism as a disease.* Berkeley: University of California Press.

Finfgeld, D. (1999) *Self-resolution of alcohol problems as a process of investing and reinvesting self*. Paper presented at the international conference on the natural history of addictions: Recovery from alcohol, tobacco, and other drug problems without treatment. Les Diablerets, Switzerland. 7-12 March.

Finn P.R., Martin, J. & Pihl, R.O. (1987) Alexithymia in Males at high genetic risk for alcoholism. *Psychother Psychosom*, 47, 18-21.

Finney, J.W. & Moos, R.H. (1991) The long-term course of treated alcoholism: I. Mortality, relapse and remission rates and comparisons with community controls. *Journal of studies on alcohol,* 52(1), 44-54.

Fiorentine, R. (1999) After drug treatment: Are 12-step programs effective in maintaining abstinence? *American Journal of Drug Alcohol Abuse*, 25(1), 93–116.

Flaherty, M. (2006) *A unified vision for the prevention and management of substance use disorders: Building resiliency, wellness and recovery. A shift from an acute care to a sustained care recovery management model.* Pittsburgh, PA: Institute for Research, Education and Training in Addictions.

Flacks, S. (2012) Deviant disabilities: The exclusion of drug and alcohol addiction from the Equality Act 2010. Available at https://ssrn.com/abstract=2185852 [last accessed 15/1/21].

Fennell, M. (1999) *Overcoming low self-esteem: A self-help guide using cognitive behavioral techniques* London, Robinson

Flink, P. (2021) Person-First & Identity-First Language: Supporting Students with Disabilities on Campus *Community College Journal of Research and Practice*, v45 n2 p79-85

Flores, P.J. (1988) Alcoholics Anonymous: A phenomenological and existential perspective.
Alcoholism Treatment Quarterly, 5(1-2), 73–94. https://doi.org/10.1300/J020V05N01_06

Flores, P.J. (2004) *Addiction as an Attachment disorder*. Plymouth (UK): Jason Aron.

Flores-Bonilla, A. & Richardson, H.N. (2020) Sex differences in the neurobiology of alcohol use disorder. *Alcohol Research: Current Reviews*, 40(2).

Fraley, R.C., Niedenthal, P.M., Marks, M., Brumbaugh, C. & Vicary, A. (2006) Adult attachment and the perception of emotional expressions: Probing the hyperactivating strategies underlying anxious attachment. *Journal of Personality,* 74, 1163-1190.

Fox, H.C. & Sinha, R. (2009) Sex Differences in Drug-Related Stress-System Changes: Implications for Treatment in Substance-Abusing Women *Harv Rev Psychiatry*. 2009; 17(2): 103–119

Frank, J., Cichon, S., Treutlein, J., Ridinger, M., Mattheisen, M., Hoffmann, P., Herms, S., Wodarz, N., Soyka, M., Zill, P., Maier, W., Mössner, R., Gaebel, W., Dahmen, N., Scherbaum, N., Schmäl, C., Steffens, M., Lucae, S., Ising, M., Müller-Myhsok, B., Nöthen, M.M., Mann, K., Kiefer, F. & Rietschel, M. (2012) Genome-wide significant association between alcohol dependence and a variant in the ADH gene cluster. *Addiction Biology,* 17(1), 171-180.

Frings, D., Wood, K., Lionetti, N. & Albery, I.P. (2019) Tales of hope: Social identity and learning lessons from others in Alcoholics Anonymous: A test of the Social Identity Model of Cessation Maintenance. *Addictive Behaviors,* 93, 204-211.

Frings, D., Wood, K. V. and Albery, I. P. (2021) New converts and seasoned campaigners: the role of social identity at different stages in the addiction recovery journey, *Drugs: Education, Prevention & Policy*, 28(5), pp. 496–503. doi: 10.1080/09687637.2021.1914551
Gadamer, H. (1990/1960) *Truth and method* (2nd rev. Edn.) New York: Crossroad.

Galanter, M., Dermatis, H., Stanievich, J. & Santucci, C. (2013) Physicians in Long-term recovery who are members of Alcoholics Anonymous. *The American Journal on Addictions,* 22(4), 323-328.

Galanter, M., Dermatis, H. & Sampson, C. (2014) Spiritual awakening in Alcoholics Anonymous: Empirical findings. *Alcoholism Treatment Quarterly,* 32(2), 319-334.

George, C., Kaplan, N. and Main, M (1996) *Adult Attachment Interview.* Unpub. Dept. of Psychology, University of California (Berkley) 3rd., Ed.

Giffney, N. (2017) web resource https://breac.nd.edu/articles/psychoanalysis-in-ireland-an-interview-with-dr-noreen-giffney/#_ftn27 [27 /7/2017, last accessed 24/10/21]

Giorgi, A. & Giorgi, B. (2008) Phenomenology. In Smith, J. A. (Ed.) *Qualitative psychology: A practical guide to research method*. London: Sage. (pp.24-42).

Glanton, C.G. & Cucciare, M (2020) Sex and gender effects in recovery from alcohol use disorder. *Alcohol Res*. 2020 Nov 19;40(3):03. doi: 10.35946/arcr.v40.3.03.

Goldstein, A.L., Haller, S., Mackinnon S. P. & Stewart, S.H. (2019) Attachment anxiety and avoidance, emotion dysregulation, interpersonal difficulties and alcohol problems in emerging adulthood. *Addiction Research & Theory*, 27(2), 130-138.

Gomberg, E.S.L. & Lisansky, J.M. (1984) Antecedents of alcohol problems in women. In Wilsnack, S.C. & Beckman, L.J. (Eds.), *Alcohol problems in women*. New York: Guilford. pp.233-259.

Gomberg, E. & Nirenberg, T. (1991) Women and substance abuse. *Journal of Substance Abuse,*
3, 255–267.

Gomes, K. & Hart, K.A. (2009) Adherence to recovery practices prescribed by alcoholics anonymous: Benefits to sustained abstinence and subjective quality of life. *Alcoholism Treatment Quarterly,* 27(2), 223-235

Gonsalkorale, K., & Williams, K. D. (2007). The KKK won't let me play: Ostracism even by a despised outgroup hurts. *European Journal of Social Psychology, 37,* 1176–1186. doi:10.1002/ejsp.392

Gorsky, T.P. (1989) *Passages Through Recovery: An Action Plan for Preventing Relapse*
Centre City, MN, Hazelden.

Gossop, M., Keaney, F., Stewart, D., Marshall, E.J. & Strang, J. (2002) A Short Alcohol Withdrawal Scale (SAWS): Development and psychometric properties. *Addiction Biology*, 7, 37-43.

Gossop, M., Harris, J., Best, D., Man, L., Manning, V., Marshall, J. & Strang, J. (2003) Is attendance at Alcoholics Anonymous meetings after inpatient treatment related to improved outcomes? A 6-month follow-up study. *Alcohol and Alcoholism,* 38(5), 421-426.

Grant, M.J. & Booth, A. (2009) A typology of reviews: An analysis of 14 review types and

associated methodologies. *Health Info Libr J.* 26(2), 91-108.
doi: 10.1111/j.1471-1842.2009.00848.x. PMID: 19490148.

Grant, B.F., Chou, S.P., Saha, T.D., et al. (2017) Prevalence of 12-month alcohol use, high- risk drinking, and DSM-IV alcohol use disorder in the United States, 2001-2002 to 2012-2013: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *JAMA Psychiatry*, 74(9), 911-923. https://doi.org/10.1001/jamapsychiatry.2017.2161.

Grilly, M.D. (2002) *Drugs and Human Behavior,* Pearson, New York, NY.

Groh, D.R., Jason, L.A. & Keys, C.B. (2008) *Social network variables in alcoholics anonymous: A literature review.* Clin Psychol Rev. 28(3): pp. 430-450

Gross, J.J. (1998) Antecedent- and response-focused emotion regulation: Divergent consequences for experience, expression, and physiology. *Journal of Personality and Social Psychology,* 74, 224–237.

Guilbaud, O., Loas, G., Corcos, M., Speranza, M., Stephan, P., PerezDiaz, F., Venisse, J.L., Guelfi, J.D., Bizouard, P., Lang, F., Flament, M., Jeammet, P. & Reseau I. (2002) Alexithymia in addictive behaviors and in healthy subjects: Results of a study in French-speaking subjects. *Annales Medico-Psychologiques,* 160(1), 77-85.

Gutierrez, D., Mason, N., Dorais, S. & Fox, J. (2021). Gradually Sudden: Vital Spiritual Experiences for Individuals in Recovery From Substance Use Disorders. *Spirituality in Clinical Practice*, 8, 16-29. https://doi.org/10.1037/scp0000218

Hadjiosif, M. (2021) The ethos of the nourished wounded healer: A narrative inquiry.
European Journal of Psychotherapy & Counselling, 23(1), 43-69.

Handel, George Frideric, (1741) *The Messiah, Ev'ry valley shall be exalted.* Oxford University Press. Available at https://global.oup.com/academic/product/messiah-9780193366688?cc=gb&lang=en& [last accessed 20/1/21]

Hanson, B., Beschner,G., Walter, J. & Bovelle, E. (1985) *Life with Heroin: Voices From the Inner City* Lexington, MA: Heath

Hanson, K.W. (1998) Public opinion and the mental health parity debate: Lessons from the Survey literature. *P.S.,* 49(8), 1059-1066.

Harris, J., Best, D., Gossop, M., Marshall, J., Man, L. H., Manning, V. & Strang, J. (2003) Prior Alcoholics Anonymous (AA) affiliation and the acceptability of the Twelve Steps to patients entering U.K. statutory addiction treatment. *Journal of Studies on Alcohol*, 64(2), 257– 261.

Harris, A.H.S., Finney, J.W. & Moos, R.H. (2010) Baseline Abstinence may moderate substance use disorder intervention effects. *Journal of Drug Issues,* 40(1), 141-154.

Heather, N. (2021) Let's not turn back the clock: Comments on Kelly et al. "Alcoholics Anonymous and 12-Step facilitation treatments for alcohol use disorder: A distillation of a 2020 Cochrane Review for clinicians and policy makers". *Alcohol and Alcoholism*, 56(4), 377–
379. https://doi.org/10.1093/alcalc/agaa137

Hedges, J. (2007) The Role of Identity in organizational storytelling. *Conference Papers -- National Communication Association*, 1.

Hefferon, K. & Gil-Rodrigues, E. (2011) Interpretative phenomenological analysis. *The Psychologist,* 24, 756-759.

Heidegger, M. (1962/1927) *Being and Time.* Oxford: Blackwell.

Helm, P. (2019) Sobriety versus abstinence. How 12-stepper negotiate long-term recovery across groups. *Addiction Research & Theory*, 27(1), 29-36. DOI:10.1080/16066359.2018.1530348

Henwood, K. & Pigeon, N. (2003) Grounded theory in psychological research. In Camic, P. M., Rhodes, J. E. & Yardley, L. (Eds.) *Qualitative research in psychology: Expanding perspectives in methodology and design.* Washington D.C.: American Psychological Association. pp.131-155.

Herman, A.M. & Duka, T. (2019) Facets of impulsivity and alcohol use: What role do emotions play? *Neuroscience & Biobehavioral Reviews,* 106, 202-216.

Hermans, H. J. (1988) On the integration of nomothethic and idiographic research methods in the study of personal meaning. *Journal of Personality,* 44, 147-163.

Hesse, E. (2008). *The Adult Attachment Interview: Protocol, method of analysis, and empirical studies.* In Cassidy, J. & Shaver, P. R. (Eds.), *Handbook of attachment: Theory, research, and clinical applications.* The Guilford Press. New York, pp.552–598.

Hester, R.K., Lenberg, K.L., Campbell, W. & Delaney, H.D. (2013) Overcoming addictions, a web-based application, and SMART Recovery, an online and in-person mutual help group for problem drinkers, part 1: Three-month outcomes of a randomized controlled trial. *J Med Internet Res.,* 11;15(7):e134.

Hien, D., Litt, L.C., Cohen, L.R., et al. (2009) *Trauma services for women in substance abuse treatment: An integrated approach.* American Psychological Association. https://doi.org/10.1037/11864-000

Hill, J.V. & Leeming, D. (2014) Reconstructing the alcoholic: Recovering from Alcohol addiction and the stigma this entails. *International Journal of Mental Health and Addiction,* 12(6), 759-771.

Holzhauer, C. G., Cucciare, M., & Epstein, E. E. (2020a). Sex and Gender Effects in Recovery From Alcohol Use Disorder. *Alcohol research: current reviews*, *40*(3), 03.

Holzhauer, C.G, Hildebrandt, T., Epstein, E.E., et al. (2020b) Mechanisms of change in

female- specific and gender-neutral cognitive behavioral therapy for women with alcohol use disorder. *J Consult Clin Psychol.,* 88(6), 541-553. https://doi.org/10.1037/ccp0000492.

Hope. A., Barry, J. & Byrne, S. (2018) *The untold story: Harms experienced in the Irish population due to others' drinking.* Dublin: Health Service Executive.

Horvath, A. & Yeterian, J. (2012) SMART Recovery: Self-empowering, science-based addiction recovery support. *Journal of Groups in Addiction & Recovery,* 7(2-4), 102-117.

Humphreys, K., Mavis, B.E. & Stöffelmayr, B.E. (1994) Are twelve-step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help group involvement. *Prevention in Human Services*, 11, 165–180.

Humphreys, K. & Moos, R. (1996) Reduced substance abuse-related health care costs among voluntary participants in Alcoholics Anonymous. *Psychiatric Services*, 47, 709–713.

Humphreys, K. & Noke, J.M. (1997) The influence of posttreatment mutual help group participation on the friendship networks of substance abuse patients. *American Journal of Community Psychology*, 25, 1–17.

Humphreys, K., Moos, R.H. & Cohen, C. (1997) Social and community resources and long- term recovery from treated and untreated alcoholism. *Journal of studies on alcohol,* 58(3), 231- 238.

Humphreys, K., Huebsch, P.D., Finney, J.W. & Moos, R.H. (1999) A comparative evaluation of substance abuse treatment: V. Treatment can enhance the effectiveness of self-help groups. *Alcoholism: Clinical and Experimental Research*. 23, 558-563

Humphreys, K. & Moos, R. (2001) Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care? A quasi-experimental study. *Alcoholism: Clinical & Experimental Research,* 25(5), 711-716.

Humphreys, K. (2004) *Circles of recovery: Self-Help organizations for addictions.* Cambridge, UK: Cambridge University Press.

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Gallant, L. & Haberle, B. (2004) Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, 26(3), 151–158. Discussion 159–165

Humphreys, K., Blodgett, J.C. & Wagner, T.H. (2014) Estimating the efficacy of Alcoholics Anonymous without self-selection bias: An instrumental variables re-analysis of randomized clinical trials. *Alcoholism: Clinical and Experimental Research,* 38(11), 2688-2694.

Ingram, I., Kelly, P.J., Deane, F.P., Baker, A.L., Goh, M.C.W., Raftery, D.K. & Dingle, G.A. (2020) Loneliness among people with substance use problems: A narrative systematic review. *Drug Alcohol Rev*., 39, 447-483.

Irish Association for Counselling and Psychotherapy, Data Protection Policy [V1.6] July

2021, [web resource n.d. https://www.iacp.ie/index.php/page/file_dwn/209/Data%20Protection%20Policy%20[V1.6]%20Jul%202021.pdf last accessed 27/2/22]

Jackson D.N. & Messick, S. (1971) *The Differential Personality Inventory*. London, Ontario Canada:

Jellinek, E.M. (1960).*The disease concept of alcoholism.* New Haven, Hillhouse Press:

Jin, H., Rourke, S.B., Patterson, T.L., Taylor, M.J. & Grant, I. (1998) Predictors of relapse in long-term abstinent alcoholics. *Journal of studies on alcohol,* 59(6), 640-646.

Jones, N., Keeling, M., Thandi, G. & Greenberg, N. (2015) Stigmatisation, perceived barriers to care, help-seeking and the mental health of British military personnel. *Soc Psychiatry Psychiatr Epidemiol*., 50(12), 1873-1883.

Jordan, J. (2019) Alcoholics Anonymous: A Vehicle for achieving capacity for secure attachment relationships and adaptive affect regulation. *Journal of Social Work Practice in the Addictions,* 19, 201-222.

Jung, C.G. (1954) *Problems of modern psychotherapy.* C.W., vol. 16. New York: Pantheon Books.

Jung, C.G. (1961) *Letter to Bill Wilson.* Available at https://www.saltlakeaa.org/2015/01/spiritus-contra-spiritum-carl-jungs-letter-to-bill-wilson-january-30-1961/ [last accessed 7/7/21]

Jung, C.G. (1983) *Psychology of transference.* London: Routledge

Kaplan, G.C. & Main, M. (1996) *Adult Attachment interview.* Unpublished manuscript, Dept. of Psychology, University of California, Berkley (third edition).

Karch, S., Krause, D., Lehnert, K., Konrad, J., Haller, D., Rauchmann, B. S., Maywald, M., Engelbregt, H., Adorjan, K., Koller, G., Reidler, P., Karali, T., Tschentscher, N., Ertl-Wagner, B., Pogarell, O., Paolini, M., & Keeser, D. (2021). Functional and clinical outcomes of FMRI- based neurofeedback training in patients with alcohol dependence: a pilot study. *European archives of psychiatry and clinical neuroscience*, 10.1007/s00406-021-01336-x. Advance online publication. https://doi.org/10.1007/s00406-021-01336-x

Kaskutas, L. (1989). Women For Sobriety: A qualitative analysis. *Contemporary Drug Problems,* 16, 177-200.

Kaskutas, L.A. (1992a) An analysis of Women for Sobriety. Doctoral dissertation, University of California, Berkeley.

Kaskutas, L.A. (1992b) Beliefs on the source of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems* (winter), 631–648.

Kaskutas, L.A. (1994) What do women get out of self-help? Reasons for attending Women

for Sobriety and Alcoholics Anonymous. *Journal of Substance Abuse Treatment,* 11(3), 185–195.

Kaskutas, L.A., Bond, J. & Humphries, K (2002) Social networks as mediators of the effect of Alcoholics Anonymous. *Addiction,* 97(7), 891-900.

Kaskutas, L.A., Bond, J. & Weisner, C. (2003) The role of religion, spirituality and Alcoholics Anonymous in sustained sobriety. *Alcoholism Treatment Quarterly,* 21(1), 1-16.

Kaskutas, L.A., Ammon, L., Delucchi, K., Room, R., Bond, J. & Weisner, C. (2005) Alcoholics anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcohol Clinical Experimental Research*, 29(11), 1983–1890.

Kaskutas, L.A. (2009) Alcoholics Anonymous effectiveness: Faith Meets science. *Journal of Addictive Diseases,* 28(2), 145-157.

Kaskutas, L.A., Bond, J. & Avalos, L.A. (2009) 7-year trajectories of Alcoholics Anonymous attendance and associations with treatment. *Addict Behav*;34 (12):1029-35

Kaskutas, L.A., Borkman, T.J., Laudet, A., Ritter, L.A., Witbrodt, J., Subbaraman, M.S., Stunz, A. & Bond, J. (2014) Elements that define recovery: The experiential perspective*. J. Stud. Alcohol*. *Drug,s* 75, 999–1010.

Katz, A.H. (1993) *Social movements past and present. Self-help in America: A social movement perspective.* New York,Twayne Publishers.

Katz, A. & Bender E.I. (1976) Self-help groups in Western society: History and prospects.
Journal of Applied Behavioral Science, 12, 265-282.

Keefer, L.A., Landau, M.J., Rothschild, Z.K. & Sullivan, D. (2012) Attachment to objects as compensation for close others' perceived unreliability. *Journal of experimental social psychology,* 48(4), 912-917.

Kelly, J.F., Myers, M.G. & Brown, S.A. (2000) A multivariate process model of adolescent 12-step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors,* 14(4), 376–389.

Kelly, J.F., Stout, R., Zywiak, W. & Schneider, R. (2006). A 3-year study of addiction mutual- help group participation following intensive outpatient treatment. *Alcohol Clinical Experimental Research*, 30(8), 1381–1392.

Kelly, J.F., Magill, M. & Stout, R.L. (2009) How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research & Theory,* 17(3), 236-259.]

Kelly, J.F. & Yeterian, J.D. (2011) The role of mutual-help groups in extending the framework of treatment. *Alcohol Research & Health*, 33(4), 350–355.

Kelly, J.F. & Greene, M.C. (2013) The Twelve Promises of Alcoholics Anonymous: Psychometric measure validation and mediational testing as a 12-step specific mechanism of behavior change. *Drug and Alcohol Dependence,* 133(2), 633-640.

Kelly, J.F. & Hoeppner, B.B. (2013) Does Alcoholics Anonymous work differently for men and women? A moderated multiple mediation analysis in a large clinical sample. *Drug Alcohol Depend.,* 130(1-3), 186-193.

Kelly, J.F. & Greene, M.C. (2014) Toward an enhanced understanding of the psychological mechanisms by which spirituality aids recovery in Alcoholics Anonymous. *Alcoholism Treatment Quarterly*, 32(2-3), 299-318. DOI: 10.1080/07347324.2014.907015

Kelly, J.F., Greene, M.C. & Bergman, B.G. (2016) Recovery benefits of the "therapeutic alliance" among 12-step mutual-help organization attendees and their sponsors *Drug Alcohol Depend.*162:64-71. doi: 10.1016/j.drugalcdep.2016.02.028.

Kelly, J.F. (2017) Is Alcoholics Anonymous religious, spiritual, neither? Findings from 25 years of mechanisms of behavior change research. *Addiction,* 112(6), 929-936.

Kelly, J.F., Humphreys, K. & Ferri, M. (2020a) Alcoholics Anonymous and other 12-step programs for alcohol use disorder. *Cochrane Database Syst Rev*.

Kelly, P. J., McCreanor, K., Beck, A. K., Ingram, I., O'Brien, D., King, A., McGlaughlin, R., Argent, A., Ruth, M., Hansen, B. S., Andersen, D., Manning, V., Shakeshaft, A., Hides, L., & Larance, B. (2021). SMART Recovery International and COVID-19: Expanding the reach of mutual support through online groups. *Journal of substance abuse treatment*, *131*, 108568. https://doi.org/10.1016/j.jsat.2021.108568

Kelly, J. F., Abry, A., Ferri, M. & Humphreys, K. (2020b) Alcoholics Anonymous and 12-Step facilitation treatments for alcohol use disorder: A distillation of a 2020 Cochrane Review for clinicians and policy makers. *Alcohol and Alcoholism*, 55(6), 641–651.

Kelly, J. F. & Abry, A. (2021) Leave the past behind by recognizing the effectiveness and cost- effectiveness of 12-step facilitation and Alcoholics Anonymous. *Alcohol and Alcoholism,* 56(4), 380–382. https://doi.org/10.1093/alcalc/agab010

Kessler, R., Michelson, K.D. & Zhao S. (1997) Patterns and correlates of self-help group membership in the United States. *Social Policy.* 27(3), 27-46.

Keyes, K.M., Hatzenbuehler, M.L., McLaughlin, K.A., Link, B., Olfson, M., Grant, B.F. & Hasin, D. (2010) Stigma and treatment for alcohol disorders in the United States. *American Journal of Epidemiology*, 172(12) 1364-1372.

Khantzian, E.J. (1980). An ego/self-theory of substance dependence: A contemporary psychoanalytic perspective. In Lettieri, D. J., Sayers, M. & Pearson, H.W. (Eds.) *Theories of drug abuse: Selected contemporary perspectives.* (DHHS Publication No. ADM8 -967), Washington, D.C.: U.S. Government Printing Office

Khantzian E. J. (1997). The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harvard review of psychiatry*, *4*(5), 231–244.

https://doi.org/10.3109/10673229709030550

Kilian, C., Manthey, J., Carr, S., Hanschmidt, F., Rehm, J., Speerforck, S. & Schomerus, G. (2021) Stigmatization of people with alcohol use disorders: An updated systematic review of population studies. *Alcohol Clin Exp Res*, 45, 899-911. https://doi.org/10.1111/acer.14598

Kim, S., Thibodeau, R. & Jorgensen, R.S. (2011) Shame, guilt and depressive symptoms: A meta-analysis. *Psychological Bulletin,* 137, 68–96. doi: 10.1037/a0021466

Kim, J., Shin, Y., Kim, B. & Kim, S. (2021) Life transformation: a meta-synthesis of recovery from alcohol addiction. *Addiction Research & Theory*, 29:5, pp. 372-391 DOI: 10.1080/16066359.2021.1875214

King James Bible. (2008). Oxford University Press. (Original work published 1769)

Kirkpatrick, L.A. & Hazan, C. (1994) Attachment styles and close relationships: A four-year prospective study. *Personal Relationships*, 1, 123-142.

Klingemann, H. (1992) Natural Recovery from Alcohol Problems in *The Essential Handbook of Treatment and Prevention of Alcohol Problems* (Eds. N. Heather & T. Stockwell), Chichester, England PO19 8SQ Ch.10, 161-176

Klingemann, H. (2001) *Alcohol and its social consequences – the forgotten dimension.* Geneva: World Health Organization Regional Office for Europe.

Kober, H., Mende-Siedlecki, P., Kross, E.F., Weber, J., Mischel, W., Hart, C.L. & Ochsner,
K.N. (2010) Prefrontal-striatal pathway underlies cognitive regulation of craving. *Proceedings of the National Academy of Sciences of the United States of America*, 107(33), 14811–14816.

Koob, G.F., Powell, P. & White, A. (2020) Addiction as a coping response: Hyperkatifeia, deaths of despair, and COVID-19. *Am J Psychiatry,* 177(11), 1031-1037.

Kownacki, R.J. & Shadish, W.R. (1999) Does Alcoholics Anonymous work? The results from a meta-analysis of controlled experiments. *Substance Use & Misuse,* 34(13), 1897-1916.

Krentzman, A.R., Brower, K.J., Cranford, J.A., Bradley, J.C. & Robinson, E.A.R. (2012) Gender and extroversion as moderators of the association between Alcoholics Anonymous and sobriety. *Journal of Studies on Alcohol and Drugs,* 73(1), 44-52.

Krentzman, A.R. (2017) Gratitude, abstinence, and alcohol use disorders: Report of a preliminary finding. *Journal of substance abuse treatment,* 78, 30-36.

Krentzman, A.R., Webb, J.R., Jester, J.M. & Harris, J.I. (2018). Longitudinal relationship between forgiveness of self and forgiveness of others among individuals with alcohol use disorders. *Psychology of religion and spirituality*, 10(2), 128–137. https://doi.org/10.1037/rel0000152

Kurtz, E. (1991) *Not-God: A history of Alcoholics Anonymous.* Hazelden, MN:

LaBelle, O.P. & Edelstein, R.S. (2018) Gratitude, insecure attachment, and positive outcomes among 12-step recovery program participants. *Addiction Research & Theory,* 26(2), 123-132.

Landry, S.H., Gamer, P.W., Swank P.R. & Baldwin, C., (1996) Effects of maternal scaffolding during joint toy play with preterm and full-time infants. *Merrill-Palmer Quarterly,* 42(2), 177- 199.

Laudet, A.B., Magura, S., Vogel, H.S. & Knight, E. (2000) Support, mutual aid and recovery from dual diagnosis. *Community Mental Health Journal*, 36(5), 457–476.

Laudet, A. B., Savage, R., & Mahmood, D. (2002). Pathways to long-term recovery: a preliminary investigation. *Journal of psychoactive drugs*, *34*(3), 305–311. https://doi.org/10.1080/02791072.2002.10399968

Laudet, A.B., Morgen, K. & White, W.L. (2006) The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality-of-life satisfaction among individuals in recovery from alcohol and drug problems. *Alcoholism Treatment Quarterly,* 24(1-2), 33-73.

Laudet A. & Storey (2006) *A comparison of the recovery experience in the US and Australia towards recognising universal and culture-specific processes.* Scottsdale: AZ International NIDA Research Forum

Laudet, A. (2007) What does recovery mean to you? Lessons from the recovery experience for research and practice. *J Subst Abuse Treat,* 33 (3):243-56

Laudet, A., Stanick, V. & Sands, B. (2007) An exploration of the effect of on-site 12-step meetings on post-treatment outcomes among polysubstance-dependent outpatient clients. *Evaluation Review*, 31(6), 613-646.

Laudet, A.B. (2008) The road to recovery: Where are we going and how do we get there? Empirically driven conclusions and future directions for service development and research. *Substance Use & Misuse,* 43(12-13), 2001-2020.

Laudet A. & White W.L. (2008) Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. *Substance Use & Misuse,* 43(1), 27-54.

Laudet, A. (2013) *Faces & Voices of Recovery Survey*. Internet resource, https://archive.org/details/life-in-recovery-survey [last accessed 9/11/2021]

Le Berre, A.P., Fama, R. & Sullivan, E.V. (2017) Executive functions, memory, and social cognitive deficits and recovery in chronic alcoholism: A critical review to inform future research. *Alcoholism, Clinical and experimental Research*, 41(8), 1432–1443. https://doi.org/10.1111/acer.13431

Le Berre, A.P. (2019) Emotional processing and social cognition in alcohol use disorder.
Neuropsychology, 33(6), 808–821.

Levine, H. (1978) The discovery of addiction: Changing conceptions of habitual drunkenness in America *Journal of Studies on Alcohol,* 39, 143-174.

Lewis, D. (1991) Spontaneous remission: A current study on Benjamin Rush. The Brown University Digest of Addiction Theory and Application, 10, In *Expanding Addictions:Critical Essays*. Eds. R.Granfield & C Reinerman, 2015 Routledge, Oxon OX14 4RN

Lewis, T., Amini, F. & Lannon, R. (2000) *A general theory of love.* New York: Random House.

Liese, B.S. & Hodgins, D.C. (2020) Insecure attachment and addiction: Testing the mediating role of emotion dysregulation in four potentially addictive behaviors. *Addictive Behaviors*, 2020 Aug;107:106432. doi: 10.1016/j.addbeh.2020.106432. Epub 2020 Apr 4.

Lindbeck V.L. (1972) The woman alcoholic: A review of the literature. *International Journal of the Addictions,* 7, 567-580.

Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A. & Pescosolido, B.A. (1999) Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *Am J Public Health*, 89(9),1328-1333.

Lock, A. (2010) *Social constructionism.* Cambridge, England: Cambridge University Press.

Lockheed, M.A. & Hall, K.P. (1976) Conceptualizing sex as a status characteristic: Applications to leadership training strategies. *Journal of Social Issues*, 32(3), 111-124.

Lofland, J. & Lejeune, R. (1960) Initial interaction of newcomers in Alcoholics Anonymous: A field experiment in class symbols and socialization. *Social Problems,* 8(2), 102-111.

Longabaugh, R., Beattie, M.C., Noel, N.E., Stout, R.L. & Malloy, P. (1993) The effect of social investment on treatment outcome. *Journal of Studies on Alcohol*, 54, 465-478.

Loos, M.D. (2002) The synergy of depravity and loneliness in alcoholism: A new conceptualization, an old problem. *Counseling and Values*, 46, 199-212.

Loprinzi, C.E., Prasad, K., Schroeder, D.R. & Sood, A. (2011) Stress Management And Resilience Training (SMART) program to decrease stress and enhance resilience among breast cancer survivors: A pilot randomized clinical trial. *Clinical Breast Cancer*, 11(6), 364-368.

Maddux, J. & Desmond, D. (1980) New light on the maturing out hypothesis in opioid dependence. *Bulletin on Narcotics*, 32, 15-25.

Maddux, J. & Desmond, D. (1986) Relapse and recovery in substance abuse careers. In Tims,
F. & Leukefeld, C. (Eds.), *Relapse and Recovery in Drug Abuse* (NIDA Monograph

Series 72).

Magura, S., Laudet, A., Kang, S.Y. & Whitney, S.A. (1999) Effectiveness of comprehensive services for crack-dependent mothers with newborns and young children. *Journal of Psychoactive Drugs*, 31(4), 321–338

Magura, S. Knight, E.L. Vogel, H.S., Mahmood, D., Laudet, A.B. & Rosenblum, A. (2003) Mediators of effectiveness in dual-focus self-help groups. *The American Journal of Drug and Alcohol Abuse,* 29(2), 301-322.

Main, M. (2000) The organized categories of infant, child, and adult attachment: Flexible vs. inflexible attention under attachment-related stress. *Journal of the American Psychoanalytic Association*, 48(4), 1055-1096.

Main, M. & Hesse, E. (1990) Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In Greenberg, M.T., Cicchetti, D. & Cummings, E.M. (Eds.), *Attachment in the preschool years: Theory, research, and intervention*. The John D. and Catherine T. MacArthur Foundation series on mental health and development. Chicago: University of Chicago Press.
pp. 161–182.

Main, M. & Solomon, J. (1990) Procedures for identifying disorganized/disoriented infants during the Ainsworth Strange Situation. In Greenberg, M., Cicchetti, D. & Cummings, M. (Eds), *Attachment in the preschool years*. Chicago: University of Chicago Press. pp.121-160

Mann, K., Hermann, D. & Heinz, A. (2000) One hundred years of alcoholism: The twentieth century. *Alcohol and Alcoholism*, 35(1), 10–15.

Manca F. & Lewsey J. (2021). Hospital discharge location and socioeconomic deprivation as risk factors for alcohol dependence relapses: A cohort study. *Drug and Alcohol Dependence,* 229, pp. 1-6. https://doi.org/10.1016/j.drugalcdep.2021.109148

Manoj, S. & Ashutosh, A. (2006) Application of transtheoretical model (T.T.M.) to addictive behaviors: Need for fine-tuning. *Lansing,* (Dec), 3-6.

Marcia, J. (1980). Identity in adolescence. *Handbook of adolescent psychology, 5*, 145

Margolis, R., Kilpatrick, A., & Mooney, B. (2000) A retrospective look at long-term adolescent recovery: Clinicians talk to researchers. *Journal of Psychoactive Drugs*, 32(1), 117-125.

Marie, D. & Miles, B. (2008) Social distance and perceived dangerousness across four diagnostic categories of mental disorder. *Aust N Z J Psychiatry* 42 (2), pp. 126-33

Martinelli, T.F., van de Mheen, D., Best. D., Vanderplasschen, W., Gera E. & Nagelhout, G.E. (2020) Are members of mutual aid groups better equipped for addiction recovery? European cross-sectional study into recovery capital, social networks, and commitment to sobriety. *Drugs: Education, Prevention and Policy,* pp. 1-22 DOI

10.1080/09687637.2020.1844638

Maslow, A.H. (1943) A theory of human motivation. *Psychological Review,* 50(4), 370-96.

Maslow, A.H. (1964/70) *Religions, values and peak experiences.* Columbus, Ohio: Ohio State University Press.

Maslow, A.H. (1987) *Motivation and personality* (3rd ed.). Delhi, India: Pearson

Education. Maslow, A.H. (2014) *Toward a psychology of being.* Floyd, VA: Sublime

Books

Matschinger, H. & Angermeyer, M.C. (2004) The public's preferences concerning the allocation of financial resources to health care: Results from a representative population survey in Germany. *Eur Psychiatry*, 19(8), 478-482.

Maurage, P., Grynberg, D., Noel, X., Joassin, F., Philippot, P., Hanak, C., Verbanck, P., Luminet, O., de Timary, P. & Campanella, S. (2011) Dissociation between affective and cognitive empathy in alcoholism: A specific deficit for the emotional dimension. *Alcoholism: Clinical & Experimental Research,* 35(9), 1662-1668.

Mays, N., Roberts, E. & Popay, J. (2001) Synthesising research evidence. In Fulop, N., Allen,
P. Clarke, A. & Black, N. (Eds.) *Studying the organization and delivery of health services: Research methods.* London: Routledge.

McCaul ME, Roach D, Hasin DS, et al. Alcohol and women: A brief overview. *Alcohol Clin Exp Res.* 2019;43(5):774-779. https://doi.org/10.1111/acer.13985

McCabe, I. (2015) *Carl Jung and Alcoholics Anonymous: The Twelve Steps as a Spiritual Journey of Individuation.* Routledge, Oxon, OX14 4RN

McCrady, B.S., Epstein, E.E. & Fokas, K.F. (2020) Treatment interventions for women with alcohol use disorder. *Alcohol Research Current Reviews,* 40(2), 1-18.

McElrath, D. (1997) The Minnesota Model. *Journal of Psychiatric Drug,s* 29, 141-144.

Mekonen, T., Chan, G., Connor, J., Hall, W., Hides, L., & Leung, J. (2021). Treatment rates for alcohol use disorders: a systematic review and meta-analysis. *Addiction (Abingdon, England)*, *116*(10), 2617–2634. https://doi.org/10.1111/add.15357

McGovern, W., Addison, M., and McGovern, R (2021) An Exploration of the Psycho-Social Benefits of Providing Sponsorship and Supporting Others in Traditional 12 Step, Self-Help Groups, *International Journal of Environmental Research and Public Health*, 18(2208), p. 2208. https://doi: 10.3390/ijerph18052208.

McHugh, P., Chairman of Psychiatry, Johns Hopkins University speaking at American Psychiatric Association's 2004 annual Convention where a symposium was held on the topic *"DSM-V Classification of Personality Disorders: The White Paper and Beyond"*.

Avaiilable at: http://www.psychdisorders.org/psych_billing_bible.html [last accessed 12/1/21].

McInerney, K. & Cross, A. (2021) A phenomenological study: Exploring the meaning of spirituality in long-term recovery in Alcoholics Anonymous. *Alcoholism Treatment Quarterly,* (39:3) 1-19. DOI: 10.1080/07347324.2021.1895016

McKay, J.R., McLellan, A.T., Alterman, A.I., Cacciola, J.S., Rutherford, M.J. & O'Brien, C.P. (1998) Predictors of participation in aftercare sessions and self-help groups following completion of intensive outpatient treatment for substance abuse. *Journal of Studies on Alcohol*, 59(2), 152–162.

McKay, J.R. (2005) Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, 100, 1594–1610.

McLachlan, J.F., Walderman, R.L., Birchmore, D.F. & Marsden L.R. (1979) Self-evaluation, role satisfaction, and anxiety in the woman alcoholic. *International Journal of the Addictions,* 14(6), 809-832.

McLellan, A.T., Lewis, D.C., O'Brien, C.P. & Kleber, H.D. (2000) Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA.* 284(13), 1689–1695.

McLellan, A.T., et al. (2005) Reconsidering the evaluation of addiction treatment. From retrospective follow up to concurrent recovery monitoring. *Addiction,* 100(4), 447-458.

McLaughlin, A., Campbell, A. & McColgan, M. (2016) Adolescent Substance Use in the Context of the Family: A Qualitative Study of Young People's Views on Parent-Child Attachments, Parenting Style and Parental Substance Use, Substance Use & Misuse, 51:14, 1846-1855, DOI: 10.1080/10826084.2016.1197941

McMurran, M. (1994) *The psychology of addiction*. Washington, D.C.: Taylor and Francis.

McQuaid, R.J., Malik, A., Moussouni, K., Baydack, N., Stargardter, M. & Morrisey, M. (2017) *Life in recovery from addiction in Canada.* Ottawa, Ont.: Canadian Centre on Substance Use and Addiction.

Mead, G. H. (1934) *Mind, Self and Society*, Ed. C.W. Morris, Chicago, University of Chicago Press.

Medora, N.l. & Woodward, J.C. (1991) Factors associated with loneliness among alcoholics in rehabilitation centers. *Journal of Social Psychology,* 131(6), 769-779.

Merleau-Ponty, M. (1962) *Phenomenology of perception*. Atlantic Highlands, New Jersey: The Humanities Press.

Mezzacappa, E.S. (1999) Epinephrine, arousal, and emotion: A new look at two-factor theory.
Cognition and Emotion, 13:2, 181-199.

Miller, W.R. & Hester, R.K. (1986) The effectiveness of alcoholism treatment. *Treating Addictive Behaviours,* 13, 121-174.

Miller, W. R. & Rollnick, S. (2002*). Motivational interviewing: Preparing people for change* New York: Guilford Press.

Miller, P., Martino, F., Gross, S., Curtis, A., Mayshak, R., Droste, N. & Kypri, K. (2017) Funder interference in addiction research: An international survey of authors. *Addict Behav.*, 72, 100-105. doi: 10.1016/j.addbeh.2017.03.026. Epub 2017 Mar 31. PMID: 28390231.

Mills, K.L., Deady, M., Proudfoot, H., Sannibale, C., Teeson, M., Mattick, R. & Burns, L. (2010) *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings.* Available at : https://ndarc.med.unsw.edu.au [accessed 17/1/21]

Minister for Health (1959), (web resource https://www.oireachtas.ie/en/debates/debate/dail/1959-11-18/62/, [last accessed 9/9/21]

Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G., The PRISMA Group (2009) Preferred reporting items for systematic reviews and meta-analyses: The PRISMA Statement. *PLoS Med* 6 (7): e1000097. doi: 10.1371/journal.pmed.1000097

Moos, R.H. & Moos, B.S. (2004) Long-term influence of duration and frequency of participation in alcoholics anonymous on individuals with alcohol use disorders. *Journal of consulting and clinical psychology,* 72(1), 81-90.

Moos, R.H, & Moos, B.S. (2006) Rates and predictors of relapse after natural and treated remission from alcohol use disorders. *Addiction*, 101(2), 212–222.

Moos, R.H. & Moos, B.S. (2007) Protective resources and long-term recovery from alcohol use disorders. *Drug and Alcohol Dependence,* 86(1), 46-54.

Moos, R.H. (2008) Active ingredients of substance use-focused self-help groups. *Addiction,*
103, 387-396. https://doi.org/10.1111/j.1360-0443.2007.02111.x

Morgan, O.J. (1994) Extended length of sobriety: The missing variable. *Alcoholism Treatment Quarterly,* 12(1), 59-71.

Morgenstern, J., Labouvie, E., McCrady, B.S., Kahler, C.W. & Frey R.M. (1997) Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, 65(5), 768–777.

Morgenstern, J., Bux, D.A., Labouvie, E., Morgan, T., Blanchard, K.A. & Muench, F. (2003) Examining mechanisms of action in 12-Step community outpatient treatment. *Drug Alcohol Dependence*, 72(3), 237–247.

Morris, A.S., Silk, J.S., Steinberg, L., Myers, S.S. & Robinson, L.R. (2007) The role of the

family context in the development of emotion regulation. *Social Development*, 16, 361-388.

Munton, A.G., Wedlock, E. & Gomersall, A. (2014) The efficacy and effectiveness of drug and alcohol abuse prevention programmes delivered outside of school settings. *H.R.B. Drug and Alcohol Evidence Review 2*. Dublin: Health Research Board.

Murphy, B. (2011a) *Loneliness in addiction recovery – 'letting go of your best friend'.* Dublin City University Assignment (unpub.)

Murphy, B. (2011b) *Effect of C.E. Schemes on criminality among recidivistic criminal heroin users*. Addiction Response Crumlin, Ireland. (unpub.)

National Institute on Alcohol Abuse and Alcoholism (1994) Advances in Alcoholism Treatment: Services for Women Rockville MA U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Rockville, MA

National Institute on Alcohol Abuse and Alcoholism (2006) https://grants.nih.gov/grants/guide/rfa-files/RFA-AA-07-005.html#Part II [web resource last accessed 17/11/21]

NIH Policy and Guidelines on The Inclusion of Women and Minorities as Subjects in Clinical Research – October 2001. [web resource, n.d. https://grants.nih.gov/policy/inclusion/women-and-minorities/guidelines.htm, last accessed 22/2/22]

National Institutes of Health (1994) *Nih Guidelines On The Inclusion Of Women And Minorities As Subjects In Clinical Research.* NIH GUIDE, Volume 23, Number 11, March 18, (https://grants.nih.gov/grants/guide/notice-files/not94-100.html)

National Opinion Research Center. General Social Survey, 1996. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2016-06-30. https://doi.org/10.3886/ICPSR35324.v3

National Council on Alcoholism and Drug Dependence *Guidelines on Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence*, published 23/11/11, last accessed 17/1/21, web resource)

Ng, S.L., Martin, J.L., Romans, S.E. A community's attitudes towards the mentally ill. *N Z Med J.,* 8;108(1013), 505-508.

Nixon, S.J. & Lewis, B. (2020) Brain structure and function in recovery. *Alcohol Research: Current Reviews*, 40(3), 04.

Noël, X., Bechara, A., Dan, B., Hanak, C. & Verbanck, P. (2007) Response inhibition deficit is involved in poor decision making under risk in non-amnesic individuals with alcoholism. *Neuropsychology,* 21, 778–786.

Nordahl, H. M., & Stiles, T. C. (1997). Conceptualization and identification of cognitive schemas in personality disorders. *Nordic Journal of Psychiatry, 51*(4), 243–250.

https://doi.org/10.3109/08039489709090715

O'Farrell, A., Kingsland, M., Kenny, S., Eldin, N., Wiggers, J., Wolfenden, L. & Allwright, S. (2018) A multi-faceted intervention to reduce alcohol misuse and harm amongst sportspeople in Ireland: A controlled trial. *Drug and Alcohol Review*, 37, 14-22.

Ojesjö, L., Hagnell, O. & Otterbeck, L. (2000) The course of alcoholism among men in the Lundby Longitudinal Study, Sweden. *Journal of Studies on Alcohol,* 61(2), 320–322.

Orford, J. (2001) Conceptualizing addiction: Addiction as an excessive appetite. *Addiction,* 96, 15-31.

O'Sickey, A.J., Hanes, J. & Tonigan, J.S. (2020) The relationship between perceived Alcoholics Anonymous social group dynamics and getting an AA sponsor*, Alcoholism Treatment Quarterly,* 38(1), 21-31

Pagano, M.E., Friend, K.B., Tonigan, J.S. & Stout, R.L. (2004) Helping other alcoholics in Alcoholics Anonymous and drinking outcomes: Findings from project MATCH. *Journal of Studies on Alcohol,* 65(6), 766-773.

Pagano, M.E., Zeltner, B.B., Jaber, J., Post, S.G., Zywiak, W.H. & Stout, R.L. (2009) Helping others and long-term sobriety: Who should i help to stay sober? *Alcoholism Treatment Quarterly,* 2 (1), 38-50.

Pagano, M.E., Krentzman, A.R., Onder, C.C., Baryak, J.L., Murphy, J.L., Zywiak, W.H. & Stout, R.L. (2010) Service to Others in Sobriety (S.O.S.). *Alcoholism Treatment Quarterly,* 28(2), 111-127.

Parkman, T.J., Lloyd, C. & Splisbury, K. (2015) Self-help groups for alcohol dependency: A scoping review. *Journal of Groups in Addiction & Recovery*, 10(2), 102-124. DOI: 10.1080/1556035X.2015.1034824

Pattison, E.M., Sobell, M.B. & Sobell, L.C. (1977) *Emerging Concepts of Alcohol Dependence.*
New York, NY: Springer; pp. 4-5.
Peabody, R. (1933) *The common sense of drinking.* Boston, MA: Little, Brown, and Company.

Peckins, M.K. & Beltz, A.M. (2020) Sex and stress hormones across development: A focus on early behavior. InBenson, J.B. (Ed.) *Encyclopedia of Infant and Early Childhood Development* (Second Edition), Elsevier, pp.125-134.

Peele, S. (1989) *Diseasing of America: How we allowed recovery zealots and the treatment industry to convince us we are out of control.* New York: Lexington Books.

Peltier, M.R., Verplaetse, T.L., Mineur, Y.S., et al. (2019) Sex differences in stress-related alcohol use. *Neurobiol Stress*, 10, 100-149. https://doi.org/10.1016/j.ynstr.2019.100149.

Peluso, E.T.P. & Blay, S.L. (2008a) Public perception of alcohol dependence*. Rev Bras Psiquiatr,* 30, 19–24.

Peluso E.T.P. & Blay, S.L. (2008b) Public perception of depression in the city of Sao Paulo.
Rev Saude Publica, 42, 41–8.

Perfas, F.B. & Spross, S. (2007) Why the concept-based therapeutic community can no longer be called drug-free. *Journal of Psychoactive Drugs*, 39(1), 69-79.

Petrakis, I., Gonzalez, G., Rosenheck, R. & Krystal, John. (2002). Comorbidity of Alcoholism and Psychiatric Disorders An Overview. Alcohol Research and Health*: The Journal of the National Institute on Alcohol Abuse and Alcoholism.* 26 (2).

Petit, G., Luminet, O., Maurage, F., Tecco, J., Lechantre, S., Ferauge, M., Gross, J.J. & de Timary, P. (2015) Emotion regulation in alcohol dependence. *Alcohol Clin Exp Res*, 39, 2471- 2479.

Pescosolido, B.A., Monahan, J., Link, B.G., Stueve, A., & Kikuzawa, S. (1999) The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *Am J Public Health.* 89(9), 1339-1345

Pescosolido, B.A., Martin, J.K., Long, J.S., Medina, T.R., Phelan, J.C. & Link, B.G. (2010) "A disease l.ike any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *Am J Psychiatry*, 167(11) 1321-1330.
Pescosolido B.A., Halpern-Manners A., Luo L. & Perry B. (2021). Trends in Public Stigma of Mental Illness in the US, 1996-2018. *JAMA Network Open*, , December 21, 2021, 1/11 https://doi.org/10.1001/jamanetworkopen.2021.40202

Pitel, A.L., Rivier, J., Beaunieux, H., Vabret, F., Desgranges, B. & Eustache, F. (2009) Changes in the episodic memory and executive functions of abstinent and relapsed alcoholics over a 6- month period. *Alcohol Clin Exp Res,* 33, 490–498.

Platt, J. (1988) What can case studies do? In Burgess, R.G. (Ed.) *Studies in qualitative methodology: A research annual: Conducting qualitative research.* Vol. 1. Greenwich, CT J.A.I. Press.

Potter-Efron, R., & Carruth, B. (2002). Shame, Guilt, and Alcoholism: Treatment Issues in Clinical Practice, Second Edition (2nd ed.). Routledge.
https://doi.org/10.4324/9781315809090

Powell A., Tommerdahl M., Abbasi Y., Sumnall H. & Montgomery C. (2021). A pilot study assessing the brain gauge as an indicator of cognitive recovery in alcohol dependence. *Human Psychopharmacology*, 36(4), pp. 1-9. https://doi.org/10.1002/hup.2782

Pringle, J., Drummond, J., McLafferty, E. & Hendry, C. (2011) Interpretative phenomenological analysis: A discussion and critique. *Nurse Researcher,* (18)3, 20-24.

Probst, C., Manthey, J., Martinez, A., et al. (2015) Alcohol use disorder severity and

reported reasons not to seek treatment: A cross-sectional study in European primary care practices. *Subst Abuse Treat Prev Policy,* 10(32), pp.1-10.

Prochaska, J.O. & Di Clemente, C.C. (1984) *The transtheoretical approach: Crossing the traditional boundaries of therapy.* Chicago: Dorsey Press.

Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992) In search of how people change: Applications to addictive behaviors. *American Psychologist,* 47, 1102–1114.

Prochaska, J.O. & Velicer, W.F. (1997) The transtheoretical model of health behavior change.
Am J Health Promot.; 12(1):38-48

Project MATCH Research Group (1997) Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcoholism*, 58, 7–29.

Rankine, J., (2020) *Negotiating an alcoholic identity within the Alcoholics Anonymous Twelve- Step recovery model: A narrative inquiry*. PhD Thesis, University of West of England. Available at www. uwe-repository.worktribe.com [last accessed 23/1/21].

Ratti, M.T., Bo, P., Giardini, A. & Soragna, D. (2002) Chronic alcoholism and the frontal lobe: Which executive functions are impaired? *Acta Neurologica Scandinavica,* 105, 276-281.

Rayburn, R. (2015) "I'm not an alcoholic anymore": Getting and staying sober without meetings. *Addiction and Research Theory,* 23(1), 60-70.

Reed, R., Grant, I., & Rourke, S.B. (1992) Long-term abstinent alcoholics have normal memory. *Alcoholism: Clinical and Experimental Research 16*(4), 677–683.

Rehm, J., Kilian, C., Rovira, P., Shield, K.D. and Manthey, J. (2021), The elusiveness of representativeness in general population surveys for alcohol. *Drug Alcohol Rev*., 40: 161-165. https://doi.org/10.1111/dar.13148

Reilly, M.T., Noronha, A., Goldman, D. & Koob, G.F. (2017) Genetic studies of alcohol dependence in the context of the addiction cycle. *Neuropharmacology,* 122, 3-21.

Reinerman, C. (2005) Addiction as accomplishment: The discursive construction of disease.
Addiction Research and Theory, 4, 307-320.

Rettie, H.C., Hogan, L.M. & Cox, W.M. Identifying the main components of substance-related addiction recovery groups. *Subst Use Misuse*, 56(6), 840-847.
doi: 10.1080/10826084.2021.1899228. Epub 2021 Mar 22. PMID: 33745420.

Riessman, F. (1965). The “Helper” Therapy Principle. *Social Work*, 10 (2), 27–32.

Right, K.B.W. (1997) Shared ideology in Alcoholics Anonymous: A grounded theory approach. *Journal of health communication,* 2(2), 83-99.

Rogers, C.R. (1951) *Client-centred therapy: Its current practice, implementation and theory.*
Boston: Houghton Mifflin.

Rogers, C.R. (1957) The necessary and sufficient conditions for therapeutic personality change.
Journal of Consulting Psychology, 21, 95–103.

Rogoff, B. (1990) *Apprenticeship in thinking. Cognitive development in social context.* New York: Oxford University Press.

Room, R., Janca, A., Bennett, L.A., Schmidt, L. & Sartorius, N. (1996) WHO cross-cultural applicability research on diagnosis and assessment of substance use disorders: An overview of methods and selected results. *Addiction*, 91, 199-220.
https://doi.org/10.1046/j.1360-0443.1996.9121993.x

Room, R. (1998) Mutual help movements for alcohol problems in an international perspective.
Addiction Research, 6(2), 131-145.

Room, R. & Mäkelä, K. (2000) Typologies of the cultural position of drinking. *Journal of Studies on Alcohol*, 61(3), 475-483.

Room, R. (2004) The cultural framing of addiction. *Janus Head*, 6(2), 221-234.

Room, R. (2005) Stigma, social inequality and alcohol and drug use. *Drug Alcohol Rev,* 24, 143–155.

Rosenberg, H., Grant, J. & Davis, A.K. (2020) Acceptance of non-abstinence as an outcome goal for individuals diagnosed with substance use disorders: A narrative review of published research. *Journal of Studies on Alcohol and Drugs*, 81(4), 405-415.

Rosenzweig, S. (1936) Some implicit common factors in diverse methods of psychotherapy.
American Journal of Orthopsychiatry, 6(3), 412-415.

Rounsaville BJ, Carroll KM. (1993) Interpersonal psychotherapy for drug users. In: Klerman GL, Weissman MM, editors. *New Applications of Interpersonal Psychotherapy*. Washington, DC: American Psychiatric Association Press; pp. 319–352.

Rourke, S. & Grant, I. (1999). The interactive effects of age and length of abstinence on the recovery of neuropsychological functioning in chronic male alcoholics: A 2-year follow-up study. *Journal of the International Neuropsychological Society,* 5(3), 234-246.

Rundle, S.M., Cunningham, J.A. and Hendershot, C.S. (2021), Implications of addiction diagnosis and addiction beliefs for public stigma: A cross-national experimental study. *Drug Alcohol Rev*., 40: 842-846. https://doi.org/10.1111/dar.13244

Rupp, C. (2021) Do social cognition deficits recover with abstinence in alcohol dependent

patients? *Alcoholism: Clinical and Experimental Research,* 45(2), 470–479.

Rutter, M. (1971) Parent-child separation: Psychological effects on the children. *Child Psychol Psychiat.,* 12, 233-226.

Rutter, M. (1981) *Maternal deprivation reassessed (Second edition).* Harmondsworth: Penguin Books.

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes in qualitative data. *Field methods*, *15*(1), 85-109.

Ryan, J, (1998) *Methods for Conducting Systematic Text Analysis run by the National Science Foundation (SRB- 9811166).* [web resource, undated https://grantome.com/grant/NSF/BCS-9811166#panel-comment last accessed 4 July 2022)

Rynes, K.N., Tonigan, J.S. & Rice, S.L. (2013) Interpersonal climate of 12-step groups predicts reductions in alcohol use. *Alcoholism Treatment Quarterly,* 31(2), 167-185.

Sagarin, E. (1969) *Odd man in: Societies of deviants in America.* NY: Quadrangle.

Sanchez-Roige, S., Palmer, A.A., Fontanillas, P., Elson, S.L., Adams, M.J., Howard, D.M., Edenberg, H.J., Davies, G., Crist, R.C., Deary, I.J., McIntosh, A.M. & Clarke, T. (2019) Genome-wide association study meta-analysis of the alcohol use disorders identification test (AUDIT) in two population-based cohorts. *AJP,* 176 2), 107-118.

Sandmaier, M. (1977) Women helping women: Opening the door to treatment. *Alcohol Health and Research World*, 2(1), 17-23.

Sandmaier, M. (1992) *The invisible alcoholics: Women and alcohol.* Bradenton, FL: Tab Books.

Sartre, J.P. (1943) *Being and nothingness.* 2nd English Translation (1956). London:

Routledge. Sartre, J.P. (1948). *Existentialism and humanism*. London: Methuen Publishing

Limited.

Saunders, W. & Kershaw, P. (1979) Spontaneous remission from alcoholism: A community study. *British Journal of Addiction*, 74, 251-266.

Saxton, J., Munro, C.A., Butters, M.A., Schramke, C. & McNeil, M.A. (2000) Alcohol, dementia, and Alzheimer's disease: Comparison of neuropsychological profiles. *J Geriatr Psychiatry Neurol* ,13, 141–149.

Sawyer, F., Davis, P. & Gleeson K. (2020) Is shame a barrier to sobriety? A narrative analysis of those in recovery. *Drugs: Education, Prevention and Policy,* 27(1), 79-85. DOI: 10.1080/09687637.2019.1572071

Scheff, T.J. (2000) Shame and the social bond: A sociological theory. *Sociological Theory,* 18, 84–89. doi:10.1111/0735-2751.00089

Scherer, M., Worthington, E. L., Hook, J. N., & Campana, K. L. (2011). Forgiveness and the bottle: promoting self-forgiveness in individuals who abuse alcohol. *Journal of addictive diseases*, *30*(4), 382–395. https://doi.org/10.1080/10550887.2011.609804

Schleiermacher, F. (1998) *Hermeneutics and criticism and other writings.* (A. Bowie Trans.) Cambridge: C.U.P.

Schimmenti, A., & Bifulco, A. (2013). Linking lack of care in childhood to anxiety disorders in emerging adulthood: the role of attachment styles. *Child and Adolescent Mental Health,* 20(1), n/a--n/a. https://doi.org/10.1111/CAMH.12051

Schneider, J. W. (1978) Deviant Drinking as Disease: Alcoholism as a Social Accomplishment,
Social Problems, Volume 25, Issue 4, pp. 361–372, https://doi.org/10.2307/800489

Schnittker, J. (2008) An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance. *Soc Sci Med.*, 67(9), 1370-1381.

Schomerus, G., Borsche, J., Matschinger, H. & Angermeyer, M.C. (2006) Public knowledge about causes and treatment for schizophrenia: A representative population study. *J Nerv Ment Dis.*, 194(8), 622-4.

Schomerus, G., Holzinger, A., Matschinger, H., Lucht, M. & Angermeyer, M.C. (2010) Public attitudes towards alcohol dependence. *Psychiatr Prax*, 37(3): 111-8. doi: 10.1055/s-0029-1223438.

Schomerus, G., Corrigan, P.W., Klauer, T., Kuwert, P., Freyberger, H.J. & Lucht, M. (2011a) Self-stigma in alcohol dependence: Consequences for drinking-refusal self-efficacy. *Drug and alcohol dependence,* 114(1), 12-17.

Schomerus, G., Lucht, M., Holzinger, A., Matschinger, H., Carta, M.G. & Angermeyer, M.C. (2011b) The stigma of alcohol dependence compared with other mental disorders: A review of population studies. *Alcohol and Alcoholism*, 46(2), 105-112.

Schutte, K.K., Nichols, K.A., Brennan, P.L. & Moos, R.H. (2003) A ten-year follow-up of older former problem drinkers: Risk of relapse and implications of successfully sustained remission. *Journal of studies on alcohol,* 64(3), 367-374.

Schwandt, M.L., Heilig, M., Hommer, D.W., George, D.T. & Ramchandani, V.A. (2013) Childhood trauma exposure and alcohol dependence severity in adulthood: Mediation by emotional abuse severity and neuroticism. *Alcohol Clin Exp Res*, 37, 984-992.

Seeley, J. (1962) Alcoholism as a disease: Implications for social policy. In Pittman, D. & Snyder, C. (Eds). *Society, culture and drinking patterns*. NY: John Wiley & Sons.

Segal, G. (2020) Alcoholics Anonymous "spirituality" and long-term sobriety maintenance as a topic for interdisciplinary study. *Behavioural Brain Research,* 389, (2020) 112645, pp. 1-9.

Seneca (1942). Epistle LXXXIII: On drunkenness. Classics of the alcohol literature. *Quarterly Journal of Studies on Alcohol*, 3, 302-307.

Seo, D., Lacadie, C.M., Tuit, K., Hong, K.I., Constable, R.T. & Sinha, R. (2013) Disrupted ventromedial prefrontal function, alcohol craving, and subsequent relapse risk. *JAMA Psychiatry,* 70(7), 727-739.

Shaffer, H.J. (1997) The most important unresolved issue in the addictions: Conceptual chaos.
Substance Use and Misuse, 32(1), 1573-1580.

Silkworth, W.D. (1937) *Alcoholism as a manifestation of allergy.* Medical Record, March 17, 1937. Available at: https://collections.nlm.nih.gov/ocr/nlm:nlmuid-2934112RX321-leaf [accessed 19/4/21].

Silverman, D. (2011) *Interpreting qualitative data (4th Ed.).* London: Sage.

Sinclair, J.M.A., Chambers, S. E. & Manson, C.C. (2017) Internet support for dealing with problematic alcohol use: A survey of the soberistas online community. *Alcohol and Alcoholism,* 52(2), 220-226.

Sinha, R., Fox, H.C., Hong, K.A., Bergquist, K., Bhagwagar, Z. & Siedlarz, K.M. (2009) Enhanced negative emotion and alcohol craving and altered physiological responses following stress and cue exposure in alcohol-dependent individuals. *Neuropsychopharmacology* 34, 1198–1208.

Sliedrecht, W., de Waart, R. & Witkiewitz, K. (2019) Alcohol use disorder relapse factors: A systematic review. *Psychiatry Res,* 278, 97-115.

Smith, J.A. & Eatough, V. (2006) Interpretative Phenomenological Analysis. In G.M. Breakwell, S. Hammond, C. Fife Schaw & J.A. Smith (Eds.) *Research methods in psychology* (3rd Ed.), London: Sage. pp.322-342.

Smith, B.W. & Tonigan, J.S. (2009) Alcoholics Anonymous benefit and social attachment.
Alcoholism Treatment Quarterly, 2(2), 164-173.

Smith, J.A., Flower, P. & Larkin, M. (2009) *Interpretative phenomenological analysis: Theory, method and research*. London: Sage Publications Ltd

Smith, J.A. (2011) Evaluating the contribution of interpretative phenomenological analysis.
Health Psychology Review, 5(1), 9-27.

Smith, J.A., Flower, P. & Larkin, M. (2022) *Interpretative phenomenological analysis: 2nd Ed', Theory, method and research*. London: Sage Publications Ltd

Sobell, L., Cunningham, J. & Sobell, M. (1996) Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. *American Journal of Public*

Health, 86, 966-972.

Stall, R. & Biernacki, P. (1986) Spontaneous remission from the problematic use of substances: An inductive model derived from a comparative analysis of alcohol, opiates, tobacco, and food/obesity literatures. *The International Journal of the Addictions*, 21, 1-23.

Starks, H. & Trinidad, S.B. (2007) Choose your method: A comparison of phenomenology discourse analysis and grounded theory. *Qualitative Health Research,* 17, 1370-1380.
Stasiewicz, P.R., Bradizza, C.M., Gudleski, G.D., Coffey, S.F., Schlauch, R.C., Bailey, S.T., Bole, C.W. & Gulliver, S.B. (2012) The relationship of alexithymia to emotional dysregulation within an alcohol dependent treatment sample. *Addictive Behaviors,* 37(4), 469-476.

Stavro, K., Pelletier, J. & Potvin, S. (2013) Widespread and sustained cognitive deficits in alcoholism: A meta-analysis. *Addiction Biology,* 18(2), 203-213.

Stevens, E.B. & Jason, L.A. (2015a) Evaluating alcoholics anonymous sponsor attributes using conjoint analysis. *Addict Behav*. 51: 12–17.

Stevens, E.B. & Jason, L.A. (2015b) An exploratory investigation of important qualities and characteristics of Alcoholics Anonymous sponsors. *Alcoholism Treatment Quarterly,* 33(4), 367-384.

Steigerwald, F. & Stone, D. (1999) Cognitive restructuring and the 12-step program of Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, 16(4), 321-327.

Squire, L.R. & Zouzounis, J.A. (1988) Self-ratings of memory dysfunction:Ddifferent findings in depression and amnesia. *J Clin Exp Neuropsychol*, 10(6), 727-738.

Sullivan, E.V. (2020) Why timing matters in alcohol use disorder recovery. *Am J Psychiatry,*
177(11)*,* 1022-1024.

Sutton S. (2001). Back to the drawing board? A review of applications of the transtheoretical model to substance use. *Addiction* (Abingdon, England), *96*(1), 175–186. https://doi.org/10.1046/j.1360-0443.2001.96117513.x

Swett C. & Halpert, M. (1994) High rates of alcohol problems and history of physical and sexual abuse among women inpatients. *The American Journal of Drug and Alcohol Abuse*, 20(2), 263-272.

Tajfel, H., Turner, J.C., Austin, W.G. & Worchel, S. (1979) An integrative theory of intergroup conflict. *Organizational identity: A reader*, eds. W.G. Austin and S. Worchel (Oxford, Oxford University Press) pp.56-65.

Tallodi, T. (2019) *How parties experience mediation.* Switzerland: Springer Nature.

Tay, L. & Diener, E. (2011) Needs and subjective well-being around the world. J*ournal of Personality and Social Psychology,* 101(2), 354–365.

The National Council on Alcoholism and Drug Dependence Inc (2018) *Definition of Recovery* (web resource, https://ncadd.org/treatment/treatment-process/recovery last accessed 16/11/2021)

Thorberg, F.A., Young, R.M., Sullivan, K.A. & Lyvers, M. (2009) Alexithymia and alcohol use disorders: A critical review. *Addictive Behaviours,* 34(3), 237-245.

Thorberg, F.A., Young, R.M., Sullivan, K.A., Lyvers, M., Hurst, C.P., Connor, J.P. & Feeney,
G.F.X. (2011) Alexithymia in alcohol dependent patients is partially mediated by alcohol expectancy Dependence, Volume, 1 July 2011, pp. 238-241

Thorne, B. (1992) *Carl Rodgers.* University of Michigan: Sage Publications.

Thune, C.E. (1977) Alcoholism and the archetypal past: A phenomenological perspective on Alcoholics Anonymous. *Journal of Studies on Alcohol,* 38(1), 75–88.

Timko, C. & DeBenedetti, A. (2007) A randomized controlled trial of intensive referral to 12- step self-help groups: one-year outcomes. *Drug Alcohol Depend*. 8;90 (2-3) pp.270-9.

Timko, C., Finney, J. W., Moos, R. H., & Moos, B. S. (1995) Short-term treatment careers and outcomes of previously untreated alcoholics. *J Stud Alcohol*. 56 (6), pp. 597-610.

Timko, C., Moos, R.H., Finney, J.W., Moos, B.S. & Kaplowitz, M.S. (1999) Long-term treatment careers and outcomes of previously untreated alcoholics. *Journal of Studies on Alcohol,* 60(4), 437-447.

Timko, C., Moos, R.H., Finney, J.W. & Lesar, M.D. (2000) Long-term outcomes of alcohol use disorders: Comparing untreated individuals with those in alcoholics anonymous and formal treatment. *Journal of Studies on Alcohol,* 61(4), 529-540.

Timko, C., Moos., R.H., Finney, J.W. & Connell, E.G. (2002) Gender differences in help-utilization and the 8-year course of alcohol abuse. *Addiction*, 97(7), 877-89.
doi: 10.1046/j.1360-0443.2002.00099.x. PMID: 12133127.

Timmons, F., Martin, C. & Plante, T.G. (2019). Spirituality and locus of control—a rapid literature review. *Spirituality in Clinical Practice*, 6(2), 83–99. DOI: 10.1037/scp0000192.

Todd, E. (1985) The value of confession and forgiveness according to Jung. *J Relig Health,*
24, 39–48.

Tonigan, J.S,. Ashcroft, F. & Miller, W.R. (1995) AA group dynamics and 12-step activity.
Journal of Studies on Alcohol, 56(6), 616-621.

Tonigan, J.S., Toscova, R. & Miller, W.R. (1996) Meta-analysis of the literature on Alcoholics Anonymous: Sample and study characteristics moderate findings. *Journal of Studies on Alcohol,* 57(1), 65-72.

Tonigan, J.S. & Rice, S.L. (2010) Is it beneficial to have an Alcoholics Anonymous sponsor?
Psychology of Addictive Behaviors, 24(3), 397-403.

Tonigan, J.S., Rynes., K.N & McCrady, B.S. (2013) Spirituality as a change mechanism in 12- step programs: A replication, extension, and refinement. *Substance Use & Misuse*, 48, 12.

Toth, S.L., Rogosch, F.A., Oshri, A., Gravener-Davis, J., Sturm, R. & Morgan-López, A.A. (2013) The efficacy of interpersonal psychotherapy for depression among economically disadvantaged mothers. *Development and Psychopathology*, 25(4), 1065–1078.

Tucker, J.A., Chandler, S.D. & Witkiewitz, K. (2020) Epidemiology of Recovery from Alcohol Use Disorder, *Alcohol Research Current Reviews* 40(3):02 https://doi.org/10.35946/arcr.v40.3.02

Turning Point (2015) *The Australian Life in Recovery Survey.* Available from: http://www.turningpoint.org.au/site/DefaultSite/filesystem/documents/Life%20In%20Recove ry%20Survey.pdf [Last accessed 20/1/21]

Tusa, A L. & Burgholzer, J. A. (2013) Came to believe: Spirituality as a mechanism of change in Alcoholics Anonymous. A review of the literature from 1992 to 2012. *Journal of Addictions Nursing,* 24(4) ,237-246.

Uekermann, J., Daum, I., Schlebusch, P., Wiebel, B., Trenckmann, U. (2003) Depression and cognitive functioning in alcoholism. *Addiction,* 98, 1521–1529.

Ulster University Code of Practice for Professional Integrity in the Conduct of Research [web resource n.d https://www.ulster.ac.uk/ data/assets/pdf_file/0005/59837/conduct-of-research.pdf Last accessed 26/2/02]

Vaillant, G.E., & Milofsky, E.S. (1982) The aetiology of alcoholism: A prospective viewpoint.
American Psychologist, 37(5), 494–503.

Vaillant, G.E. (1988) What can long-term follow-up teach us about relapse and prevention of relapse in addiction? *British Journal of Addiction,* 83(10), 1147-1157.

Vaillant, G.E. (2003) A 60-year follow-up of alcoholic men. *Addiction,* 98(8), 1043-1051.

Vaillant, G.E. (2012) *Triumphs of experience: The men of the Harvard Grant Study*. Cambridge, MA: The Belknap Press of Harvard University Press.

Vaillant, G.E. (2014) Positive emotions and the success of Alcoholics Anonymous. *Alcoholism Treatment Quarterly*, 32(2-3), 214-224.

Vernon, M.L. (2010) A review of computer-based alcohol problem services designed for

the general public. *J Subst Abuse Treat*., 38(3), 203–11.

Vygotsky, L.S. (1978) *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.

Waldorf, D. (1983) Natural recovery from opiate addiction: Some social-psychological process of untreated recovery. *Journal of Drug Issues*, 13, 237-280.

Walitzer, K.S. & Dearing, R.L. (2006) Gender differences in alcohol and substance use relapse.
Clin Psychol Rev. 2006;26(2):128-148. https://doi.org/10.1016/j.cpr.2005.11.003.

Wallen, J. (1990) Issues in alcoholism treatment. In R. Engs (Ed.), *Women: Alcohol and other drugs.* Dubuque, IA: Kendall/Hunt. pp.103-110.

Walsh, D. C., Hingson, R. W., Merrigan, D. M., Levenson, S. M., Cupples, L. A., Heeren, T.,
Coffman, G. A., Becker, C. A., Barker, T. A., Hamilton, S. K., McGuire, T. G., & Kelly, C. A. (1991). A randomized trial of treatment options for alcohol-abusing workers. *The New England Journal of Medicine, 325*(11), 775–782

Walsh, D., Daly, A. & Moran, R. (2016) The institutional response to mental disorder in Ireland: censuses of Irish asylums, psychiatric hospitals and units 1844–2014. *Ir J Med Sci* **185,** 761–768

Weiss, R.D., Griffin, M.L., Gallop, R.J., Najavits, L.M., Frank, A., Crits-Christoph, P., Thase, M.E., Blaine, J. Gastfriend, D. R., Daley, D. & Luborsky, L. (2005) The effect of 12-step self- help group attendance and participation on drug use outcomes among cocaine-dependent patients. *Drug and Alcohol Dependence,* 77(2), 177-184.

Weissbach, T.A., Vogler, R.E. & Compton, J.V. (1976) Comments on the relationship between locus of control and alcohol abuse. *Journal of Clinical Psychology,* 32(2), 484–486.

West, R. (2001) Theories of addiction [Editorial]. *Addiction,* 96(1), 3–13. West, R. (2006)

Theory of addiction. UK: Blackwell Publishing.

Whelan, P.J.P., Marshall, E.J., Ball, D.M. & Humphreys, K. (2009) The role of AA sponsors: A pilot study. *Alcohol and Alcoholism*, 44(4), 416–422.
https://doi.org/10.1093/alcalc/agp014

White, W.L. (2000a). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*, 18(1), 1-23. doi:10.1300/J020v18n01_01

White, W.L. (2000b) The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly,* 18(2), 1-25.
DOI: 10.1300/J020v18n02_01

White, W.L. (2001) Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly,* 19(2), 1-21.

White, W.L. (2004) Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction,* 99(5), 532-538.

White, W.L. (2007a) Addiction recovery: Its definition and conceptual boundaries. *J Subst Abuse Treat,* 33(3), 229-241.

White, W.L. (2007b) The new recovery advocacy movement in America. *Addiction,* 102(5), 696-703.

White, W.L. (2010) Nonclinical Addiction Recovery Support Services: History, Rationale, Models, Potentials, and Pitfalls. *Alcoholism Treatment Quarterly,* 28(3), 256-272.

White, A.M. (2020) Gender differences in the epidemiology of alcohol use and related harms in the United States. *Alcohol research: current reviews*, 40(2), 01.

White, W. & Laudet, A. (2006) Spirituality, science, and addiction counseling. *Counselor*, *Magazine*, 7(1), 56-59.

Williams I. W. (2021) An Apologetic Interpretation of Alcoholics Anonymous (AA): Timeless Wisdom, Outdated Language, *Substance Use & Misuse*, 56:8, 1079-1094, DOI: 10.1080/10826084.2021.1892134

Willig, C. (2008) *Introducing qualitative research in psychology.* (2nd Edn.) Maidenhead: Open University Press.

Wilsnack, S. (1973) The needs of the female drinker; dependency, power, or what? In M.E. Chafetz (Ed.), Proceedings of the second annual alcoholism conference of the *National Institute on Alcohol Abuse and Alcoholism*. Washington, DC: U.S. Government Printing Office. pp.65-83.

Wilsnack, S., Klassen, A.D., Schur, B.E. & Wilsnack, R.W. (1991) Predicting onset and chronicity of women's problem drinking: A five-year longitudinal analysis, *American Journal of Public Health*, 81, 305-318.

Wilson, B. (1958) The next frontier: Emotional sobriety. *AA Grapevine*, New York pp. 2-5.

Winick, C. (1962) Maturing out of narcotic addiction. *Bulletin on Narcotics*, 14, 1-7.

Witkiewitz, K., Montes, K.S., Schwebel, F.J. & Tucker, J.A. (2020a) What is recovery?
Alcohol research: Current Reviews, 40(3), 01.

Witkiewitz, K., Pearson, M.R., Wilson, A.D., Stein, E.R., Votaw, V.R., Hallgren, K.A., Maisto, S.A., Swan, J.E., Schwebel, F.J., Aldridge, A., Zarkin, G.A. & Tucker, J.A. (2020b) Can alcohol use disorder recovery include some heavy drinking? A replication and

extension up to 9 years following treatment. *Alcoholism, Clinical and Experimental Research*, 44(9), 1862– 1874. https://doi.org/10.1111/acer.14413

Winzelberg, A. & Humphreys, K. (1999) Should patients' religiosity influence clinicians' referral to 12-step self-help groups? Evidence from a study of 3,018 male substance abuse patients. *Journal of Consulting and Clinical Psychology,* 67(5), 790–794.

Witbrodt, J. & Delucchi, K. (2011) Do women differ from men on Alcoholics Anonymous Participation and abstinence? A multi-wave analysis of treatment seekers. *Alcoholism: Clinical and Experimental Research,* 35(12), 2231-2241.

Witbrodt, J., Kaskutas, L., Bond, J. & Delucchi, K. (2012a) Does sponsorship improve outcomes above Alcoholics Anonymous attendance? A latent class growth curve analysis. *Addiction,* 107(2), 301-311

Witbrodt, J., Mertens, J., Kaskutas, L.A., Bond, J., Chi, F. & Weisner, C. (2012b) Do 12-step meeting attendance trajectories over 9 years predict abstinence? *J Subst Abuse Treat*. 2012 Jul; 43(1): 30–43.

Wnuk, M. (2017) Hope as an important factor for mental health in alcohol-dependent subjects attending Alcoholics Anonymous. *Journal of Substance Use,* 22(2), 182-186.

World Health Organization (1993) *ICD-10*: *International statistical classification of diseases and related health problems.* Tenth revision. Geneva: World Health Organization.

World Health Organization, The Human Development Index (WHO) covered 189 countries in 2018. (https://hdr.undp.org/content/wide-inequalities-peoples-well-being-cast-shadow-sustained-human-development-progress)
World Health Organization (2010) International Classification of Diseases and Related Health Problems. 10th Revision, (ICD-10). Geneva, Switzerland

World Health Organization (2013) "Who We Are" (web resource available at https://www.who.int/about/who-we-are/constitution, [last accessed 16/1/21]

World Health Organization (2018a) *Global status report on alcohol and health 2018*. Geneva: World Health Organization.

World Health Organization. (2018b). *International classification of diseases for mortality and morbidity statistics* (11th Revision). Geneva, Switzerland and retrievable from https://icd.who.int/browse11/l-m/en (also referred to ICD 11-MMS)

World Health Organization (2018c) *Fact sheet, alcohol*, (web resource https://www.who.int/news-room/fact-sheets/detail/alcohol last accessed 7/11/21)

World Health Organization (2019). International Classification of Diseases, (11th Revision) 2019. https://doi.org/10.1016/S0140-6736(19)31205-X.

World Health Organization (2021a) Internet resource: https://www.who.int/data/stories/the- true-death-toll-of-covid-19-estimating-global-excess-mortality (n.d., last accessed 24/01/21)

World Health Organization (2021b) Internet resource, https://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use (n.d. last accessed 24/1/22)

Wood, C., Giles, D. & Percy, C. (2009) *Your psychological project handbook: Becoming a researcher.* Essex: Pearson Education Ltd.

Wurmser, L. (1978) *The hidden dimension: Psychodynamics in compulsive drug use.* New York: Jason Aronson.

Wurmser, L. (1980) Drug use as a protective system. In D.J. Lettieri, M. Sayers & H.W. Pearson (Eds.) *Theories of drug abuse: Selected contemporary perspectives.* (DHHS Publication No. ADM8 -967). Washington, D.C: U.S. Government Printing Office.

Yalom, I. (2010) *The Gift of Therapy.* Harper Collins e-books, Harper Collins Publishers Ltd. London, W6 8JB, UK: p.109. [Also available at https://www.academia.edu/3774663/Irvin_Yalom_The_Gift_of_Therapy]

Young, L.B. (2013) Characteristics and practices of sponsored members of Alcoholics Anonymous. *Journal of Groups in Addiction & Recovery,* 8(2), 149-164.

Zahr, N.M. & Pfefferbaum, A. (2017) Alcohol's effects on the brain: Neuroimaging results in humans and animal models. *Alcohol Research: Current Reviews,* 38(2), e1-e24.

Zakhour, M. Haddad, C., Salameh, P., Akel, A., Fares, K., Sacre, H., Hallit, S. & Obeid, S. (2019) Impact of the interaction between alexithymia and the adult attachment styles in participants with alcohol use disorder, *Alcohol,* 83, 1-8.

Zaplana, F., Brousse, G., Picard, V., Arnaud, B., Planche, F., Karim, M., Geneste, J., Blanc, O., Malet, L. & Llorca, P.M. (2010) Is alexithymia a risk for relapse on alcoholism? Prospective study on 56 alcohol dependent patients. *European Archives of Psychiatry and Clinical Neuroscience,* 260, S57.

Zemore, S.E, Kaskutas L.A, Mericle, A. & Hemberg, J. (2017) Comparison of 12-step groups to mutual help alternatives for AUD in a large, national study: Differences in membership characteristics and group participation, cohesion, and satisfaction. *J Subst Abuse Treat.,* 73, 16- 26.

Zemore, S.E., Lui, C., Mericle, A., Hemberg, J. & Kaskutas, L.A. (2018) A longitudinal study of the comparative efficacy of Women for Sobriety, LifeRing, SMART Recovery, and 12-step groups for those with AUD. *Journal of Substance Abuse Treatment,* 88, 18-26.

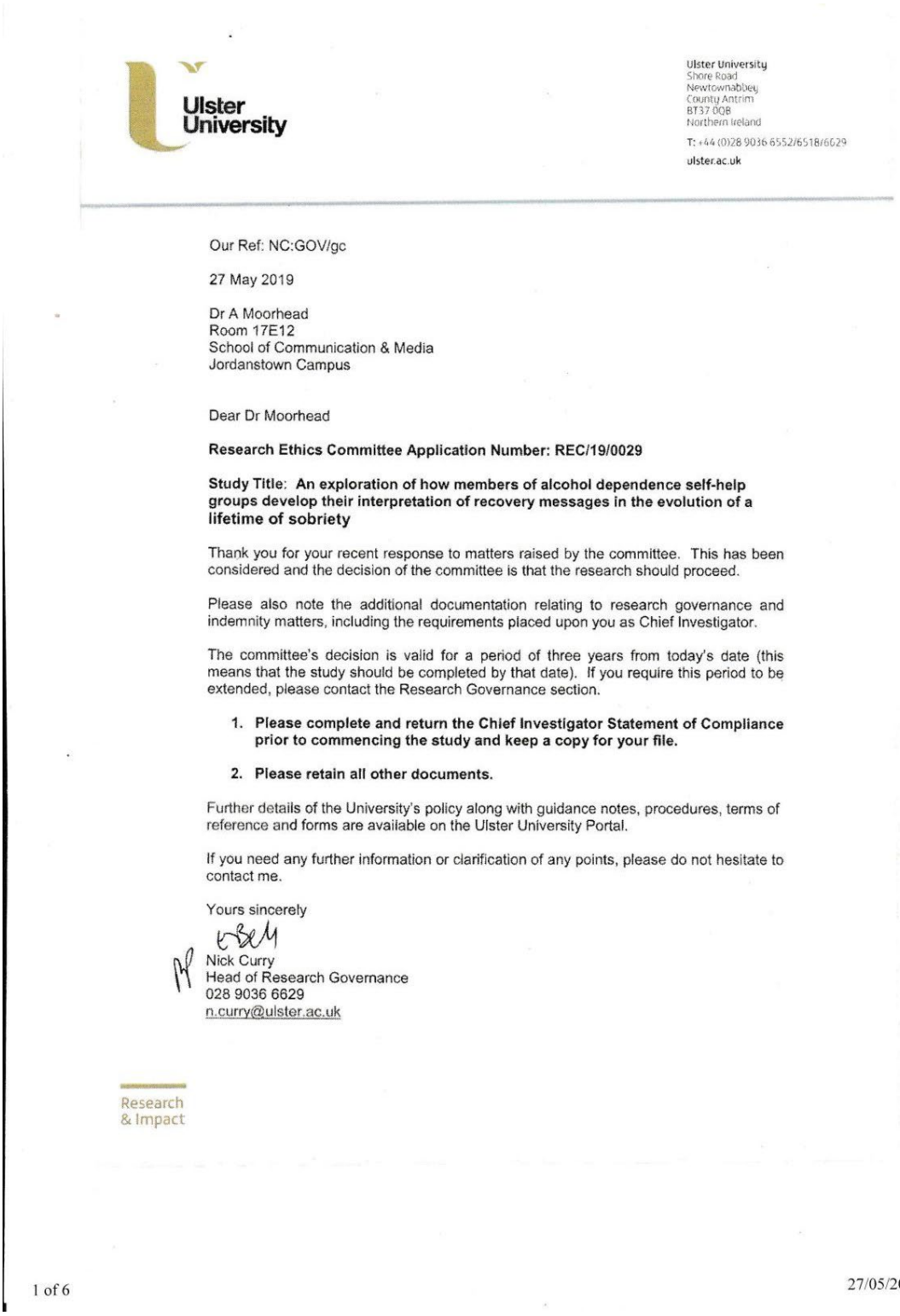
Zerubavel, N. & O'Dougherty Wright, M. (2012) The Dilemma of the Wounded Healer, *Psychotherapy,* 2012, Vol. 49, No. 4, 482–491

Zimmermann, P. & Iwanski, A. (2014) Emotion regulation from adolescence to emerging adulthood and middle adulthood: Age differences, gender differences and emotion-specific development. *International Journal of Behavioral Development,* 38(2),182-194

Zinberg, N. (1984) *Drug, set and setting*. London: Yale University Press.

APPENDICES

Appendix 1: Ulster University Research Ethics Committee Approval.



Ulster University

Ulster University
Shore Road
Newtownabbey
County Antrim
BT37 0QB
Northern Ireland
T: +44 (0)28 9036 6552/6518/6629
ulster.ac.uk

Our Ref: NC:GOV/gc

27 May 2019

Dr A Moorhead
Room 17E12
School of Communication & Media
Jordanstown Campus

Dear Dr Moorhead

Research Ethics Committee Application Number: REC/19/0029

Study Title: An exploration of how members of alcohol dependence self-help groups develop their interpretation of recovery messages in the evolution of a lifetime of sobriety

Thank you for your recent response to matters raised by the committee. This has been considered and the decision of the committee is that the research should proceed.

Please also note the additional documentation relating to research governance and indemnity matters, including the requirements placed upon you as Chief Investigator.

The committee's decision is valid for a period of three years from today's date (this means that the study should be completed by that date). If you require this period to be extended, please contact the Research Governance section.

1. **Please complete and return the Chief Investigator Statement of Compliance prior to commencing the study and keep a copy for your file.**
2. **Please retain all other documents.**

Further details of the University's policy along with guidance notes, procedures, terms of reference and forms are available on the Ulster University Portal.

If you need any further information or clarification of any points, please do not hesitate to contact me.

Yours sincerely

Nick Curry
Head of Research Governance
028 9036 6629
n.curry@ulster.ac.uk

Research & Impact

1 of 6

27/05/2019, 18:28

Appendix 2: Sample Participant Information Sheet

An exploration of how members of alcohol dependence self-help groups develop their interpretation of recovery messages in the evolution of a lifetime of sobriety

Participant Information Sheet

You are invited to take part in a research project entitled: An exploration of how members of substance dependence self-help groups develop their interpretation of recovery messages in the evolution of a lifetime of sobriety.

Please take time to read the following information carefully before you decide if you want to take part. It is important for you to understand about the purpose of the research and what it will involve for you. If there is anything you are unsure about, please ask for more information or explanation on any points or concerns.

What is the purpose of the study?
The aim of the study is to explore how members of self-help groups develop their interpretation of their recovery messages from alcohol dependence into a lifetime of sobriety.
You are not obliged to take part in this study. Participation is entirely voluntary, and you have offered to participate.

Why have you been selected?
You have been selected to participate in this study because you fit the criteria of one of the age ranges of sobriety lived through your interpretation of the messages of AA.

How long will participation in the study take?
Your participation should take approximately one hour but may take longer if you decide to take a break at any point before completion.

Do I have to take part?
This is an invitation to be a voluntary participant. If you decide to be involved, you will be asked to indicate your agreement by signing a Consent Form. You will be free to withdraw from the study at any time without giving a reason and you may also ask that your participation be not used and any references whatsoever to you be destroyed.

What will I be asked to do if I take part?

You will be asked to participate in an interview with the researcher in a private room to ensure confidentiality but adjacent to your friends and colleagues. If you prefer, a more distanced safe place, one will be arranged that suits you. The interview will be recorded and subsequently transcribed. A copy of the transcription will be made available to you if you so wish. You will be asked to describe how you came into the fellowship, what it had been like and how your life has evolved through your growing understanding of the messages of AA to how life is for you now.

What are the possible disadvantages or risks of taking part?

In studies that involve the discussion of unpleasant or traumatic experiences (what it was like before you joined AA) there is always the possibility for the experiencing of some emotional discomfort or distress. While it is not expected that any such effects will occur, there is a Distress Protocol to cover such an eventuality. A copy of the Protocol will be given to you and explained how it will work. This will include a free phone so that you may call your sponsor, or other person that you feel may be of assistance in speaking with.

If you do experience any distress at any time, then the interview will be stopped at your request or at the discretion of the researcher and the Distress Protocol will be put in to effect. You may at any time take a break if you wish to do so for any reason which you need not disclose.

The researcher will remind you that you can end your involvement at any time.

How will I benefit from participating in this study?

There is no financial incentive for your taking part in this research. However, your participation in this study will make a significant contribution to the understanding of the evolving nature of AA messages of recovery over the life course. Insights gained from this research may guide the further development of other 12-step based support services and future research projects.

If I need to speak to someone about the research who should I contact?

If you have any questions about any aspect of the research project you may contact the persons named below or you can request more information from the researcher directly.

Confidentiality

Confidentiality is of paramount importance to this research. Throughout the research report all names will be anonymised as will any identifiable person or material. Data will be securely stored electronically on a stand-alone computer with password protection enabled. This will include voice recordings of interviews and any transcriptions made of them. Once the research has been

completed, any personally identifiable material will be permanently deleted from the computer and recordings and

any paper material will be safely destroyed. Only anonymised material will be retained. This research data must be stored securely for a period of ten years.

General Data Protection Regulations 2018/ Data Protection Act 2018 (Post Brexit Provisions)

Privacy notice and sponsor compliance with GDPR and the Data Protection Act 2018

Ulster University is the sponsor or managing organization for this study and we will use information gathered from you and/or your records in order to carry it out.

We will act as the data controller, which means that we are responsible for looking after your information and using it properly, as stipulated in GDPR and the Data Protection Act 2018. Ulster University will keep identifiable information about you for 10 years after the study has finished. You can find out more about how we look after your information at:

As a university we use personal identifying information to conduct research to review and improve people's health, wellbeing and care, the services they use and our understanding of the world in which we live. As a publicly-funded organization, we have to ensure that it is in the public interest when we use personal identifying information from people who have agreed to take part in research. This means that when you agree to take part in a study, we will use your data to conduct the research and analyse the information and findings.

We need to manage your information in specific ways in order for the research to be reliable and accurate and therefore your rights to access, change or move your information are limited.

You should note that if you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personal identifying information possible.

Health, care and other human research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following University and appropriate UK policies and codes of practice.

The only people in the University who will have access to your personal identifying information will be those who need to contact you for the study or to carry out audits of the research

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO).

Our Data Protection Officer is Eamon Mullan; you can contact him at e.mullan@ulster.ac.uk. The

formal research participant privacy notice is replicated at the end of this document.

How will the results of this research be used?

The results of the study will add significantly to knowledge on the nature of recovery messages, how they are initially interpreted and how that interpretation evolves/changes over time in sober living. They will form part of a study by the researcher leading to the award of the degree of Doctor of Philosophy. The written thesis will be available to others interested in developing the addressing of the problem of alcoholism/addiction and extracts may be used in academic journals. However, neither you nor any other participant will be compromised by this in any way as your participation will have been anonymised along with the deletion of any personally identifiable details.

Can I read a copy of the transcript of my interview?

Yes, a copy of the transcript will be sent to you on application directly to the researcher whose details are set out below.

Will I able to know the outcome of the study?

If you participate in the study, you may request a summary sheet of the research findings from any of the contacts listed below.

Who has reviewed the ethics of this study?

This study has obtained ethical approval from the Ulster University Research Ethics Committee. Research Policies and Procedures may be found and read at https://www.ulster.ac.uk/research/policies

Contact information:

Researcher: **Brendan Murphy:** PhD Researcher
Phone: +44 28 9036 6542
Email: murphy-b13@ulster.ac.uk

Chief Supervisor: **Dr Anne Moorhead:** Senior Lecturer in Health Communication School

of Communication and Media
Ulster University
Phone: +44 28 9036 8905
Email: a.moorhead@ulster.ac.uk

Supervisor: **Dr Maggie Long,** Lecturer in Counselling School of Communications and Media
Ulster University Phone: +442890366282
E-mail: m.long@ulster.ac.uk

Appendix 3: Sample of Distress Protocol

Distress Protocol

This protocol for managing distress in the context of this study's interviews is based on Draucker, Martsolf and Poole's (2009*) Developing Distress Protocols for research on Sensitive Topics* and the British Association of Counsellors and Psychotherapists *Ethical Guidelines for Research in the Counselling Professions* (BACP, 2018a). While the risks possibly posed are minimal in the light of the durations of sobriety of the participants, the distress protocol was developed to cover every conceivable eventuality -no matter how remote the possibility. Because of the anonymity attaching to AA membership generally, the fact that participants may only be in a particular location for the purpose of attending a specific AA meeting or convention, the researcher will require to be alert to any developing signs of distress as some of the normal recourses may not be readily available. This will require careful pre-planning and ascertainment of local resources. Regarding level three distress, where a participant could become a risk to some other person in their area of origin, the researcher will ascertain the relevant contacts in the participant's home locality. This can be achieved through an internet search. The researcher will require to be alert to the development of such eventualities and be prepared to stop any interview that may be leading into a high-risk area for a participant. At all interviews, a free phone supplied by the researcher will be available to the participant should the need to call someone arise. While the researcher is a qualified counsellor/psychotherapist, it would be antithetical to act in that capacity during the course of this research.

Distress Level 1

Level 1 distress is where a participant indicates they are experiencing a high level of stress or emotional distress or exhibits behaviours suggestive that the reviving of old memories is proving stressful to the extent that they are crying, shaking, etc.

Response:

Stop the research interview and recording.

Provide tea, coffee etc. together with immediate support asking questions about how the person is feeling and what their needs are such asTell me what thoughts you are having?

Tell me what you are feeling right now?

How do you normally handle upsetting situations? Do you feel safe?

Do you feel you are able and will be able to go on about your day?

The researcher, as a counsellor/psychotherapist, will use their professional expertise to make an assessment of the situation and, after an appropriate break, ask the participant if they able or willing to carry on. If so, the research interview will be continued.

Distress Level 2

Level 2 is where a participant distress level means that they are unable or unwilling to carry on, or, if in the researcher's opinion, continuation is inadvisable.

Response:

1. discontinue and remove participant from the situation and accompany to quiet area
2. assist the participant to feel safe and calm
3, encourage the participant to contact their AA sponsor, intimate friend/partner, on call GP or mental health provider of their choice
4. offer, with participant consent, for the interviewer to do so, by three-way call if requested
5. with participant consent, consult with someone who provides their health care for further advice/support.
6. when they are safe to leave ensure the participant has information about where to find further help if this becomes necessary
7. If it appears unsafe to allow the participant on leave on their own, ask them to nominate whom they would like to accompany/be present with them.
7. follow up with courtesy call, if participant consents, to both participant and their support contact.
8. encourage the participant to call counselling service if he experiences increased distress in the hours/days following participation in the research.
9. The participant will be assured that no part of their participation will be used or referenced in any way in the research.
10. Advice research supervisors of the course of events

Distress Level 3.

This level of distress is exhibited where the participant has indicated that they present an imminent danger to themselves or others. Because of the location issue mentioned earlier, the researcher will not allow any interview to approach this stage and will have terminated the interview before it reaches this point. However, in the unlikely event that something is suddenly recalled or brought up by a participant, then the following action will be taken. BACP, (2018b, paragraphs 9-10 and 55 sub-clauses (d), (e) and (f)).

Response:

A.

1. Where the participant expresses the intent to harm themselves, the interview will immediately be stopped, the doctor on call or the participant's doctor will be summoned and, with their permission, their sponsor/intimate friend/family member will be contacted, and the researcher will await the outcome of medical person's intervention. The participant will not be left alone until assistance arrives.
2. Request the participant's permission to check on how they are feeling later that day and each day for the next week or are returning home before then.
3. Promptly notify research supervisors of the event and the actions taken. B.
1. Where the participant expresses a clear intent to harm another individual, the interview will be promptly terminated.
2. The police in the locality of the participant's home will be appraised of the alleged threat and against whom it is made, and the participant will be advised that this is being done.
3. The participant will be encouraged to talk to a doctor, counsellor, sponsor, intimate friend/relation and the researcher will ensure that one of those persons is contacted and the matter in question is stated in the call. Permission will be sought by the researcher to also speak with that individual to ensure the matter will be followed up once the participant returns home.
4. Permission will be sought from the participant to be contacted later that day and the following one by the researcher to check on how they are feeling.
5. Promptly notify research supervisors of the event and the action taken.

Hotel or Location Name…….

Address……...

Doctor on call……

Participants Doctor…….

Address……...

Phone No…….....

Participant's immediate contact No…….....

. Family member and ph. No.…….

Appendix 4: Sample of 'Consent to Participate' form

RESEARCH GOVERNANCE

Title of Study	An exploration of how members of alcohol dependence self-help groups develop their interpretation of recovery messages in the evolution of a lifetime of sobriety.
Chief Investigator	Dr Anne Moorhead (CI) PhD Researcher Brendan Murphy

Please confirm, by initialling the boxes provided, that you agree with the following statements:

1. I have been given and have read and understood the information sheet for the above project and have asked and received answers to any questions raised.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my rights being affected in any way.

3. I understand that the researchers will hold all information and data collected during the project securely and in confidence and that all efforts will be made to ensure that I cannot be identified as a participant in the project (except as might be required by law) and I give permission for the researchers to hold relevant personal data.

4. I agree to take part in the interview for the above research project and give permission for the interview to be audio recorded for analysis purposes only.

Name of Participant (please print)	Signature	Date (dd/mm/yy)	
Name of person taking consent (if different from researcher)	Signature	Date (dd/mm/yy)	
Name of Researcher	Signature	Date (dd/mm/yy)	

1 copy for Participant; 1 copy for Researcher

Appendix 5 : ULSTER UNIVERSITY RESEARCH GOVERNANCE
Formal privacy notice for research participants

GDPR/Data Protection Act Privacy Notice – Research Participants

How we use your personal information

1. Why have I been directed to this webpage?

The purpose of this notice is to supplement the project-specific information that you have already been given (for example on a participant information sheet or a consent form) in connection with your participation in a research study run by researchers at Ulster University. The information below – which we are obliged by law to provide – applies to all studies and projects that we run. If there is any contradiction between this general information and the specific information that you have already been given, the specific information takes precedence.

2. Who will process my personal information?

The information published here applies to the use of your personal information by Ulster University, including its Departments, Schools and Research Centers/Units. You have already been told if you are participating in a research study being run by the University in collaboration with other organizations, such as other universities or hospitals.

You have already been told about the types of personal information we will use in connection with the specific research study or project you are participating in and (where applicable) its sources, any data sharing or international transfer arrangements, and any automated decision- making that affects you.

3. What is the purpose and legal basis of the processing?

As a publicly-funded university, we have to ensure that it is in the public interest when we use personally-identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use your data in the ways needed to conduct and analyse the research study. Therefore, in general terms, we use your personal information (including, where appropriate, sensitive personal information) to carry out academic and/or translational research in the public interest.

On occasions, we may have asked for your consent to use your personal information for research purposes. If we asked for your consent, you can withdraw this at any time; you should have already been told how to do this but if not, or if you are in doubt, please use the contact details below. Please note that your consent to use your personal information is separate from your ethical consent to participate in a particular research study.

You are not legally or contractually obliged to supply us with your personal information for research purposes.

4. How can I access my personal information?

Various rights under data protection legislation, including the right to access personal

information that is held about you, are qualified or do not apply when personal information is processed solely in a research or archival context. This is because fulfilling them might adversely affect the integrity of, and the public benefits arising from, the research study or project.

The full list of (qualified or inapplicable) rights is: the right to access the personal information that is held about you by the University, the right to ask us to correct any inaccurate personal information we hold about you, to delete personal information, or otherwise restrict our processing, or to object to processing (including the receipt of direct marketing) or to receive an electronic copy of the personal information you provided to us.

If you have any questions regarding your rights in this context, please use the contact details below.

5.How long is my information kept?

You have already been told about the long-term use (and, where applicable, re-use) and retention of your personal information in connection with the specific research study or project you are participating in. General information about how long different types of information are retained by the University is published in the retention schedules on our website.

6.Who can I contact?

If you have any questions about the particular research study you are participating in, please use the contact details you have already been given.
If you have any general questions about how your personal information is used by the University, or wish to exercise any of your rights, please consult the University's data protection webpages at https://www.ulster.ac.uk/about/governance/compliance/gdpr
If you need further assistance, please contact the University's Data Protection Officer at e.mullan@ulster.ac.uk

7.How do I complain?

If you are not happy with the way your information is being handled, or with the response received from us, you have the right to lodge a complaint with the Information Commissioner's Office.

Appendix 6: Sample of Flyers used at Conventions

ARE YOU 40, 30, 20 OR 10 YEARS SOBER and would like to help to "Carry the Message"?

Would you like to help others understand how members of AA develop their interpretation of recovery messages into a lifetime of sobriety?

Ulster University is carrying out research into how members achieve these remarkable results.

The research project is seeking to find out how continued membership of the Alcoholics Anonymous Fellowship can lead to living a lifetime sober. It is hoped to recruit members (in an individual capacity) at different stages of their recovery careers – 10, 20, 30 and 40 years, to share their experiences, strengths and hopes with us so that we can answer the question posed above. The research format will be a face to face interview lasting approximately one hour. There will be 6 participants from each of the 'recovery age' categories. All participants identities will be completely anonymised, and no participant will come from anywhere remotely near one another.

A detailed information sheet about this research, setting out in fuller detail all aspects of the protection of anonymity, safety and well-being will be provided to any one that is willing to consider participation.

The research is being carried out with the approval of Ulster University

Research Ethics Committee reference No REC/19/0029

We hope you will consider becoming a participant and would be very grateful for your contribution. Understanding how long-term sobriety evolves and grows will help to carry the message to the alcoholic that still suffers.

Thank you for reading this brochure - we would really like to hear from you!

Contact information:

Researcher: **Brendan Murphy:** PhD Researcher
Phone: +44 28 9036 6542
Email: murphy-b13@ulster.ac.uk

Chief Supervisor: **Dr Anne Moorhead:** Senior Lecturer in Health Communication School of Communication and Media
Ulster University
Phone: +44 28 9036 8905
Email: a.moorhead@ulster.ac.uk

Supervisor: **Dr Maggie Long,** Lecturer in Counselling School of Communications and Media
Ulster University Phone: +442890366282
E-mail: m.long@ulster.ac.uk

University of Ulster,
School of Communication and Media, Shore Road,
Jordanstown, Belfast BT37 0QB

Appendix 7: The 12 Steps of Alcoholics Anonymous. (A.A., 2001, pp. 59-60)

Step 1: We admitted we were powerless over alcohol – that our lives had become unmanageable.

Step 2: Came to believe that a Power greater than ourselves could restore us to sanity.

Step 3: Made a decision to turn our will and our lives over to the care of God as we understood Him.

Step 4: Made a searching and fearless moral inventory of ourselves.

Step 5: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

Step 6: Were entirely ready to have God remove all these defects of character. Step 7:

Humbly asked Him to remove our shortcomings.

Step 8: Made a list of all persons we had harmed, and became willing to make amends to them all.

Step 9: Made direct amends to such people wherever possible, except when to do so would injure them or others.

Step 10: Continued to take personal inventory and when we were wrong promptly admitted it.

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 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.

Appendix 8:

The 12 Traditions of Alcoholics Anonymous (A.A. World Services, 1981, S.M., F-122) – Short Form.

1. Our common welfare should come first; personal recovery depends upon A.A. 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 A.A. membership is a desire to stop drinking.

4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.

5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.

6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.

7. Every A.A. group ought to be fully self-supporting, declining outside contributions.

8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.

9. A.A., 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 A.A. 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].

Appendix 9:

The 12 promises of Alcoholics Anonymous (A.A., 2001, pp. 83-4) and as converted into the numeric format by Kelly & Green, 2013).

1. "*We are going to know ta 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".*
4. "*We will know peace".*
5. "*No matter how far down the scale we have gone, we will see how our experience can benefit others".*
6. "*The feeling of uselessness and self-pity will disappear".*
7. "*We will lose interest in selfish things and gain interest in our fellows".*
8. "*Self-seeking will slip away".*
9. "*Our whole attitude and outlook upon life will change".*
10. "*Fear of people and economic insecurity will leave us".*
11. "*We will intuitively know how to handle situations which used to baffle us".*
12. "*We will suddenly realise that God is doing for us what we could not do for ourselves".*

Appendix 10: - Extract from 'The Doctor's Opinion'

(A.A., 2001, p. xxvi – an *open letter first written in June 1939,* (date unclear) signed by William D. Silkworth, M.D.

"We believe, and so suggested a few years ago, 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".

Also by Dr W Silkworth, a paper in the *Medical Record*, March 17, 1937,

"The inevitable conclusion is that true alcoholism is an allergic state, the result of gradually increasing sensitization by alcohol over a more or less extended period of time. The constancy of the symptoms and progress is too fixed to permit any other explanation. Some are allergic from birth, but the condition usually develops later in life. The development and course of these cases are quite comparable with the history of hay fever patients in many respects. One may enjoy absolute freedom for many years from any susceptibility to pollen. Year after year, however, there gradually develops a sensitivity to it in certain individuals, culminating at last in paroxysms of hay fever that persist indefinitely when the condition is fully established.

It is noteworthy also, that such patients may be deprived of liquor altogether for a long period, a year or longer for example, and become apparently normal. They are still allergic, however, and a single drink will develop the full symptomatology again."

Appendix 11: The message or messages of A.A. - as perceived by participants.

Group A:

Anne: "*Stick with it, give it your best shot and see how it goes; the door swings both ways. I would say give it your all, go with the flow and see what's ahead of you*" (15:424-7).

Arthur: *"I'd seen the hope right at the very start"* (4:100). [The programme gives me the ability] "*... to be the best version of me"* (14:409-411). *"We only know but just a little".* (10:284) **Alan**: **"***It is a day at a time. Big time, it's a work in progress"* (17:535-6).

Aidan: **"***If you don't pick up that first drink, you can't get drunk.* (15:445-6*). That's a constant message that stays basic and straightforward* (450-451*) "What A.A. has taught me to take life on a day-to-day basis. Not to worry too much of the future, and not to fret about things that went wrong in the past"* (16:482-3).

Amy: "*Hope* (6:176), *love* (8:242), *kindness* (14:425) *"Service has been the root of my growth"*

(30:948).

Adam: **"***What I took from that was I have to keep growing. I don't have to but it's important I keep growing"* (9:262-3).

Group B:

Breda did not specify any message except that without A.A., "*life would be barren, dry and joyless*" (29:865). She felt that she could not survive indefinitely without it. She loves the fact that her journey of personal development will continue.

Brian is confident he would be dead without the programme – he used to drink 3 litres of vodka per day. The key message he picked up from the beginning is *"I would say it's been a gradual process how I've adapted my way of life to A.A. way of living the 12 steps on a daily basis"* (18:514-5), and he tries to bring the principles into his everyday life (18:519). When asked directly about what had carried him through the last 20 years, Ben' said it was the message of A.A.'s disease concept – that he is still an alcoholic. He has an allergy to alcohol, and if he picks it up again, he will revert to where he was at on his last relapse.

Bart's view of the key messages of A.A. is that alcoholism is an illness, and there was a way out.

Basil identified four key messages for him *1. Keep coming back; 2. You don't get well and do the steps; you do the steps and get well; 3. Get a sponsor and go through the steps with them, and 4. Get involved in service.*

Group C:

Charlie believes the message is threefold: "*First of all, to get me well. To get me out of where I was*" (25:693-5); that "*love and service"* (quoting from Dr Bob Smith's last words (Appendix 9)) are essential ingredients and that the programme helped him "*...to become the person he was born to be and not became"* through its slogans and everything else that they promulgate. **Colm**'s view of the message(s) is that "... *there's a nice, comfortable life out there. Now life happens and you just have to go along with it"* (29:822-3)

Carl was clear that the message (as he believed it to be)

"*... is very simple, that a) they were alcoholic and cannot manage their own lives, b) That probably no human power that can relieve them of their alcoholism and c) that God could and would if he were sought.* [AA, 1976, p.60]. *The whole purpose of the A.A. programme is to find God...as we understand Him"* (14:435-41),

Cyril did not explicitly identify any but stated that his life had turned around 360 degrees and that the biggest thing for him was that he was coping on a daily basis without lifting a drink. **Cathy** had to think for a few minutes and suggested that the programme is a solution for anybody prepared to give it an honest effort and an honest chance.

Group D:

Denise put her understanding of the 12-step message as follows "*The phrase that comes to my mind is there is a solution, which is in the big book* [A.A., 1976, Chapter 2 pp. 17-29]. *I did not feel like there was a solution before I came into the programme, and then I found that there was a solution for the drugs and the alcohol. Then I thought there was no solution with sugar, and then I found that there was a solution there"* (17:470-4).

Dan had no clear view of the group messages but feels they have changed as people with other addictions join in. He absolutely believes that within the 12-step group, there is a solution to alcohol dependency – a way of life. He is sure that if he drinks again, he will not be able to stop. He attends meetings every day "*Because I need them"* (23:25). Gratitude plays a significant part in his sobriety for the way his life and children have turned out.

David believes the message of the 12-step group is "*That there was hope. A new life for an old life, there was a way out of the misery and that I could maybe pass on what was passed on to me, to somebody else, continue the chain"* (6:149-51). Gratitude plays a big part in David's day to day outlook – knowing how many have 'not made it'. He believes that

A.A.'s approach is holistic in its defense against the disease -that it is the future and the past that break a man. He appreciates his recovery "*…its always to"ay*" (18:467).

Declan's interpretation of the group's messages was, "*Well, there's hope to start with. That's the whole message of A.A. and it's a different way of life. It's a new way of living. It's adopting a new way of living and then working on what needs to be worked on from your previous life. I see my sober life as a separate life"* (10:257-60).

Des picked up the message that *"The feeling I got was hope and it was possible"* [to live sober] (6:156) but found it was like a drip, very slow going. To this day, he still finds it a challenge to trust himself every day.

Group L:

Despite or maybe because of his public speaking ability, Participant 22 did not directly answer what he considered the message(s) of the 12-step group. Instead, he said:

"...the good thing about Alcoholics Anonymous was that they said - they didn't say you'll never be able to drink again in your life, which would have been an impossibility. All they said to me was all we want you to do is to stay away from one drink for one day at a time, *and when you go to bed at night, when you go to sleep when you wake up tomorrow morning, it is not tomorrow, it's today, and you repeat the process. That was the way that I was told in the beginning. That registered with me. I kept that in the foremost of my mind as I was staying sober.* But it was only done a day at a time." (23:737-745).

Participant 23 had a clear view of what the message meant to him

"The message of A.A., for me anyway, the message of A.A. is the Twelve Steps, the programme that's built into those Twelve Steps whereby you're learning to live your life one day at a time - very important - and that encapsulated in that one day is the fact that you must learn. The biggest lesson that I have learned is that in that one day that I must by what I say, by what I do or by what I fail to do, that I won't hurt any other human being within that day" (18:539-45) and *"I have to do my service in the fellowship. That's a huge part of the message of A.A. Giving back. You have to give back"* (18:546-8).

Appendix 12: Participant's reservations of the fulfilment of promises of A.A., 2001, pp. 83-4)

Anne

Promise 1: When you described your first few years in A.A., you didn't have that freedom, really, did you? *No. Maybe I got a glimpse of it* (16:478-81)

Promise 3: *You don't regret the past, but you can't really shut the door, you can't*…(17:485- 6). [I noted reservations from the tone of her reply.]

Promise 10: *No, I probably do have a bit of fear, I think yeah. But yeah, I think having a fear of certain situations probably and then recognising that fear and doing it anyway. Like going into, I don't know, a fear of - what am I trying to say there? Not people as such, Situations, of course, there would be a hint of a fear there put into any situation, I suppose, but I kind of do it anyway*. (19:535-40)

Arthur

Promise 1: *I don't regret the past, I have disappointments in the past, but I don't regret the past because of what I do now*. (12:365-7)

Promise 3: *It's not there all the time, but that's the human side of anything (13:376-7).* The participant is still 'driven' a bit.

Promise 7: *Yes, well I've a bit of work to do on that. That's a work in progress.* (13; 395 & 398)

Promise 8 (not realized): *There are certain days the bit's fairly big; it's all self-seeking. When I'm aware of it I can take it to God and say this isn't what I want. I don't want this in my life and I want you to help me and guide my thinking but it's still in my life (14:400-5)*

Promise 10: *Yes, a bit of that still is in my life, comes back when I don't - insecurity can slip into my life. That's the devil putting temptation in my life; he wants to take my eyes off my God* (14:416-9)

Alan

Promise 1: *Obviously I'm upset about my family issues, but I can't change them,*

Promise 3: *I didn't even know what serenity meant when I came in, it wasn't in my language*

Promise 4: *I don't know if I've found peace yet.*

Promise 8: *Probably, yes. Yes. I can still be stubborn if that's the same thing.*

Promise 10: *In eight years sobriety I've been stopped and breathalysed three times, and I've absolutely shat myself when the old bill pulled me in.* [But he was sober!]

Promise 12: *I read one of my books; if the word God was there I used to skip it. I actually say it now. Now that for me is a big step forward. (But no genuine belief)*

Aiden

Promise 4**:** *I still have my ups and downs. Everybody does. Good days and bad days, but I can control it better now. That was one of my problems because of my ego*

Promise 10: *That's definitely helped. You can only (experience personal) insecurity.*

Amy

Promise 1: *Do I have it fully every day, all day? No. But I do experience pockets of it. I do experience happiness. All day, every day? No.*

Promise 3: *[After 8 years] I have it now - so, I understand what it is*

Promise 4: *Again, not all day, every day, but I experience it every day*

Promise 7:*[After 8 years] That took time as well, because I truly believed that I wasn't me unless I had material stuff around me.*

Promise 8: *Is it fully gone for me? No, because I'm going to be working on these for the rest of my life.*

Promise 10: *That is a nemesis for me. I still have to work on feeling less than, and I'm in my 13th year*.

Adam

Promise 1: *I've experienced that at different times beyond – very fleeting actually because of the nature of our mind.*

Promise 3: *First thing in the morning. It scares me that sometimes my life has gone so quiet that that scares me.*

Promise 7:*I struggle with that one. That's not one that's fully – I think that one I struggle with. And in a negative way.*

Promise 8: *At times, yes, but at times no. That's going back to a bit of work I need to do on myself.*

Promise 10: *The fear is not as strong. It's still a little bit sometimes. I suppose these all develop a little more as you go along as well.*

Breda

Promise 3: *Yes, absolutely. I find that it comes and goes.*

Promise 7: *I don't think I'm self-centred anymore. I think I'm still selfish. By that, I mean, selfish, in that I will often put myself first over other people.*

Promise 8: *Self-seeking - I think that I'm less - there's less urgency in the self-seeking.*

Promise 10: *In my first years, I wanted to carry on behaving at the party. I wanted to be better than them. I like me now. It doesn't matter if you find me boring or not.*

Promise 12: *If I take God to be the power greater than myself, yes, yes. It is thanks to this Group Of Drunks or thanks to this God. I mean, it's just ridiculous to think that I could have done it on my own.*

Ben

Promise 1: *Now, I don't have that all the time, but I had that experience, and I continue to have those experiences from time to time. But I don't have it automatically.*

Promise 2: *Now, I sometimes do regret the past, especially the harm I've done to others. I can't say that I wouldn't want to change that.*

Promise 4: *Yeah, I've had peaceful moments at times. It's not like I say, it's not a constant thing.*

Promise 6: *Sometimes, when I feel self-pity, I try to do something about it right away. Because it seems - it's one of these negative experiences*

Promise 8:*Yeah, I still get it sometimes, but I often - I've surprised myself by going out of my way to help other people, and they don't even know it.*

Promise 10:*Yeah, I get that from time to time. I feel like I can let that go. I do actually experience it now. It can kind of creep in. I can get fears about this and that.*

Promise 11: *Yeah, that's one that comes through quite often. I've noticed that in the last few years.*

Promise 12: *If you can get into that regular habit of service, it frees you from that small ego. I'm just an employee of the universe.* (God/ Higher Power etc. avoided)

Cathy

Promise 3: *Yes, but that took me a long, long time.*

Promise 7: *First half of it, I'd say yes. The second half, no not yet.*

Promise 9: *Mm, no, I don't think has happened for me yet, no.*

Promise 10: *Fear of people hasn't left me, but I was never economically insecure.*

Denise

Promise 6: *Once in a while, if I do something, I can get this old useless feeling, and then I go into self-pity: poor me. I'm not doing it right.*

Promise 8: *If somebody else has bad misfortune, how is that going to affect me? I can still have a bit of that going on nowadays, if I'm truthful, but it's nothing like what it used to be.*

Des

Promise 5: *Mumm... That's a difficulty. When I say difficult, part of my disease or illness, if I'm not at ease and serenity and things like that, and because of my low self-esteem - would be, I don't have much to offer.*

Promise 12: *See, that's the 64 million $ question. It's hard to believe that there is a God. It's a terrible thing to say. And it's hard to believe that there isn't.*

Appendix 13: The 9 Main Slogans displayed at meetings of AA/NA etc

1. Let Go, Let God

2. Easy Does it

3. Think, Think, Think

4. Pass It On

5. There but for the Grace of God

6. Keep It Simple.

7. This Too Shall Pass

8. Live and Let Live

9. One Day at A Time

There can be local variations, but in general, these are the most often used.

Appendix 14: Main prayers associated with steps Step 3:

"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!" (A.A., 2001, p. 63)

Step 7 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." (A.A., 2001, p. 76)

Step 11 Prayer (Prayer of St Francis of Assisi)

Lord, make me an instrument of thy peace! That where there is hatred, I may bring love. That where there is wrong, I may bring the spirit of forgiveness. That where there is discord, I may bring harmony.
That where there is error, I may bring truth. That where there is doubt, I may bring faith. That where there is despair, I may bring hope. That where there are shadows, I may bring light. That where there is sadness, I may bring joy.
Lord, grant that I may seek rather to comfort, than to be comforted. To understand, than to be understood.
To love, than to be loved.
For it is by self-forgetting that one finds. It is by forgiving that one is forgiven.
It is by dying that one awakens to Eternal Life. (A.A., 2012, p.99 – Prayer of St Francis of Assisi)

Appendix 15: Spiritual experiences/ awakenings

(a) Comments by Carl Jung

"You have the mind of a chronic alcoholic, and I've never seen one single case recover where that state of mind existed to the extent that it does in you."

and

"*Exceptions to cases such as yours has been occurring since early times, here and there, once in a while, Alcoholics have had what are called vital spiritual experiences. To me, these occurrences are phenomenon. They appear to be in the nature of huge emotional displacements and rearrangements. These emotions and attitudes, which were once the guiding forces of the lives of these men, are suddenly cast to one side and a completely new set of conceptions and motors begin to dominate them. In fact, I've been trying to reduce some such emotional rearrangements with you. With many individuals, the method which I apply are successful, but I have never been successful with an alcoholic of your description."* (A.A., 1976, p. 27)

(b) SPIRITUAL EXPERIENCE - the educational variety (A.A., 1976, pp.567-8)

"The terms "spiritual experience" and "spiritual awakening" are used many times in this book which, upon careful reading, shows that the personality change sufficient to bring about recovery from alcoholism has manifested itself among us in many different forms. Yet it is true that our first printing gave many readers the impression that these personality changes, or religious experiences, must be in the nature of sudden and spectacular upheavals. Happily, for everyone, this conclusion is erroneous. In the first few chapters a number of sudden revolutionary changes are described. Though it was not our intention to create such an impression, many alcoholics have nevertheless concluded that in order to recover they must acquire an immediate and overwhelming "God-consciousness" followed at once by a vast change in feeling and outlook. Among our rapidly growing membership of thousands of alcoholics such transformations, though frequent, are by no means the rule. Most of our experiences are what the psychologist William James calls the "educational variety" because they develop slowly over a period of time. Quite often friends of the newcomer are aware of the difference long before he is himself. He finally realises that he has undergone a profound alteration in his reaction to

life; that such a change could hardly have been brought about by himself alone. What often takes place in a few months could seldom have been accomplished by years of self-discipline. With few exceptions our members find that they have tapped an unsuspected inner resource which they presently identify with their own conception of a Power greater than themselves. Most of us think this awareness of a Power greater than ourselves is the essence of spiritual experience. Our more religious members call it "God-consciousness." Most emphatically we wish to say that any alcoholic capable of honestly facing his problems in the light of our experience can recover, provided he does not close his mind to all spiritual concepts. He can only be defeated by an attitude of intolerance or belligerent denial. We find that no one need have difficulty with the spirituality of the program. Willingness, honesty and open-mindedness are the essentials of recovery. But these are indispensable. "There is a principle which is a bar against all information, which is proof against all arguments and which can not fail to keep a man in everlasting ignorance—that principle is contempt prior to investigation."—Herbert Spencer."

Appendix 16: Extract from Dr Bob Smith's last talk:

"There are two or three things that flashed into my mind on which it would be fitting to lay a little emphasis. One is the simplicity of our program. Let's not louse it all up with Freudian complexes and things that are interesting to the scientific mind but have very little to do with our actual A.A. work. Our Twelve Steps, when simmered down to the last, resolve themselves into the words, 'love' and 'service.' We understand what love is, and we understand what service is. So let's bear those two things in mind." (Cleveland Convention, Ohio, July 1950)

(Internet resource: https://aachilternthames.org.uk/discover-aa-december-2015-dr-bobs-last- message/ last accessed 27/7/20)

Appendix 17: Alcohol dependence as a disease (participant's perceptions)

Alan: This is the nature of this illness, isn't it? (16;482)

Amy: I was a prime candidate for the disease of alcoholism. (10;316)

Anne: oh my God, I'm not alone here, I'm not mad, I'm not crazy. I have -it's a disease. (4;101) Arthur: But if we don't keep growing spiritually, our disease will take over. 8;239

Bart: I can remember to this day the guy saying that you suffer from an illness. (15;478& 574) Ben: It's a specific disease with specific symptoms. (14;408)

Carl: It's a progressive illness, and it progresses whether we're drunk or sober. (11;340)

Cyril: They said we're human beings who have an illness. 20;597

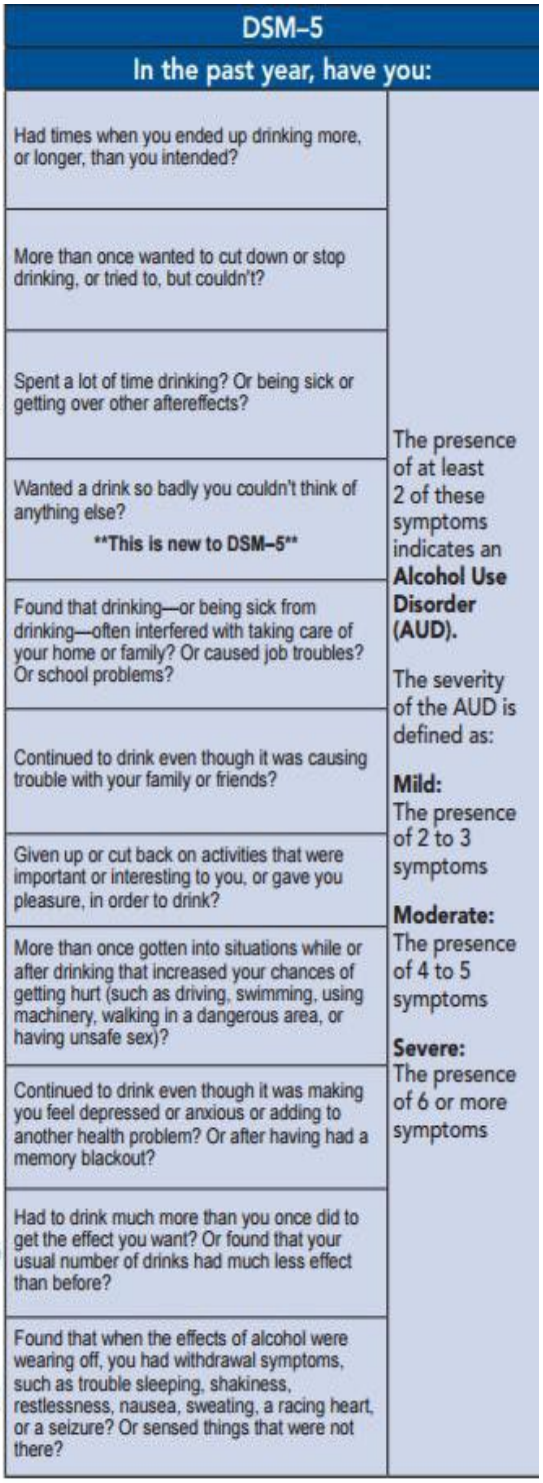
David: I'd learnt about alcoholism being an illness, that abstinence was the only key. (8;200) Denise: By that time, my illness had progressed enough that I thought, "I don't care". (8;211)

Des: When I say difficult, part of my disease or illness if I'm not at ease and serenity and things like that, and because of my low self-esteem. (20;595)

Participant 22: I wanted to find out more about the illness of alcoholism. (12;388)

Appendix 18

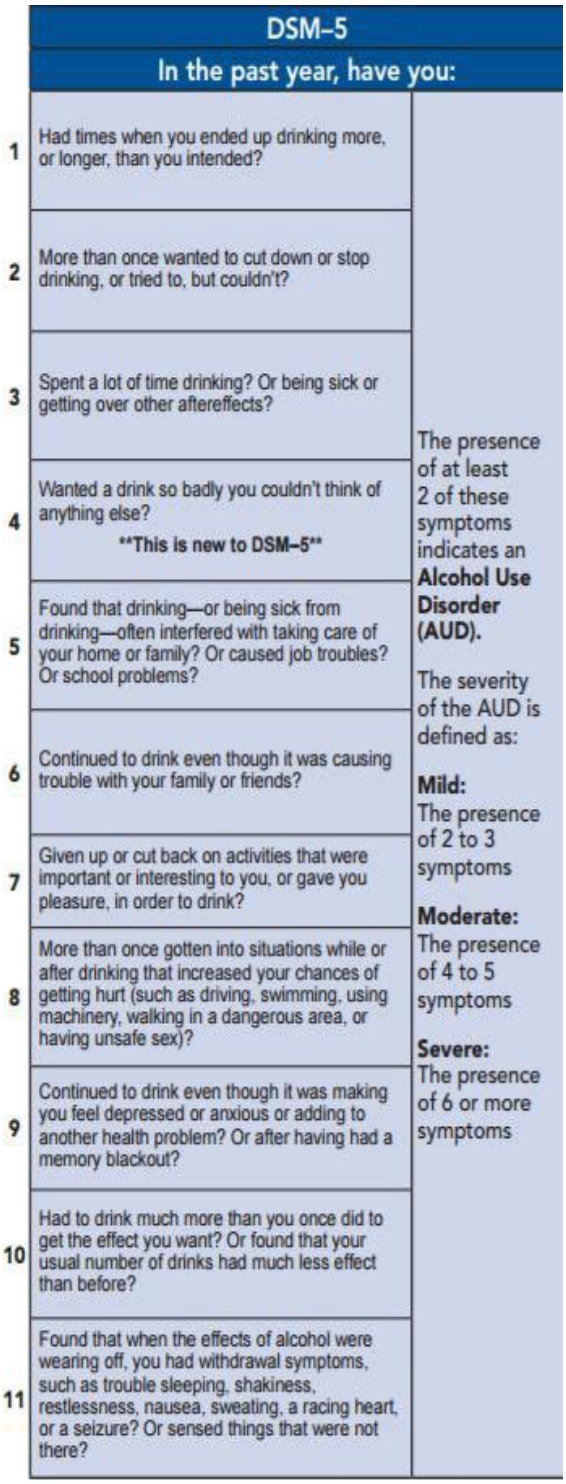
DSM-5 evaluation of participant's drinking pattern – Group 1



DSM–5		
In the past year, have you:		
1	Had times when you ended up drinking more, or longer, than you intended?	The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).** The severity of the AUD is defined as: **Mild:** The presence of 2 to 3 symptoms **Moderate:** The presence of 4 to 5 symptoms **Severe:** The presence of 6 or more symptoms
2	More than once wanted to cut down or stop drinking, or tried to, but couldn't?	
3	Spent a lot of time drinking? Or being sick or getting over other aftereffects?	
4	Wanted a drink so badly you couldn't think of anything else? ****This is new to DSM–5****	
5	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	
6	Continued to drink even though it was causing trouble with your family or friends?	
7	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	
8	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	
9	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	
10	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	
11	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	

Adam	Alan	Arthur	Aidan	Anne	Amy
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y

DSM-5 evaluation of participant's drinking pattern – Group 2



	DSM–5	
	In the past year, have you:	
1	Had times when you ended up drinking more, or longer, than you intended?	The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).** The severity of the AUD is defined as: **Mild:** The presence of 2 to 3 symptoms **Moderate:** The presence of 4 to 5 symptoms **Severe:** The presence of 6 or more symptoms
2	More than once wanted to cut down or stop drinking, or tried to, but couldn't?	
3	Spent a lot of time drinking? Or being sick or getting over other aftereffects?	
4	Wanted a drink so badly you couldn't think of anything else? ****This is new to DSM–5****	
5	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	
6	Continued to drink even though it was causing trouble with your family or friends?	
7	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	
8	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	
9	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	
10	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	
11	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	

Breda	Brian	Ben	Bart	Basil	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	

DSM-5 evaluation of participant's drinking pattern – Group 3

DSM–5		
	In the past year, have you:	
1	Had times when you ended up drinking more, or longer, than you intended?	The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).** The severity of the AUD is defined as: **Mild:** The presence of 2 to 3 symptoms **Moderate:** The presence of 4 to 5 symptoms **Severe:** The presence of 6 or more symptoms
2	More than once wanted to cut down or stop drinking, or tried to, but couldn't?	
3	Spent a lot of time drinking? Or being sick or getting over other aftereffects?	
4	Wanted a drink so badly you couldn't think of anything else? ****This is new to DSM–5****	
5	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	
6	Continued to drink even though it was causing trouble with your family or friends?	
7	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	
8	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	
9	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	
10	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	
11	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	

Charlie	Colm	Carl	Cyril	Cathy	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	

DSM-5 evaluation of participant's drinking pattern – Group 4

DSM–5		
In the past year, have you:		
1	Had times when you ended up drinking more, or longer, than you intended?	The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).** The severity of the AUD is defined as: **Mild:** The presence of 2 to 3 symptoms **Moderate:** The presence of 4 to 5 symptoms **Severe:** The presence of 6 or more symptoms
2	More than once wanted to cut down or stop drinking, or tried to, but couldn't?	
3	Spent a lot of time drinking? Or being sick or getting over other aftereffects?	
4	Wanted a drink so badly you couldn't think of anything else? ****This is new to DSM–5****	
5	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	
6	Continued to drink even though it was causing trouble with your family or friends?	
7	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	
8	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	
9	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	
10	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	
11	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	

Denise	Dan	David	Declan	Des	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	
Y	Y	Y	Y	Y	

DSM-5 evaluation of participant's drinking pattern – Group 5

	DSM–5 In the past year, have you:		Participant 22	Participant 23
1	Had times when you ended up drinking more, or longer, than you intended?	The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).** The severity of the AUD is defined as: **Mild:** The presence of 2 to 3 symptoms **Moderate:** The presence of 4 to 5 symptoms **Severe:** The presence of 6 or more symptoms	Y	Y
2	More than once wanted to cut down or stop drinking, or tried to, but couldn't?		Y	Y
3	Spent a lot of time drinking? Or being sick or getting over other aftereffects?		Y	Y
4	Wanted a drink so badly you couldn't think of anything else? ****This is new to DSM–5****		Y	Y
5	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?		Y	Y
6	Continued to drink even though it was causing trouble with your family or friends?		Y	Y
7	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?		Y	Y
8	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?		Y	Y
9	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?		Y	Y
10	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?		Y	Y
11	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?		Y	Y

Appendix 19

Participants reaction to seeing the word 'God' in 12-steps Scrolls at their first 'real' meeting

Participant ID	Interview Name	Age (years)	
Participant 1	Anne	51	Not a problem
Participant 2	Arthur	53	Not a problem
Participant 3	Alan	60	Atheist – repugnance
Participant 4	Aidan	47	I thought that God had forsaken me
Participant 5	Amy	50	"God for me was male."
Participant 6	Adam	35	Unsure and unsettling- Maybe the God thing

Group B:

Participant ID	Interview Name	Age (years)	
Participant 7	Breda	60	Atheist
Participant 8	Brian	78	Oh, here we go, it's a big Godly thing.
Participant 9	Ben	67	I had a belief in God anyway.
Participant 10	Bart	65	..whereas it was a God of Hell and Wrath..
Participant 11	Basil	60	I was very much, I don't know, agnostic

Group C:

Participant ID	Interview Name	Age (years)	
Participant 12	Charlie	67	I have a God of my own understanding.
Participant 13	Colm	60	I don't know what God is
Participant 14	Carl	66	.. talking about this God in a different way...
Participant 15	Cyril	61	Unsure about the emphasis on "God."
Participant 16	Cathy	68	Not an issue

Group D:

Participant ID	Interview Name	Age (years)	
Participant 17	Denise	69	They were talking about God and I thought [groans], I don't want to deal with that…
Participant 18	Dan	76	Didn't bother me in the slightest.
Participant 19	David	65	I thank God I'm in the AA,.no earlier comment
Participant 20	Declan	66	I had great trouble with …concept of God.
Participant 21	Des	62	it's hard to believe that there is a God and it's hard to believe there isint.

Group L:

Participant ID	Interview Name	Age (years)	
Participant 22	Participant 22	93	I saw this "But for the Grace of God" I thought, oh goodness, I've landed in some mission house, some religious sect.

Participant 23	Participant 23	82	I never seriously thought about whether there was a God…. or wasn't

MEMO ON PARTICIPATION OF A.A. MEMBERS IN RESEARCH AND OTHER NON-A.A. SURVEYS

Since the early days of our Fellowship, the participation of A.A. members in research and surveys has been sought – and has occurred. In recent years there has been an escalation of concerns about alcoholism in all parts of our society. As a result, A.A. can expect that requests for participation in research may increase.

In general, within A.A. there is a favourable attitude toward research. As Bill W. wrote, “Today the vast majority of us welcome any new light that can be thrown on the alcoholic’s mysterious and baffling malady. We welcome new and valuable knowledge, whether it issues from a test tube, from a psychiatrist’s couch or from revealing social studies.” Historically, participation has been worked out on a case by case basis. Some of the attempts to cooperate have led to strained relationships while more have been successful, mutually satisfying, and produced new insights.

How A.A. members might cooperate with research has been discussed by the trustees’ Committee on Cooperation with the Professional Community. At the suggestion of that committee, we offer this memo both to those who would solicit the participation of A.A. members in research and to those A.A. members who will be approached about such request.

1. The best research relationships between A.A. members and researchers have been those in which the researcher has become thoroughly familiar with the Fellowship before making an inquiry about participation. At the same time, the A.A. members who would be involved have become acquainted with the researcher so that they trusted him or her, and have been convinced of the researcher’s commitment, competence, integrity and respect for the Traditions of A.A. The investigator has been forthright in giving the A.A. members all the information about his or her research which they needed in order to make an informed decision about it.

2. For A.A. members, cooperating with the researcher and being part of research program raises most of the same issues as cooperating with any other non-A.A. professional or engaging in any other non-A.A. undertaking. The questions are amenable to the same kinds of solutions. See: “How A.A. Members Cooperate with Professionals” and the C.P.C Workbook. As long as there is frank communication and attitudes of open-mindedness and flexibility, it has proved possible to work out ways
of participating in research which do not require A.A. members to compromise A.A.’s Traditions and which permit the researcher to arrive at valid findings.

3. he researcher should be aware that Central Offices in A.A. cannot offer the

kinds of assistance he or she may be used to from the headquarters of other organization, e.g. access to records, endorsement, etc. However, the researcher may receive some help from the General Service Office, Intergroup Offices, Intergroup Offices, and local offices of other kinds.

a. Individuals in these offices may be willing to give the researcher their opinions about the projects and about their feasibility.

b. Literature can be provided which will prove helpful to the researcher in understanding A.A., what it is, what it can and cannot do, as well as how A.A. members cooperate with non-A.A. undertaking.

c. A copy of this memo can be provided.

4. Decisions about whether or not to cooperate in research are always made at the local level where the research will occur. Almost always the request for participation has been made to individual A.A. members who have then sought the cooperation of other members. In rare instances, the request has been made to a group. When A.A. members have decided to cooperate, it has been in their capacity as private citizens.

5. Those individuals approached about cooperation will want to make an informed judgment about whether to participate and about whether to seek the participation of others. Indeed, with the increased requests for research cooperation, it is necessary that selection take place. Some of the kinds of questions the individual might have are: What is being studied, by whom why and how; who will carry out the research at the local level; what will cooperation involve, e.g. interviews, questionnaires, amount of time; who will evaluate the findings; who will use the findings for what purpose; in the light of A.A. Traditions, is cooperation possible; what arrangements are made to ensure anonymity, etc.?

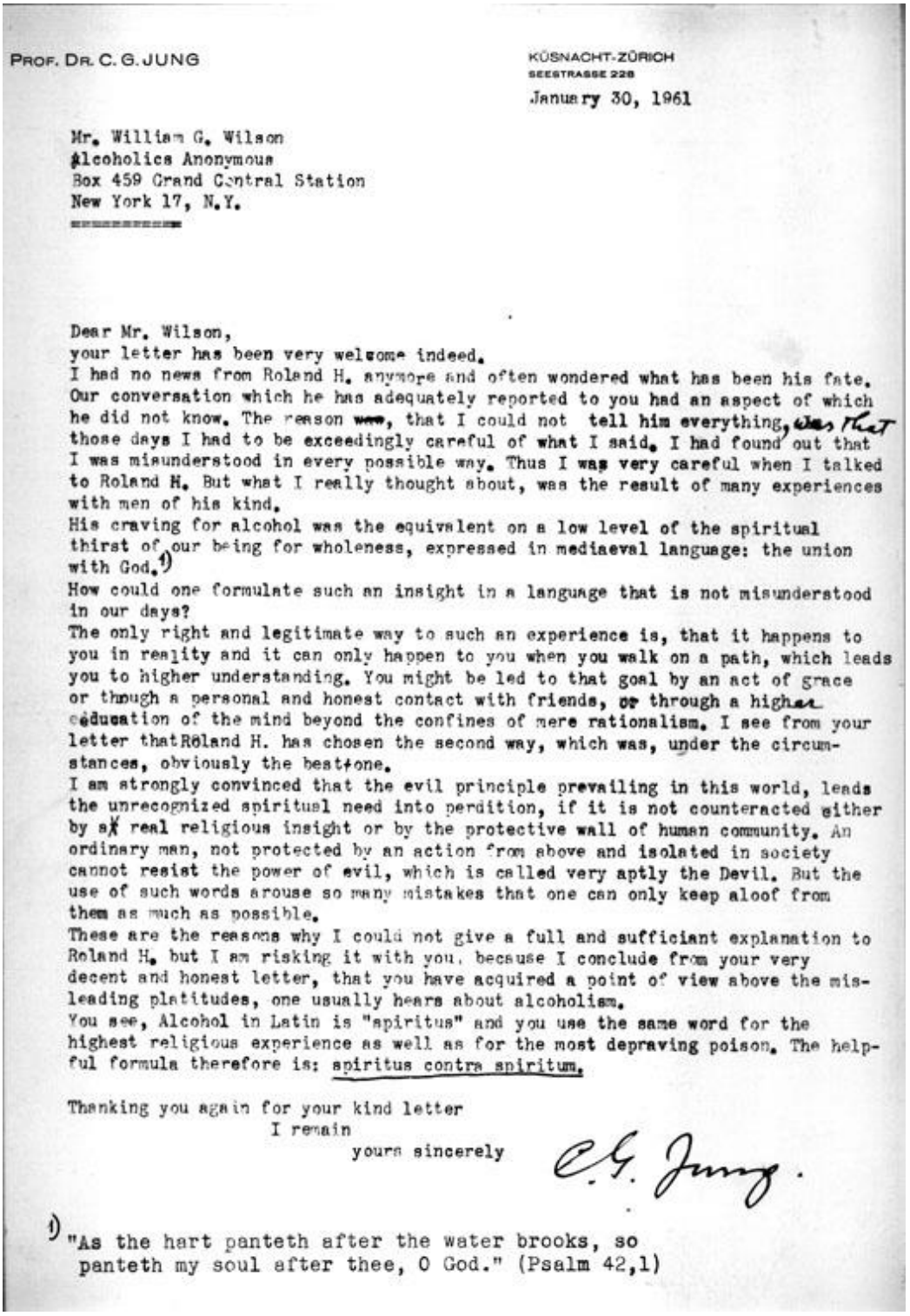
6. A.A. is concerned solely with the personal recovery and continued sobriety of alcoholics who turn to the Fellowship for help. Meetings are devoted exclusively to the A.A. program. No research which could interfere with this goal could be tolerated. Some groups have permitted questionnaires or interviews to occur after meetings provided that participation is on a personal, voluntary basis.

7. A.A. and its members are particularly concerned with anonymity. While most researchers are skilled at ensuring anonymity, A.A.'s concerns may raise unique issues. For example, as no A.A. can break the anonymity of another, there may be ticklish issues in soliciting cooperation from others. Some research procedures may also require extra precautions.

And, a final quote from Bill W. about cooperation with non-A.A.'s working to resolve the problems of alcoholism, "So let us work alongside all these projects of promise to hasten the recovery of those millions who have not yet found their way out. These varied labors do not need our special endorsement; they need only a helping hand when, as individuals, we can possibly give it."

We welcome additional information from researchers and from members of A.A. who have experience to share or comments to make.

Appendix 21: Letter from Carl Jung to Bill Wilson dated 30 Jan, 1961



PROF. DR. C. G. JUNG

KÜSNACHT-ZÜRICH
SEESTRASSE 228

January 30, 1961

Mr. William G. Wilson
Alcoholics Anonymous
Box 459 Grand Central Station
New York 17, N.Y.

Dear Mr. Wilson,
your letter has been very welcome indeed.
I had no news from Roland H. anymore and often wondered what has been his fate. Our conversation which he has adequately reported to you had an aspect of which he did not know. The reason was, that I could not tell him everything, was that those days I had to be exceedingly careful of what I said. I had found out that I was misunderstood in every possible way. Thus I was very careful when I talked to Roland H. But what I really thought about, was the result of many experiences with men of his kind.
His craving for alcohol was the equivalent on a low level of the spiritual thirst of our being for wholeness, expressed in mediaeval language: the union with God.[1]
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 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 a personal and honest contact with friends, or through a higher education of the mind beyond the confines of mere rationalism. I see from your letter that Roland H. has chosen the second way, which was, under the circumstances, obviously the best one.
I am strongly convinced that the evil principle prevailing in this world, leads the unrecognized spiritual need into perdition, if it is not counteracted either by a real religious insight or by the protective wall of human community. An ordinary man, not protected by an action from above and isolated in society cannot resist the power of evil, which is called very aptly the Devil. But the use of such words arouse so many mistakes that one can only keep aloof from them as much as possible.
These are the reasons why I could not give a full and sufficiant explanation to Roland H. but I am risking it with you, 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.
You see, 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.

Thanking you again for your kind letter
I remain
yours sincerely

C. G. Jung.

[1] "As the hart panteth after the water brooks, so panteth my soul after thee, O God." (Psalm 42,1)

Indices

Index 1. Details of all Participants

Group 1:

Participant ID	Interview Name used	Age (years)	Gender	Locations of residence over the last 10 years	Length of Sobriety (years)
Participant 1	Anne	51	Female	Spain	12
Participant 2	Arthur	53	Male	Wales	10
Participant 3	Alan	60	Male	England	9
Participant 4	Aidan	47	Male	Scotland	10
Participant 5	Amy	50	Female	Ireland	12
Participant 6	Adam	35	Anne	Spain	12

Group 2:

Participant ID	Interview Name used	Age (years)	Gender	Locations of residence over the last 20 years	Length of Sobriety (years)
Participant 7	Breda	60	Female	Caribbean/London	22
Participant 8	Brian	78	Male	Scotland	19
Participant 9	Ben	67	Male	USA/Ireland	20
Participant 10	Bart	65	Male	Lanzarote	20
Participant 11	Basil	60	Male	London South	22

Group 3:

Participant ID	Interview Name used	Age (years)	Gender	Locations of residence over the last 30 years	Length of Sobriety (years)
Participant 12	Charlie	67	Male	England	30
Participant 13	Colm	60	Male	Spain	30
Participant 14	Carl	66	Male	Ireland	30
Participant 15	Cyril	61	Male	Wales	32
Participant 16	Cathy	68	Female	Spain	30

Group 4:

Participant ID	Interview Name used	Age (years)	Gender	Locations of residence over the last 40 years	Length of Sobriety (years)
Participant 17	Denise	69	Female	Spain	39
Participant 18	Dan	76	Male	Ireland	38
Participant 19	David	65	Male	Scotland	40
Participant 20	Declan	66	Male	England	38
Participant 21	Des	62	Male	Wales	38

Group 5:

Participant ID	Interview Name used	Age (years)	Gender	Locations of residence over the last 50 years	Length of Sobriety (years)
Participant 22	Leo	93	Male	Europe	54
Participant 23	Luke	82	Male	Europe	50

Index 2. Participants who had been through a treatment Centre

Group 1:

Anne	N
Arthur	N
Alan	N
Aidan	N
Amy	N
Adam	**Y**

Group 2:

Breda	N
Brian	N
Ben	**Y**
Bart	N
Basil	N

Group 3:

Charlie	N
Colm	N
Cyril	**Y**
Carl	N
Cathy	N

Group 4:

Denise	N
Dan	N
David	N
Declan	N
Des	**Y**

Group 5:

Luke	N
Leo	N

Index 3. Years in recovery of years of significant instability indicated

Participant ID	Interview Name used	Year of 1st major instability	Year of 2nd major instability	Year of 3rd significant instability	Length of Sobriety (years)
Participant 1	Anne	5			12
Participant 2	Arthur				10
Participant 3	Alan	5			9
Participant 4	Aidan				10
Participant 5	Amy		8		12
Participant 6	Adam	3	8		12
Participant 7	Breda	6	9		22
Participant 8	Brian				19
Participant 9	Ben				20
Participant 10	Bart				20
Participant 11	Basil				22
Participant 12	Charlie				30
Participant 13	Colm	10	16		30
Participant 14	Carl				30
Participant 15	Cyril				32
Participant 16	Cathy	14	20+		30
Participant 17	Denise				39
Participant 18	Dan	10			38
Participant 19	David				40
Participant 20	Declan				38
Participant 21	Des				38
Participant 22	Luke				54
Participant 23	Leo				50

Index 4. Psychological states of participants before engagement with A.A.

Group 1: Name; Alcohol dependency related issues

Name	Alcohol dependency related feelings/emotional experiences
Anne	Very argumentative, Angry, bad tempered; Father & brother alcoholic
Arthur	Shyness, stuttered as a child then ostracized when alcoholism developed
Alan	Bullied at school, football hooligan, alcohol provided courage
Amy	Anger/temper; trust issues; alcoholic home
Adam	Rage, temper, law breaking, drugs, violent dysfunctional home
Aidan	Feelings of despair worry, insecurity – refused to talk about childhood

(Participants psychological state before joining a 12-step group; n=6)

Group 2: Name; Alcohol dependency related issues

Name	Alcohol dependency related feelings/emotional experiences
Bart	Both parents were alcoholic; "there was never any kind of love"
Basil	"I'm completely emotionless" – 17 years of therapy, 7 years of psychoanalysis and he continued to drink until joining 12-step group
Ben	Moved to US at 4, drank at 14. physical dependence was later followed by emotional dependence; "I was completely flat, affect-wise"
Breda	Lack of confidence, low self esteem, alcohol turbo charged life
Brian	Drinking alcoholically by 23 and got worse after marriage

(Participants psychological state before joining a 12-step group; n=5).

Group 3: Name; Alcohol dependency related issues

Name	Alcohol dependency related feelings/emotional experiences
Charlie	Mother alcoholic, father frequently absent.
Colm	Unhappy and unsettled as a child; felt lost as a child; frequent hospitalization
Carl	Constant family squabbles, felt he did not fit in at home or school
Cyril	At 16/17 yrs. old his father, sister and grandparents died; married following year –early and two more children followed shortly after
Cathy	Had to be the best at everything; Found it hard to hold a conversation with anybody; alcoholism developed after same-sex relationship broke up; binge drank until daily occurrence by mid 30's.

(Participant's psychological state before joining a 12-step group; n=5).

Group 4: Name; Alcohol dependency related issues

Name	Alcohol dependency related feelings/emotional experiences
Denise	Moved at 4, then fearful, shy, inhibited, felt stupid and inhibited, alcohol, drugs multiple other addictions.
Dan	Father violent alcoholic, poverty, stress, full of fear
David	Declined to talk about childhood/ early years
Declan	Declined to talk much about his childhood except to say, "I'd have a drink before I went drinking " He feels that that was a different life.
Des	Parents died when he was very young. Felt the lesser of two twins, felt shy, insecure & backward

(Participant's psychological state before joining a 12-step group; n=5).

Group 5: Name; Alcohol dependency related issues

Name	Alcohol dependency related feelings/emotional experiences
Leo	Brought up in a tea-total home. Happy childhood: Mother told him in later life he was a mistake, he shouldn't have happened; From day one" chasing the buzz"
Luke	Mother died very young; father away a lot; raised by grandparents; member of Pioneer Movement through college. Full of fear, shyness, and insecurity.

(Participant's psychological state before joining a 12-step group; n=2).

(i) General abbreviations

AA Alcoholics Anonymous AAI Adult Attachment Interview

APA American Psychiatric Association AUD Alcohol Use Disorder

DSM Diagnostic and Statistical Manual

ICD International Classification of Diseases

NA Narcotics Anonymous

WHO World Health Organization

(ii) Abbreviations used by participants

"Twelve-step" and "12-stepping" are terms deriving from the twelfth step of Alcoholics Anonymous (and other similar programmes) that states, "*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"* (AA, World Services, 2001, p.60). Details of how this may be done are set out in Chapter 7 of that book (pp. 89-103). It is the process whereby a person who is actively drinking/using may be approached and told there is a solution to their problem with alcohol/substance use through the programme; the member tells them how they did it themselves. The chapter starts with *"Practical experience shows that nothing will so much insure our immunity from drinking as intensive work with other alcoholics."* (AA, World Services, 2001, p.89).

"Big Book" is the name members use for the principal textbook "Alcoholics Anonymous" (2001).

"Doing service" or "service" is an integral part of the 12-step ethos. It can mean anything from preparing a room for a meeting, arranging a meeting, acting as Treasurer or Secretary, to representing a group at an Intergroup meeting (which coordinates groups within an area so that they do not send out mixed messages).

"Doing the steps" means going through each of the 12 steps sequentially with a sponsor in detail in the format laid out on pp.65-6 of the book "Alcoholics Anonymous" (AA, World Services, 2001). The sponsee is supposed to write a detailed account before the discussion with the sponsor.

"Group Of Drunks", "God" and "Good Order and Direction" are used interchangeably in AA.

“Front-line group” refers to a group that is singular in the way it approaches its meetings. There are many differing bases for this label e.g., the type of attendees (‘beginners’ or ‘old-timers’). Mainly, however, it means a group that remains focused on a particular Step, Tradition or AA topic - allowing only slight variation, and usually a speaker is time-constrained to a few minutes.

“Geographicals/geographics” is a term used to describe moving to a different place or country to get away from life problems. When used, it is to point out that the problems remain with the individual – no matter where they go – until they deal with them.

“Group sponsorship” is where a small number of members get together to discuss an individual problem and how they could deal with it.

“ISMs” is a term used by 12-step groups to describe the behaviours attached to alcohol dependence deriving from splitting the word *alcohol* and *ism*. Members believe they can still manifest themselves, even when not actively drinking or in recovery. It covers a diverse range of negative behaviours, such as ways of thinking, selfishness and self-centeredness. There are several colloquialisms for what it means, such as “I Sabotage Me”. This colloquialism is often used in association with the term “dry drunk”. It also draws on the WHO’s ICD-10 classification of diseases 1993 definition of addiction as cited by Crilly (2002, p.119):

“*A state of periodic or chronic intoxication detrimental to the individual or society, produced by the repeated consumption of a drug, characterized by an overpowering desire or need (compulsion) to continue taking the drug, because of either psychological or physical dependence on the effects of the drug, and a tendency to increase the dose or frequency of use.*”

“Prison service” is seen as a vital role in carrying the message of AA/NA that alcohol/drug abuse is the reason why many people are in prison. Prisoners, per se, could not set up a group in prison without a prison guard being present – breaching the twelfth tradition *“Anonymity is the spiritual foundation of all our traditions – ever reminding us to place principles before personalities”* (AA World Services Inc., 2012, p. 188). However, when an AA/NA member from outside a prison approaches a prison governor hoping to set up a

meeting within the prison, they are usually allowed to while in sight of, but not the hearing of, a prison officer. Many new members are recruited this way and go on to lead everyday decent lives when they are released.

“Sponsors” are members with several years of experience from whom a member may seek guidance or help. They are available 24 hours a day, seven days a week, but usually meet weekly at pre-determined times.

“Step meetings” are meetings that address a specific step of the 12 steps. The group usually addresses a step and then moves on to the next step at each subsequent meeting, week or month until all 12 are visited, and then they repeat the process. The focus is on how each of the steps works and impacts members. Generally, the discussion follows the subject as set out in the AA publication “*Twelve Steps and Twelve Traditions”* (AA World Services Inc., 2012).

“Open meetings” are meetings where non-members are allowed to attend, and the speakers usually include 1-3 active members, a member of Al-Anon and an addiction professional. Each speaker gives their perspective on alcoholism and recovery, and there is a question-and-answer session towards the end.

“War stories” are lengthy monologues given by alcohol-dependent people at a meeting describing, in detail, their drinking behaviour and careers. They are usually given by relative newcomers who are in the early stages of their recovery. “Long-termers” tend to find them repetitive and boring as they very rarely hear anything they have not heard before.

Table 42 *Table 1. Successful remittance rates by study (Spinelli and Thyer, 2017)*

Year	Study	Sample Size[a]	1 year	18 months	2 years	3 years	8 years	16 years
1976	Imber et al.	73	13%	n/a	n/a	n/a	n/a	n/a
1993	Sobell et al.	71	Participants recruited having already achieved a minimum recovery period of 3 years					
1994[b]	Timko et al.	123	16%	n/a	n/a	n/a	n/a	n/a
1995[b]	Timko et al.	118	n/a	n/a	n/a	17%	n/a	n/a
2000[b]	Timko et al.	78	n/a	n/a	n/a	n/a	25%	n/a
2005[b]	Moos et al.	99	n/a	n/a	n/a	n/a	n/a	24%
1995	Tucker et al.	18	Participants recruited having already achieved stable remission between 2–10 years					
1998[b]	Bischof et al.	178	Participants recruited having already achieved a minimum recovery period of 1 year					
2007[b]	Bischof et al.	167	n/a	n/a	67.6%	n/a	n/a	n/a
2000	Pukish et al.	18	Participants recruited having already achieved a minimum recovery period of 2 years					
2001	Booth et al.	623	11.5%	12.9%	n/a	n/a	n/a	n/a
2002	Kubicek et al.	6	Participants recruited having already achieved a minimum recovery period of 6 years					
2007	Mohatt et al.	21	Participants recruited having already achieved a minimum recovery period of 5 years					
2011	Klingemann	24	Participants recruited having already achieved a minimum recovery period of 2 years					
2013	Grella et al.	614	Participants recruited having already achieved a minimum recovery period of 1 year					
2013	Carballo et al.	16	50%	n/a	n/a	n/a	n/a	n/a

a Size of remitted, untreated sample
b Data reflects the same group over of participants over time.