"'How It Works': Social Relationships, Coping Mechanisms, and Abstinence in Alcoholics Anonymous"

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ABSTRACT

Andrew R. Payton: "'How It Works': Social Relationships, Coping Mechanisms, and Abstinence in Alcoholics Anonymous"
(Under the direction of Andrew Perrin)

For over three decades, research has consistently documented a causal relationship between social relationships and health. Despite this voluminous literature, we still have little idea of the underlying mechanisms through which social relationships operate. As a result, for nearly as long as this literature has existed, researchers have called attention to the need to explain *how* social relationships have their effects. However, such research has not been forthcoming. This research is critically important for designing effective interventions, which is especially significant because large-scale behavioral interventions designed to promote positive health outcomes have been largely unsuccessful. The present research attempts to step into this gap through an ethnographic study of Alcoholics Anonymous (AA). Based on detailed interviews with 59 members of eight AA groups, as well as observations over a one-year period, I attempt to document underlying processes through which members of AA groups achieve and maintain abstinence. My analysis suggests that AA groups can be profitably divided into two ideal types. One type of group focuses extensively on social support and network restructuring processes and appears to excel with early abstinence efforts. Another type of group focuses less on these processes in order to turn attention to helping members develop a repertoire of coping strategies. These latter groups appear to excel with long-term

abstinence efforts. My research therefore reveals significant cultural processes underlying the socialization of members into AA and isolates and explains how and why specific stress moderating resources function as explanatory mechanisms in the link between social relationships and behavioral change. This suggests that stress moderating resources identified in the stress process paradigm offer precisely the mechanisms that have been sought after in the call to understand how social relationships have their effects. It therefore offers specific mechanisms that may be particularly fruitful in the design of effective interventions and explains the underlying rationale. The present research also suggests the need to add complexity to how we conceptualize and model behavioral change and the concomitant interventions since they may require multiple mechanisms at different stages of the change process.

TABLE OF CONTENTS

LIST OF TABLES

Table

CHAPTER 1

BACKGROUND

Theoretical Overview

Social Relationships, Health, and the Absence of Underlying Mechanisms

Research consistently documents a causal relationship between social relationships and health (for recent reviews see Cohen and Janicki-Deverts 2009; Ertel, Glymour, and Berkman 2009; Taylor 2007; Uchino 2004; Umberson et al. 2010). This expansive body of literature traces its contemporary origins to work linking social integration and networks to health outcomes such as mortality (Berkman and Syme 1979; Cassel 1976; Cobb 1976). This stream of research can also be traced back to the very origins of sociology in Durkheim's classic work on the social sources of suicide, particularly social integration (Durkheim [1897] 1997).

However, despite a large body of research demonstrating this relationship, research has neglected to pay close attention to the underlying processes through which social relationships have their effects. For over three decades, researchers have consistently called for an investigation into the underlying processes, i.e., *how and why*, social relationships actually work to pattern health (see, e.g., Cobb 1976; Cohen and Wills 1985; House et al. 1988; Thoits 1995; Kawachi and Berkman 2001; Uchino 2004; Cohen and Janicki-Deverts 2009). In fact, the social sciences in general have become

increasingly interested in specifying pathways and understanding underlying mechanisms, as opposed to demonstrations of causal association (see Hedstrom 2005 for an excellent recent review and attempt). Nonetheless, such research, particularly in the domain of social relationships and health, has not been forthcoming.

The stakes are no small matter. As numerous researchers have pointed out, understanding underlying mechanisms is vital if we want to design effective interventions (see, e.g., Gottlieb 2000; Heller et al. 1991a; Heller et al. 1991b; Kawachi and Berkman 2001; Seeman 1996; Thoits 1995). Otherwise interventions can only be "…ad hoc in design and hit-or-miss in their effects" (Thoits Forthcoming).

This absence is particularly striking because the stress process, which constitutes an enormous body of literature, provides compelling theoretical mechanisms linking social relationships to health (Thoits Forthcoming). The stress process, as a whole, provides a theoretical framework for understanding how acute, chronic, and/or repeated strains lead to negative health outcomes (Pearlin 1981). Stress is conceived of as fundamentally social in nature because stress exposure arises out of the contexts of people's lives (Pearlin 1989). A classic example of the social origins of stress is the increased rates of stress exposure due to minority or low socioeconomic (SES) status (Dowd and Goldman 2006; Turner and Avison 2003; Turner et al. 1995; see Link and Phelan 1995 for an introduction into the enormous body of literature on the social origins of health more generally).

Biological research helps explain the underlying physiological processes through which stress has its effects (see Uchino 2006 for an excellent review), or, put differently, how environmental factors "get under the skin" (Taylor, Repetti, and Seeman 1997).

Generally speaking, stress exposure is thought to have a "weathering" effect on the body (Geronimus 1992; Geronimus et al. 2006). Persistent exposure to elevated levels of stress gradually takes a toll on the body and, over the course of years, and decades, slowly begins to manifest itself in poorer health outcomes. Research in this area often relies on the concept of "allostatic load" to explain how biological processes, such as elevated cortisol and/or epinephrine levels, can have short-term benefits (e.g., the classic "fight-or-flight" survival mechanism) yet long-term consequences (McEwen 1998; McEwen and Stellar 1993; McEwen and Seeman 1999; Seeman et al. 1997). The link between stress exposure and health outcomes is incredibly well-documented (see, e.g., Avison et al 2007; Cohen et al. 2002; Karlsen and Nazroo 2002; Lloyd and Turner 2008; Mooy et al. 2000; Turner and Avison 2003; Vitaliano et al. 2002).

Though there is an important social basis to stress exposure, and biological processes can be used to explain the etiology, individuals differ in how they experience and deal with stress exposure; causation occurs across levels of analysis (Glass and McAtee 2006). This individual-level variation suggests social psychological resources, or mechanisms, that might emanate from social relationships and mediate and/or moderate the harmful effects of stress (Pearlin 1981). These resources are thought to be the primary site for locating what it is about the substance of social relationships that has effects on health yet little research has been done in this area (Thoits Forthcoming).

A number of possible mechanisms exist within the conceptual model offered by the stress process paradigm. Coping is a central mechanism in the stress process and is typically defined as "behaviors that individuals employ on their own behalf in their efforts to prevent or avoid stress and its consequences" (Pearlin 1999). Coping consists of

both coping resources and coping strategies. Coping resources include personality characteristics such as self-esteem (Taylor and Stanton 2007; Thoits 2003; Turner and Lloyd 1999; Turner and Roszell 1994) and mastery/self-efficacy (Bandura 2001; Mirowsky and Ross 2003; Taylor and Stanton 2007; Taylor et al. 2003; Turner and Roszell 1994; Turner and Lloyd 1999). "Resources… reflect a latent dimension of coping because they define a potential for action, but not action itself" (Gore 1985: 266). Coping strategies can be divided into problem-focused (which target the stress-inducing problem directly), meaning-focused (which focus on changing the meaning of the situation to make it less threatening), and emotion-focused strategies (which target the emotional reactions that accompany the stress-inducing problem, for example, through venting or avoidance) (see, e.g., Lazarus and Folkman 1984; Thoits 1995). Research rarely looks at the interplay between coping resources and coping strategies, particularly in terms of treating personality characteristics as dependent on coping efforts (Thoits 1995).

Social support is another major social psychological resource in the stress paradigm that might be useful in explaining what it is about social relationships that matters for health. Social support is often divided between structural support (e.g., the number of ties and/or the interconnectedness of those ties) and functional support (which focuses on the provision of meaningful aid) (Cohen et al. 2000; Cohen and Wills 1985). Functional support is traditionally divided into instrumental support (e.g., help with tasks), informational support (e.g., advice), and emotional support (e.g., listening to the other person and giving them the sense that they are loved) (Lin and Wescott 1991). Functional social support is often conceptualized in terms coping assistance, suggesting that social support might be thought of as the interpersonal application of coping

strategies (Thoits 1986). Perceived social support is an especially robust predictor of health outcomes (for reviews, see Bolger and Amarel 2007; Uchino 2004, 2009). Other mechanisms closely related to social support include providing a sense of belonging (Barrera 2000; Berkman 1995; Cobb 1976; Thoits 1985; Uchino 2004) or mattering (Berkman et al. 2000; Brissette et al. 2000; Cohen 2004; House et al. 1988b; Rosenberg and McCullough 1981; Uchino 2004; Umberson 2010), and social control (Berkman et al. 2000; Cohen 1988; House et al. 1988b; Uchino 2004; Umberson 1987; Umberson 2010). Few studies examine the actual influence of social relationships on these underlying processes with the aim of understanding how and why these mechanisms might operate to have their effects on health.

Many of these mechanisms are thought to operate primarily through their effects on health behaviors (Kaplan et al. 1994; Thoits Forthcoming; Uchino 2006). Health behaviors are thought to explain about 40% of premature mortality (McGinnis et al. 2002). Understanding how social ties affect health behavior is highlighted in "Healthy People 2010," the U.S. government's statement regarding plans to improve the health of all Americans (U.S. Department of Health and Human Services 2000). The link between social relationships and health behaviors, just as with social relationships and health more generally, is not entirely straightforward. The effects of social ties are thought to have counterbalancing effects (see Umberson et al. 2010 for an excellent review). Briefly, the issue is that relationships with others can be a source of support, as well as encouraging bad habits or acting as a source of immense stress (e.g., the caregiver role). As such, the total effects of ties are widely considered to be much larger than estimates tend to suggest

because the effects occur in contradictory directions and thus suppress the total contribution.

While not the focus of the present research, one area in particular where there has been some effort to connect social relationships through stress moderating resources to health is the religion-health literature. The link between health outcomes and religion is fairly well-established at this time (see Idler et al. 2003; Pargament and Cummings 2010 for introductions to this field). The effort to connect religion to stress moderating resources, however, is less well-established. Much of this literature mirrors the larger social relationships and health literature in that the links are hypothesized but not tested outright (for reviews, see Ellison 1994; Ellison and Levin 1998; George et al. 2002; Idler et al. 2003; McCullough and Willoughby 2009). In the very few cases where researchers have attempted to test mechanisms the results have been mixed, inconsistent and, at best, suggestive (see George et al. 2002 in particular). The religion-health literature is therefore strikingly similar to the larger social relationships-health literature in that mechanisms, and the need to study them, have been identified but the relationship exists mostly in theory. Why, and especially how, the mechanisms underlying relationships actually have their effects on health remains poorly studied; we need a much clearer picture of what these processes actually look like.

Alcohol Abuse and Dependence, Alcoholics Anonymous, and a Growing Interest in Mechanisms

Much like the religion-health literature, work in the field of alcohol abuse and dependence (AAD), and specifically in the study of Alcoholics Anonymous (AA), has begun to take this challenge more seriously in recent years. Given the hypothesized links between social relationships, coping, and behavioral change, studies on AAD and AA may be a natural site to assess the processes through which social relationships have their effects. AAD and AA are also much more proximally related to interventions, which may explain the heightened interest in understanding underlying mechanisms within the AAD and AA literature. To the extent that we can draw any conclusions, albeit tentative ones, from the religion-health literature, finding parallels between the AAD literature and religion literature offers very compelling evidence that these processes may be generalizable beyond their specific cases to social relationships more generally.

AAD studies are an important body of research in their own right. Alcohol has been found to be causally related to more than 60 medical conditions (Rehm et al. 2003) and a dose-response relationship exists for many, if not most, of these relationships (Room et al. 2005). An estimated 4% of the global burden of disease is attributable to alcohol. To put this into perspective, this effect size is comparable to the morbidity and mortality attributable to tobacco or hypertension across the globe (Room et al. 2005). An estimated 85,000 deaths (3.5% of all deaths) in the U.S. were attributable to alcohol-related causes in 2000. Roughly 70,000 of these deaths were not attributable to alcohol-related motor vehicle accidents. These remaining deaths were due primarily to alcohol poisoning, chronic liver disease, and cirrhosis (Mokdad 2004). Lifetime prevalence of alcohol abuse and dependence are estimated at 13.2% and 5.4% of the total adult population in the U.S., respectively. Alcohol dependence is second only to major

depressive disorder in lifetime prevalence of a single disorder and the prevalence of alcohol abuse is roughly comparable to that of generalized anxiety disorder (Kessler et al. 2005).

The study of AA is also an important literature of its own. AA was founded in 1935 by "Bill W.," a stock broker, and "Dr. Bob," a physician. AA defines itself as "…a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism" (Alcoholics Anonymous 2002). AA is mutual-aid program free of charge, run by its own members, and open to anyone who feels they have a problem with alcohol; its focus is on complete and continuous abstinence from alcohol. The organization traces its origins to the Oxford Group, an Evangelical Christian organization founded in the 1920's (Kurtz 1979) though it is not allied with any denomination. It is, however, a "spiritual" program that places emphasis on a "higher power" (also referred to as "God as you understand him").

It is estimated that there are more than 117,000 groups and over 2,000,000 members in over 180 countries. Roughly 1,265,000 members (60%) live in the U.S. (Alcoholics Anonymous 2006). The program's basic text, *Alcoholics Anonymous*, commonly referred to as the "Big Book" because the first edition was printed with a large typeface that literally made it large in size (Kurtz 1979), has sold nearly 30 million copies in more than 50 languages. For comparison, this puts its sales on par with books such as *To Kill a Mockingbird*, *The Very Hungry Caterpillar*, and *Le guide Michelin France* (which is published annually). This is despite the fact that the book is available free, in its entirety, in English, French, and Spanish, online at the organization's website

www.aa.org. AA is often referred to as a "12-Step program" because of its development of and reliance on a 12-Step model of recovery (see Appendix A for a list of the 12 Steps of Alcoholics Anonymous). This model has been applied to a number of other problem behaviors such as compulsive eating (Overeaters Anonymous), gambling (Gamblers Anonymous), and drug use (Narcotics Anonymous).

AA is the most frequently sought resource for problems related to alcohol in the U.S. (Room and Greenfield 1993). An estimated 90% of private substance abuse and dependence facilities in the U.S. are based on 12-Step principles and roughly half of the remaining 10% incorporate these principles along with other approaches (Roman and Blum 1998). The largest public treatment system in the U.S., the Department of Veterans Affairs (VA), relies heavily on a 12-Step model of recovery. Nearly 80% of VA patients are referred to AA post-discharge (Humphreys 1997).

Traditional studies of AA can be divided into two rough camps. The first, which is more characteristic of sociological studies of AA, and also far less common in the literature, focuses on the identity transformation process that occurs in AA. This body of research investigates the ways in which AA successfully relabels the deviant alcohol abuser, or alcoholic, and reincorporates him or her back into society (Denzin 1987; Trice and Roman 1970). Research has paid particular attention to the role of storytelling and the use of metaphor in the identity transformation process (Cain 1991; Davis and Jansen 1998; Humphreys 2000; Rappaport 1993). This process is thought to act similarly to a meaning-focused coping strategy in that it ascribes new meaning to past suffering (Steffen 1997). The second line of research, which captures the lion's share of research on AAD and AA, studies the efficacy of AA in its own right and relative to other

treatment modalities (e.g., cognitive-behavioral therapy (CBT) and motivational enhancement therapy (MET)).

Early research on the efficacy of AA is often criticized for its poor study quality (see Groh 2008; Kelly 2003; Kownacki and Shadish 1999; Tonigan et al. 1996). These studies find that AA attendance is associated with long-term abstinence, though it is often unclear whether respondents might do just as well with other forms of therapy due to underlying self-selection issues surrounding motivation to change (Room et al. 2005). One problem that characterizes all studies of behavioral change is the sheer difficulty of the task. Relapse levels are extremely high across the board (Polivy and Herman 2002); even AA's own estimates suggest 50% of newcomers drop out within the first three months (Alcoholics Anonymous 2008).

A second wave of research has been more convincing. This body of research has focused primarily on comparative efficacy studies. The most rigorous and best designed random control trial, Project MATCH, tested Twelve-Step Facilitation (TSF; importantly, this is not involvement in AA itself, but the application of the principles of the program as a form of treatment) versus CBT and MET. The results of this research suggest that TSF better promotes abstinence, particularly if continuous abstinence is the measure, and that patients with more severe dependence and less severe psychological problems have better outcomes with TSF versus other treatments (Cooney et al. 2001; Project MATCH Research Group 1997). This research also suggests that AA is especially effective for people whose social network includes a large number of heavy drinkers. Follow-up analysis suggests that AA attendance post-treatment was the primary predictor of continued abstinence (Project MATCH Research Group 1998), and this was true

regardless of initial treatment modality (Tonigan et al. 2003). This suggests that regardless of initial treatment modality AA involvement is an important predictor of long-term abstinence. The other study often credited as a "best of" is a large project in a naturalistic setting conducted by the VA. This research found that patients treated in 12-Step programs were more likely to be abstinent at a 1-year follow-up than those treated with CBT or an eclectic program that combined various philosophies and practices (Ouimette et al. 1997).

This body of research has been extremely important for advancing our understanding of AAD treatment; however, researchers in the field of AAD treatment have begun to criticize it as well. Though understanding the effectiveness of various forms of intervention has been important to the field, researchers are becoming increasingly interested in understanding the underlying processes driving their effectiveness (Huebner and Tonigan 2007). The problem within this literature, then, is identical to the problem identified in the social relationships literature. Despite clear evidence linking treatment to outcome in the AAD literature, researchers know little regarding *how* these various forms of treatment have their effects (Longabaugh and Morgenstern 1999; Morgenstern and Longabaugh 2000). Again, understanding underlying processes emerges as critical to designing effective interventions. The growing realization of the need for this line of research led the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to develop a "Mechanisms of Behavior Change Initiative" in 2005, develop a funding mechanism in 2006, and implement this funding stream beginning in 2007.

Though this body of literature is small and hard to draw firm conclusions from, it has taken the absence of knowledge regarding mechanisms more seriously than the social relationships literature. At the same time, this literature complements the social relationships literature because it relies on the stress process to conceptualize underlying mechanisms linking treatment to outcome. At the broadest level, researchers typically conceive of AA as "working" by altering the coping resources, particularly self-efficacy, coping strategies, and motivation of participants, and by facilitating changes in network composition (Humphreys et al. 1994; Kelly et al. 2009). Tentative evidence suggests that 12-Step groups work through enhancing coping resources and coping strategies (Connors et al. 2001; Humphreys et al.1999; Morgenstern et al. 1997; Tonigan 2003) and motivation (Kelly et al. 2002). In particular, sponsorship, reading the literature, and working the steps have been found to be correlated with abstinence (Owen et al 2003). Social support is thought to be a particularly important mediator because newcomers rid themselves of pro-drinking influences and gain access to role-modeling and coping assistance (Kaskutas et al. 2002). Other research suggests that getting a sponsor, developing 12-Step friends, and reading literature are important for maintaining abstinence early in recovery, but working the Steps is not (Kelly and Moos 2003; Tonigan and Rice 2010). Alternatively, it may simply be that these processes change commitment to abstinence, which then predicts outcomes (Kelly et al. 2000; 2002). One important implication of this research is that common stress process mechanisms may be responsible for the success of AA rather than its specific content (Kelly et al. 2009). The task of understanding underlying mechanisms has been elusive, however, and one reason may be the modeling, which has been criticized for being restricted and over-simplified

(Longabaugh 2007). Such research has therefore done more to model underlying mechanisms but the results can only be described as tentative and mixed and they still give us little understanding of how and why these mechanisms have their effect. This latter deficiency may, in fact, explain the results have been mixed.

Research in this area is very promising yet it is only in its early stages and represents a small minority of research on AAD and its treatment. Put simply, there is growing interest in understanding the mediators of the AA-abstinence link but the underlying processes are not well understood. Results are tentative and, at times, contradictory because research on basic mechanisms has been slow to surface, just as with the social relationships literature. AAD research seems to have a sense of where to look but has only just begun to investigate mediating factors and, as with the social relationships literature, has barely scratched the surface in terms of understanding *how* the underlying processes have their effects. Little is known substantively about how aspects of AA, such as working the Steps, sponsorship, and reading the literature, might actually work to produce outcomes.

Other issues with AA studies are less well recognized. There is a strong tendency in studies of AA to treat AA as homogeneous (Horstmann and Tonigan 2000; Montgomery et al. 1993). The effects of this are hard to predict but it is reasonable to assume that the beneficial effects of AA may depend on the group, and the match between individual and group. Also, very little is known about the processes involved in maintaining long-term abstinence. Traditionally, studies focus on how AA involvement affects changes in alcohol-related behavior at 1, 3, and 6 month intervals. The best research designs study a 1 or 3 year window. Yet roughly half of AA members have been

sober for over 5 years (Alcoholics Anonymous 2008) and most attempts at behavioral change fail, be they AAD or otherwise. This suggests the need to study factors that keep people coming back and that result in long-term success (Kelly et al. 2009). Again it is hard to predict in advance, but the abstinence mechanisms may also shift at different stages of the recovery process. Research also often fails to distinguish between attendance and involvement (Owen et al. 2003), particularly aspects of involvement such as sponsorship and working the Steps (Montgomery et al. 1995), opting instead to study the low-hanging fruit of attendance. This may be an important distinction to make when assessing AA's efficacy. Finally, research tends to take a very narrow perspective on abstinence outcomes, assessing only abstinence itself and not other measures such as quality of life.

To summarize thus far, the social relationships and AAD literatures have extremely close parallels and appear to inform one another in important ways. Both point to the need to study mechanisms, both point to the stress process to as a means to do so. Additionally, the social relationships literature suggests behaviors may be central to understanding the link between the stress process and outcomes while the AAD literature focuses specifically on behaviors. However, both still languish in their ability to account for underlying processes. Missing from accounts of both the social relationships and AAD literatures are accounts of the underlying processes, or mechanisms, through which affects are to be found. The AAD literature has begun to look at mechanisms but only in a small number of studies and those appear to not dig deeply enough. Absent is a detailed focus on the underlying processes in order to understand how it is that mediating/moderating resources in the stress process work to have their effects. This

absence suggests the need to pay attention to the actual substance of what is occurring in these relationships and how these processes are connected to individual's behaviors.

The deficiencies in the AAD and AA literature are thus reflective of larger issues in the study of the social relationships and health behaviors. Large-scale behavioral interventions intended to promote positive health outcomes have been largely ineffective (Susser 1995; Glass 2000; Relman and Angell 2002). Perhaps the most pervasive explanation for this failure is the lack of attention to how social context shapes behavior (McKinlay and Marceau 2000). It has been said that researchers have become "prisoners of the proximate" (McMichael 1999). In essence, researchers have focused on detailing associations and generating complex methods for determining causality while neglecting the study of what gives rise to the relationships (i.e., the underlying mechanisms or processes) and how outcomes are embedded in social context. In a particularly instructive critique of the current state of the art, Glass and McAtee say, "…the processes that give rise to the social patterning of risks remain poorly described and understood… We need better theory, and better data, to understand how social factors regulate behaviors, or distribute individuals into risk groups, and how those social factors come to be embodied" (2006: 1651). In short, the intersecting literatures on social relationships, health behaviors, and AAD all share in common a lack of attention to the underlying mechanisms through which outcomes emerge and this deficiency appears to have undermined our ability to intervene in health outcomes.

Cultural Sociology, the Study of Mechanisms, and a Growing Interest in Health

Health researchers have undoubtedly attempted to incorporate culture into their models; however, they have yet to incorporate the sophisticated conceptualizations of culture offered by contemporary cultural sociologists ("culturalists"). Typically, health researchers conceptualize culture in terms of race/ethnicity (see, e.g., Brown et al. 1999) or cultural capital (e.g., Abel 2007; Abel 2008; Malat 2006). The problem with such approaches is that they over-simplify how culturalists understand culture and in doing so they do little to help us understand the underlying processes. At the same time, culturalists have rarely paid attention to the work that has traditionally defined the field of health and illness. Cultural sociology and the sociology of health and illness tend to be very disparate fields of inquiry and rarely communicate with one another.

This situation may be changing. Recently, a small group of prominent researchers have called attention to this lack of communication and have attempted to bridge the divide (Hall and Lamont 2009; Helman 2007). Such work attempts to lay the foundations for research at the intersection of culture and health. Implicit in this research is the notion that cultural sociology may offer a way to get at the underlying mechanisms that are of increasing interest to health researchers. This is not to suggest cultural sociology is *the* way; rather, it may provide useful theoretical fuel.

Current cultural sociology conceptualizes culture as a system of ideas, meanings, and mental representations (so-called "cultural repertoires" [Swidler 2001]) that simultaneously enable, guide, and constrain the behaviors of individuals. Recent thinking in cultural sociology suggests that culture works by providing structures for interpreting and participating in social life through defining rules, strategies, and resources. Culture is

therefore a repertoire of resources and guidelines that simultaneously enables and constrains behavior. At its base, then, cultural sociology offers a theory of behavior (Swidler 1986); it offers a theoretical perspective for understanding how people act. To paraphrase Michele Lamont, one of the premiere culturalists in the field and a trailblazer in the culture-health connection, the range of possible behaviors for a given person is circumscribed by the repertoires made available to that person and therefore what their repertoires are and whether or not and how these repertoires facilitate or constrain action is critical to understanding behaviors (Lamont 2009).

These insights have led culturalists to the study of process and mechanisms. Sociologists increasingly realize that all action involves cultural interpretation and that "where meanings vary across actors, cultural interpretation may generate more explanatory specifications of mechanisms" (Gross 2009: 373-374). Cultural sociology is, in essence, increasingly viewed as a way to get at the "black box" of how social relationships translate into behavior through in-depth analysis of how cultural repertoires emerge and have their effects. As such, it may offer an important lens into the underlying processes through which social relationships have their effects.

Present Research

Contribution

To characterize entire bodies of literature in a few short words undoubtedly obscures diversity. Nonetheless, the above review suggested that the social relationships

and AAD literatures have spent considerable energy studying whether or not things work (i.e., what works) and not *how* and *why* they work. This seems perfectly intuitive to my mind. First you survey the field in order to assess what works, and then you focus more closely on figuring out the underlying processes that account for the what. AAD researchers are ahead of social relationships researchers on this hypothesized trajectory. Thus far, AAD researchers have taken it more seriously but progress has nonetheless been minimal. What appears to be needed is basic research targeted at understanding these underlying processes in order to explain how the things we know to have effects actually have the effects that they do. I have suggested that cultural sociology may have a valuable contribution to make toward this end.

The present research is an attempt to fill this gap. In my analysis, I target coping as a particularly important site for investigating the underlying processes through which social relationships operate and draw on the theoretical orientation of cultural sociology to aid in this task. The study of coping has its roots in clinical psychiatry and psychology and therefore is often treated as an individual disposition occurring in a contextual vacuum (Pearlin 1999). As a result, we know very little about the social contexts of coping, and yet it is thought to be a key mechanism linking social relationships to health. This suggests to me fertile grounds for research: coping is implicated at the individual level and at least partly determined by contextual factors, and is also thought to be a key component of the positive effects of social relationships yet little work has been done in this area. Others have pointed to coping as particularly crucial research target because it is seems to offer the clearest site for intervention in the stress process (Taylor and Stanton

2007). Coping is a key piece of the puzzle because it is importantly linked to behavior and helps us understand how individuals actually achieve behavioral modification.

The principle question that preoccupies the present research, and that has plagued the study of the link between social relationships and health for decades, is how do individuals help other individuals cope? We need to have a better understanding of how other people shape how an individual responds to stressors, and ultimately shapes their behaviors. The question therefore begs for an account of the underlying processes through which other people have their effects on a given individual's ability to cope with stress, and thereby on their behaviors. I have suggested that, theoretically, the problem requires a behavioral theory that gets at processes underlying the stress process, and that cultural sociology may offer such a bridge. My aim is to use insights from cultural sociology to inform an ethnographic study of coping as I try to understand how social relationships produce coping strategies and how these coping strategies then operate to have effects, using Alcoholics Anonymous as a case.

In the chapters that follow, I attempt to systematically work through this task. Chapter 1 introduces the reader to the AA groups studied within this research project. It immediately breaks with other studies of AA by calling attention to significant heterogeneity among the groups and attempts to classify these groups into two types. At the heart of this chapter is the suggestion that long-term abstinence is a key indicator of group type and to give some indication as to underlying processes that characterize the differences between group types. These processes are reading the literature and working the Steps with a sponsor. Chapter 2 more fully explores these underlying processes attempting to understand how they have their effects. Crucial to this chapter is the

suggestion that these processes generate a repertoire of coping strategies for members. Chapter 3 then explores this repertoire of coping strategies produced through reading the literature and working the Steps with a sponsor. It seeks to understand how members actually put this repertoire to use in order to achieve and maintain abstinence. Finally, the Conclusion offers a brief discussion of how the work in these substantive chapters relates to the issues and gaps outlined in this introduction attempting to explain how the research helps move our thinking forward in a number of important ways.

Methods

The data in this study are based on an ethnographic study of Alcoholics Anonymous. Throughout the chapters that follow, I draw primarily on in-depth, semi-structured interviews that I conducted with 59 members of Alcoholics Anonymous in eight different AA groups (for an average of roughly 7.5 members interviewed per group) in a large metropolitan area over the course of approximately one year. Questions within the interviews elicited data on the background characteristics of members, their experience with the recovery process and struggles with abstinence, and group-level dynamics, as well as other subject matter (see Appendix B for the interview schedule; see Chapter 1 for more information on the groups I observed). These questions were developed a priori based on my initial questions and hypotheses and then evolved as I immersed myself in the population. Interviews averaged approximately 90 minutes in length (minimum 49 minutes, maximum 144 minutes) for roughly 5,300 minutes of

interview data. At times, I also draw on AA literature such as the Big Book, extensive observations made while attending meetings of Alcoholics Anonymous, and informal conversations with members over the course of this roughly one year period.

The sample design was structured to maximize variation while minimizing potential breaches of anonymity. IRB approval for the protection of human subjects was sought and obtained through the University of North Carolina at Chapel Hill. Samples were drawn specifically from individual groups and only among "home group" members of a given group. A given individual only has one home group and in order to formally become a home group member an individual simply states their desire to join the group and then provides their contact information to that group. An underlying expectation of being a home group member is that, first and foremost, the member will regularly attend meetings of the group and, secondarily, will contribute to the continued functioning of that group (e.g., helping set up chairs before the meeting, cleaning up after the meeting, chairing a meeting, etc.).

Groups and individual respondents were based on a snowball sampling method. A key liaison within the AA community in the area of study put me in touch with a member of one of the AA groups that I studied. From there, this member put me in touch with members of other groups, who in turn put me in touch with members of other groups, who in turn put me in touch with members of other groups. After finding someone to serve as an introduction into a particular group, I then had that individual speak with their home group members to assess potential interest in participating in my research. No group refused to participate. I was then invited to attend a meeting of the group. Typically, I was introduced to group members before and/or after the meeting and after

being introduced we usually had a brief conversation where I explained the nature of my study in broad terms and answered any questions that they might have. They then provided me with their first name and last initial, and contact information. Subsequently, I contacted these individuals and scheduled an interview at a time convenient to the respondent and at a place where the respondent would feel comfortable. By far the majority of interviews were conducted in coffee shops; the respondents own home was the next most popular location.

Through this process no individual or group refused to participate, though some members undoubtedly opted to not volunteer. I was unable to schedule a very small number of interviews (four) because I was never able to contact an individual to set-up an interview after repeated attempts to do so (three to four tries). Nonetheless, I have no reason to suspect that this systematically biases my sample in some way. As the data presented in Chapter 1 suggest, my sample consists of a broad range of members and groups. Given the size of several of the groups in my sample, I attempted to conduct interviews with a sample of group members that represented a cross-section of that group: new (6 or more months of abstinence, in order to minimize harm to the population) and old (the oldest respondent had 53 years of continuous abstinence), black and white, male and female, single and married, young and old, etc. Throughout the process, I also attended additional meetings at a number of the groups both in and out of the sample in order to better familiarize myself with the program itself and to assess whether or not the interview data seemed to conform to what I saw in the meetings themselves and in groups more generally. In keeping with AA norms and in order to preserve anonymity, I operated on a first name and last initial basis with virtually every

member of the program. When this was violated, it was done so willingly by members themselves without any prompting on my behalf. The names of all groups and individuals throughout this project have been anonymized in order to protect their anonymity.

Limitations

Based on my ethnographic approach, my research is necessarily suggestive in nature. The data I draw on place natural limitations on my claims-making abilities. I do not have a representative sample of the U.S. population, nor of the AA population most likely. I did not follow individuals longitudinally over time. This study is nested at the group level making selection effects entirely possible. Ultimately, my argument is based on an observed association between abstinence outcomes and the underlying processes that characterize different kinds of groups. It could be that some groups appear to better promote abstinence because they only welcome those who already have long-term abstinence. Or perhaps groups with long-term abstinence kick out newcomers in order to appear "better." My observations could be particular to my sample. (Though, of course, I have no reason to suspect that any of these possible explanations are the case.) Causal inference and generalizability are indeed problematic when marshalling the kind of ethnographic evidence that I have.

The following ethnographic research is therefore not an attempt to test whether or not AA works, or the extent to which it works. It is also not meant as a direct assessment of whether or not some kinds of AA do better than others. These are undoubtedly

important questions and I am personally interested in them; however, the purpose of the present research is not to answer these questions. It may speak to these issues and I may, at times, attempt to offer suggestive insights related to these questions, but answers to these questions are ultimately beyond the scope of the present work. Instead, this project is an investigation into mechanisms by which AA, and social relationships more generally, do their work. It is an attempt to use ethnographic means to dig deeply into a single case, Alcoholics Anonymous, in an effort to begin to elucidate long sought after but elusive underlying processes through which social relationships might pattern health behaviors.

Taking an ethnographic approach has a number of strengths that are intimately related to the express purposes of the present research. After spending roughly a year with the population attending meetings and interviewing members, I have gained a very intimate knowledge that is simply not possible with other methodological approaches. Such access is not routine for most populations, particularly one such as AA that is *founded* on anonymity. I have necessarily sacrificed breadth for depth. I have done so because understanding underlying mechanisms (i.e., how social relationships actually operate to have their effects) is the kind of question that is not easily answered by other means. It is, in essence, a question of *Verstehen* (i.e., loosely, "understanding" or "interpretation").

This is not to suggest that it is impossible to assess mechanisms through quantitative approaches. I make no such claim. My claim is that in order to do so it is first necessary to have an understanding of what to look for. To put it simply, an ethnographic approach such as the present is designed to point to future directions of research giving

researchers leads on where to follow up with additional analysis. It is meant to inform causal analysis, pointing the way toward new lines of inquiry and/or specific areas to target research. Perhaps the best analogy is to a reconnaissance mission.

Such an approach is necessary because, as discussed above, research at present has done an excellent job of documenting the causal association between social relationships and health but has failed to understand what gives rise to these relationships. There is little need to tread the old ground; it has been done repeatedly, with increasing sophistication, for over three decades. What is missing is an in-depth examination of how and why this association exists. This is a different kind of question and with it comes different methods, different tools, for answering the question. What is required initially, I maintain, is a close investigation of underlying processes through an initial ethnographic approach such as the one taken here.

It is my sincere hope that the present research generates insights that are amenable to causal analysis. As the AAD and larger health behavior literatures make clear, the prevailing research is not enough if we want to design effective interventions. Efficacy rates for behavioral change are depressingly low and large-scale, well-designed interventions (at least based on the prevailing insights we have into interventions and behavioral change) have been spectacularly unsuccessful. If we want to design better inventions, and thus raise efficacy rates, then we need to understand the underlying processes at work. To do so we must first take a microscopic lens to the issue in order to delineate the processes through which effects might be found. We need to move beyond the observation of causal association to an understanding of how cause produces effect. I argue that an ethnographic approach is the place to start and hope that doing so will

eventually produce better outcomes by enabling us to better design treatments through a detailed understanding of the underlying mechanisms through which such outcomes are produced.

Though the ethnographic approach taken here cannot definitively "prove" any argument, I nonetheless make every effort to logically connect the underlying processes that I discuss to the outcome of interest. I draw on direct quotes from members that are meant to serve as exemplars of what I encountered repeatedly during the course of my research. My hope is that the analysis in the succeeding chapters will present a compelling explanation of variation in abstinence outcomes by detailing underlying processes, or mechanisms, through which these outcomes likely emerge.

In summary, my goal is ultimately exploratory in nature. I seek to understand the underlying processes through which social relationships pattern health and to demonstrate how differences might matter. Volumes of research have tested the association between social relationships and health, whereas virtually no research has sought to investigate the underlying mechanisms and build theory on how these processes operate. The present research should therefore be complementary to the existing body of research, building theory that opens up new avenues for testing and introduces greater complexity to previous models. Along the way I hope it also reveals important insights into the nature of AAD and its treatment, and Alcoholics Anonymous in particular.

CHAPTER 2

A CLOSER LOOK AT AA GROUPS

Introduction

There is a nearly universal assumption, at least implicitly, that AA groups are homogeneous.[1] To clarify, it is well-known that specific AA meetings, and even groups, target special populations such as women- or men-only groups, groups for homosexuals, groups for Hispanics, etc. However, despite a difference in focus, AA is treated as a "McDonaldized" institution,[2] wherein participation in a group in Albuquerque, NM is virtually identical to a group in Kalamazoo, MI, much less in the same community. Distinguishing between groups and seeing them as an important source of variation is unheard of in the research community and AA itself promulgates the stance that AA is the same everywhere. In fact, the homogeneity of AA is thought to be one of its greatest strengths, and is championed by the organization itself.

In this chapter, I provide an introduction to the Alcoholics Anonymous (AA) groups that I studied in the course of my research. This chapter challenges the notion of homogeneity among groups, a fact that is apparent to the individual member. It suggests

[1] Montgomery et al. (1993) are an important exception, though their call for more attention to differences among AA groups seems to have gone unheard.

[2] Rizter 1993.

instead that there is marked variation at the level of the individual group even within the same community. In the section that follows, I introduce the groups in my sample and discuss a basic fault line upon which AA groups in general can be classified. Importantly, I note that perceived social support appears to be constant across these groups. Instead, my research suggests that amount of long-term abstinence is a key indicator of differences among groups. This, however, is not an explanation in and of itself.

I then seek to complicate the picture, suggesting that groups with higher levels of long-term abstinence tend to be less attractive to participants, particularly the newcomer. Subsequently, I provide an initial sense of the practices that might account for the differences among groups. This sets the stage for a closer investigation into group-level differences in subsequent chapters. Ultimately, my purpose is to attempt to account for the processes underlying these group-level differences and in doing so to come to a better understanding of the mechanisms through which (i.e., how and why) social relationships, and AA, have their effects.

Heterogeneity in AA Groups

The Presumption of Homogeneity

Research typically treats AA as a monolithic entity. The program is the same the world over, or so the research, and AA, suggest. My subsequent analysis rests on the basic insight that groups differ systematically, and then seeks to explain how it is that they differ. In doing so, it seeks to provide directions for future research regarding how

social relationships affect health. In the following paragraphs I explain why I believe the presumption of homogeneity exists.

First and foremost, AA itself makes claims of homogeneity. It maintains that anyone can go to a meeting anywhere in the world and they will find the same program at work. In a sense, this is true. Most meetings look and sound very similar, often conforming to stereotypical images of AA meetings, though many diverge as well.

More often than not, meetings occur in churches. As you approach the building people are often congregating outside chatting and smoking prior to the start of the meeting. When you entering the meeting space, the rooms are often dimly lit and/or use fluorescent overhead lighting, though sometimes they are bright with lots of natural light. You see people casually conversing and sitting quietly. People hug and shake hands. Some look happy to be there while others look rather dour, even miserable. Fresh pots of coffee are in the back and free of charge. Sometimes light snacks such as cookies are provided as well.

The AA literature is also consistent. The 12 Steps are displayed somewhere in the room. It is also easy to spot AA-produced pamphlets. These pamphlets cover a wide range of topics giving a brief introduction to various aspects of the program. The Big Book is also there, consistent across every group. The same basic ingredients for "working the program" are therefore consistent across all meetings and groups of Alcoholics Anonymous: the 12 Steps, the Big Book, and AA pamphlets.

Furthermore, meetings sound extremely similar. At the opening of the meeting, the chair introduces him or herself, "Hi, my name's Bob and I'm an alcoholic." "Hi, Bob," everyone answers in unison. Then several documents, or "readings," are read from

the AA literature. Every group reads several of the exact same documents and most groups read only those documents, though some include additional readings such as a brief statement about their group. Before the meeting begins in earnest, members also recite the Serenity Prayer in unison. “God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference,” you hear and find yourself repeating.

At this point any given meeting may take one several different forms but even these different formats are consistent across groups. Most common are discussion and speaker meetings. In discussion meeting either the chair brings a topic related to AA and abstinence or will solicit a topic from the participants. At that point, participants will go around the room sharing stories of their own that relate in some way to the topic under discussion, though it does not have to. And though I make the point subsequently that meetings vary considerably, even what you hear people discuss in a discussion meeting sounds very similar from one group to the next, at least to the untrained ear. In a speaker meeting, someone, often the chair, will introduce the speaker who will then spend roughly 45 minutes telling their story. The narrative is taken directly from the Big Book and always consists of “what you were like, what happened, and what you are like now.” At the close of the meeting additional readings are read, a basket is passed around for members to voluntarily donate money, often a dollar. The meeting usually closes with everyone standing up, forming a circle, holding hands, and reciting the Lord’s Prayer. Members then variously mingle and chat, clean up, close down, and/or leave. Sometimes members go out afterwards to a local restaurant, diner, or coffee shop, or even to another meeting.

The differences, therefore, are not immediately apparent, particularly to the outsider. All groups rely on the same literature and look almost identical experientially. The things they discuss even sound similar to the casual observer. Even after accruing considerable experience, I had no clue what kind of group I was in after a single meeting; by and large, it is impossible to know. Most obviously, a single meeting may not be indicative of the kinds of meetings that typically occur. Were I to rely solely on observations within the meetings, it would have taken me much longer to identify differences among groups. It was only through immersion into the population, and especially through in-depth interviews with individuals, that subtle differences began to emerge. It is one thing to walk into a meeting and observe and quite another to repeatedly ask probing questions over the course of an hour and a half with multiple members of a given group. Based on these factors, it should be unsurprising that homogeneity is the presumption. It is only through the sort of in-depth ethnographic approach offered here, which is highly uncharacteristic, that such differences can initially be illuminated.

Alcoholics Anonymous Groups in Focus: Two Ideal Types

Table 1, "Descriptive Statistics of AA Groups in Sample," provides basic information about the demographic characteristics of the eight groups studied in my research. The first column lists anonymized names of these groups: "Rigorous Honesty," "Unity," "Recovery," "Traditions," "Big Book," "Serenity," "Willingness," and

"Surrender."[3] The second column lists the number of years that each group has been in existence. Each of my groups is relatively well-established, having been in existence for more than five years. Column three lists the number of home group members in a given group, both as a raw estimate and in terms of the number of "active" members. An "active" member is a home group member that, at a minimum, regular attends meetings of the group (see the Introduction for more information on home groups). In the groups that I studied, the share of active home group members is consistently between one-half and two-thirds of total home group members. Conversations with individual members suggested that this is accurate for virtually every group. Subsequent columns become much more important for the purposes of the present research.

Column four lists the mean number of perceived sources of social support both in terms of total available support and sources of support that members regularly turn. Members were asked, "How many members of the program would you say you *could* turn to for support?" I then followed up by asking, "How many members would you say you *regularly* turn to for support?" The median fits almost perfectly with the mean and, interestingly, group size appears to be uncorrelated with perceived support. Across all groups, members consistently suggest that they have between 20 and 30 members that they could draw on for support (at times after first saying they could draw on anyone in the program), and that they regularly turn to between three and five of those members. One of these three to five members included their sponsor (all members I interviewed had sponsors). This is important because it suggests that, in my sample, perceived support is a constant and thereby cannot be used to explain the differences among groups, at least in

[3] While it would not surprise me to learn that there are many groups out there that bear these anonymized names, or even groups in the area in which my data collection took place, these names have been anonymized and therefore do not correspond to any of their actual names.

and of itself. If support matters, thinking of it structurally (e.g., in terms of low numbers to high numbers) oversimplifies how the relationships matter and does not explain group-level differences.

Column five lists the number of members with long-term abstinence according to two estimates of long-term abstinence. These estimates are a share of, rather than in addition to, the estimate of total members (column three). Two estimates are provided because there is no single agreed-upon definition of long-term abstinence within the AA community. Early in my interviews, and almost without fail, I would ask a respondent how many of their members have long-term abstinence and they would reply, "What do you mean by long-term abstinence?" I would then respond, "Tell me how you would define it and then how many members conform to your definition." After repeating this process with a number of early respondents, 10+ years and 20+ years emerged as normative definitions of long-term abstinence. In subsequent interviews I therefore asked respondents to provide me with their definition of long-term abstinence and then asked them to provide estimates based on the 10+ and 20+ norm if they had not already done so. Variation in definitions of long-term abstinence depended almost entirely on the number of years of abstinence of the member being interviewed (i.e., the more years of continuous abstinence a respondent had the higher the definition of what constituted long-term abstinence). In my sample there is considerable variation in terms of the number of members with long-term abstinence in a given group, ranging from almost no long-term abstinence (by either definition) in some groups to a majority in others (depending on the definition).

The data in columns two, three and five (number of years in existence, number of (active) members and number of members with long-term abstinence) were gathered by asking a number of questions of each respondent in each group[4] and answers did not always perfectly correspond across respondents. A definitive answer was therefore not always possible. I used two strategies to derive these estimates. First, I attempted to "triangulate" an estimate based on the spread of responses. The estimate is not a simple mean in such instances, however, as I gave additional weight to responses that clustered tightly around a similar value. Put differently, if lots of members roughly agreed and one member had a wildly different estimate then I ignored the outlier. Second, under most circumstances I privileged certain respondents as "expert witnesses." In the case of estimates of number of years in existence (column two), a number of my respondents were founding members of the group and therefore were able to name the specific year, or even date, in which the group was founded. In the case of estimates of number of (active) members (column four) and number of members with long-term abstinence (column five), a number of my respondents were able to produce a list of group members and thereby provide a count of their membership. Having the list in front of them also gave them a better sense of how many of those members were active and the years of abstinence for the members of their group. Through the combination of these two strategies, I was able to obtain relatively precise estimates, particularly given the population under study and the emphasis on anonymity at the level of the individual, group, and organization. Groups are organized according to percentage of active members with 20+ years of abstinence as this seems to be the clear "gold standard" when trying to determine what constitutes a group with a high level of long-term abstinence. In

[4] See Introduction and Appendix B for more information on study design and implementation.

most cases, using the 10+ standard does not impact the ordering and, even then, doing so would not impact column seven, which I explain below.

Column six provides a conservative estimate of the percentage of active members with long-term abstinence in a given group using each definition of long-term abstinence. This is a conservative estimate because where number of members with long-term abstinence (the numerator) is a range I use the minimum value and where number of active members (the denominator) is a range I use the maximum value. For instance, "Rigorous Honesty" has 5 to 6 members with 10+ years of abstinence among 10 to 12 total active members. I therefore calculate their percentage of active members with 10+ years of abstinence as 5/12, or 42%.

Columns five and six are extremely important. In my effort to understand the processes underlying group-level differences, the data in these columns suggest long-term abstinence varies at the level of the individual group. These data therefore serve as an indicator of underlying processes at the level of the group and suggest that variation in long-term abstinence is nested, at least in part, at the level of the group rather than depending entirely on the individual. It is here that the fault line separating AA groups emerges.

Column seven categorizes each of the groups according to a division that I argue can be used to distinguish among all AA groups: "structured" versus "social" groups. The term structured comes directly from the respondents themselves. It suggests, in their mind, that the group is deliberately focused on working the Steps and all that this entails (a key point in subsequent analysis). Since groups are realized in their meetings, being structured also means an emphasis on a particular kind of sharing within meetings.

Though this aspect of being structured is not central to my claims, it is addressed subsequently in this chapter. More importantly, however, is that, for structured groups, the meetings serve as a place for alcoholics to find a sponsor that will get them engaged in the Steps. Social groups, on the other hand (and as their name suggests), revolve less around the Steps and more on the social benefits of AA. The term social is not one that the groups themselves use; rather, it is a term I employ to highlight what I perceive as the key benefit of these groups. In social groups, members focus on developing a new peer network devoid of drinkers, and on a spirit of camaraderie and what I refer to as "feel-good" support. The distinction between structured and social groups is not a zero-sum game. Structured groups foster lasting friendships among members and are a powerful source of social support (as evidenced by column four in Table 1) but, as I spell out below, in doing so they appear to sacrifice inclusiveness.

Turning again to Table 1, it should immediately be clear that there is a pattern between long-term abstinence and type of group. The groups that tend to be structured tend also to have more long-term abstinence, both in absolute terms and as a proportion of total members. The remainder of this chapter attempts to account for this basic pattern in order to begin to understand the underlying processes through which group differences emerge and thereby to point to additional work to be done in subsequent chapters, and in future research.

The Problem of Structured Groups

As I have already hinted (and as the sub-heading suggests), the differences among groups are not as straightforward as they might first appear. Structured groups are not universally better at providing social support (or the perception that it exists), as Table 1 suggests, and, as I suggest in this section, many members, especially newcomers, often see structured groups as a off-putting. The defining feature of structured groups, I argue, is their heavy emphasis on working the Steps and reading the Big Book with a sponsor. The next chapter focuses more closely on what this means and why it might be an important difference between groups. In this chapter, however, I make some suggestive remarks and call attention to this difference in order to complicate the story.

Many participants, especially newcomers, actively dislike or even denigrate (in private) structured groups. Members I interviewed that belonged to social groups never openly attacked a structured group during the course of my interviews; however, many of the members of structured groups expressed knowledge of distaste or even animosity toward their group and its kind. I was also witness to it on one occasion while attending an "eating meeting" (i.e., where members of the group host a potluck and serve dinner prior to the start of the meeting) at a structured group. While quietly enjoying my meal and waiting for the meeting to begin, I overheard three individuals seated next to me, whom I knew to be non-members because of my intimacy with the group, quietly discussing their issues with the group. They thought the group was "weird," did not like the way "they take themselves so seriously," and thought they were "nitpicky."

Viv C.[5] suffered from a codependent alcohol/crack addiction for a number of years, one that she shared with her husband. Eventually she decided to deal with her

[5] As mentioned in the Introduction, the names of individuals, along with the names of groups, have been anonymized.

crack addiction so her and her husband “lived in different parts of the house” for an extended period of time. When she first quit she “didn’t see [her drinking] as a problem.” After all, she was able to hold a job, pay the bills, and otherwise maintain some semblance of normalcy. Before long she realized that her problem with alcohol required attention as well. In fact, she realized that it had been a problem long before she began using crack. Viv C. found her alcohol dependence much more difficult to address than her crack addiction. Subsequently, her husband overcame his crack addiction and realized alcohol had long been a problem for him as well. Both turned to AA and have made remarkable progress.

Viv C. used to belong to a social group in the area before transitioning to “Recovery,” a structured group. She had a “slip” (i.e., she broke her abstinence) after more than a year of abstinence. When she slipped, she was attending a social group.Viv C. is therefore able to offer valuable insight into the perceptions of structured groups on the part of non-members. During the course of our interview, she offered the view of her current group, “Recovery,” from the perspective of the outsider, i.e., her former, social group, which is located nearby: “I heard people talking about the group I'm a part of now and a lot of people say they're like ‘Big Book thumpers.’ A lot of people, I don't want to say they don't like the group, but, umm, they don't want all that stuff.” The term “Big Book thumper” is clearly a derogatory term, much like “Bible thumper,” and suggests that members of structured groups are too focused on the Big Book. Perhaps they are too “serious” and “nitpicky.”

Another respondent whom we will meet in more detail subsequently, Laura, used to attend a structured group “on the extreme end of structure.” She moved and now

attends the less structured, yet still undoubtedly structured, Recovery with Viv C. Laura said many referred to her old group as a “Gestapo group,” a undoubtedly derogatory term, because of the emphasis they placed on studying and adhering to the Steps of the program.

Mindi H. described herself as child as “intelligent,” “friendly,” “outgoing,” and “sheltered.” When she hit puberty she began to suffer from self-esteem issues. At age 12 she started to drink as a means to cope, she said. When Mindi H. first began to drink she “felt cool” and “rebellious.” However, it quickly became a double-edged sword. She said she “…alternated between feeling like I'm cool, this is cool, and the, umm, depressive symptoms like, you know, alternating from being really happy to, umm, hating myself and starting to cut myself and burn myself and make myself throw up.” She described her adolescence as “a huge, like, Dr. Jekyll and Mr. Hyde sort of situation.” The Dr. Jekyll and Mr. Hyde analogy is an extremely popular one among alcoholics. When asked how she sees herself now she responded, “I see myself now as a successful, contributing member to society and, umm, a participating member in my family, of course in my home group. I have a career, a husband, a family; I go to prisons, treatment centers.”

Mindi H. is a member of “Big Book,” another structured group in my sample. She used to attend “Willingness,” a social group in my sample, and therefore is another important source of information on the differences between the two. She reiterates the point made by Viv C. that structured groups can be a turn-off while expanding the point in an extremely important way. After asking Mindi H., “How would you say your group is in terms of helping the newcomer achieve abstinence?” she responded, “I'd say, umm, we get less of a success rate [than some other groups] because a lot of people don't like

the structure and the conformity, umm, a lot of people like a more lax environment." Mindi H. thus suggests that structured groups actually perform *worse* at helping the newcomer achieve abstinence. The strong emphasis on close adherence to the Steps, both in terms of the discussion in meetings and in individual sponsorship outside meetings, can be very off-putting. As a result, newcomers are significant less likely to declare "Big Book" as their home group, she suggests. The "more lax environment" of the social group is more appealing to the newcomer.

Tim N.'s recovery story is characteristic of what an outsider might expect to find in AA yet very atypical in my many interactions with members. Tim N. was a soldier in Vietnam and described himself as an "agitator" of the racial tensions within the military during this time. After returning to the U.S., he slowly lost everything due to his alcoholism. He became unemployable and spent several years of his life homeless. His was the story of the Vietnam vet brought to homelessness by addiction. Through Alcoholics Anonymous, Tim N. was able to completely turn his life around. He now has a career, a family, and over 30 years of abstinence. Tim N. spells out the point made by Mindi H. more clearly than I ever expected anyone would do:

> "It looks like to me, at the risk of being a little bit bold with this, it looks like to me if you want to paint with a broad brush today, people approach AA in two basic ways; there are two major approaches going on. One is the man or woman that's socialized into the kind of AA that says put these principles first in all of your affairs and you will stay sober and everything else will come along…. The other way people approach AA, it's a lot more, it looks better to the uninformed, is figure out all the areas where they're leaking and plug 'em up and the drinking will go away. That kind of AA where somebody, where people go bring up a problem and the whole meeting is taken up with that, can look a whole lot more attractive than what we're offering."

Tim N., with this statement, reinforces and clarifies the point made by both Viv C. and Mindi H. The environment of the social group is more appealing at the outset, they

suggest, because the heavy emphasis on the Steps can be very intimidating or off-putting for the newcomer with little prior exposure. More attractive is the emphasis on bonding over common problems.

When I first began to attend meetings as part of my research, I was made to feel extremely welcome in structured groups (in fact probably more so, on average, than in social groups), but it nonetheless felt more foreign than social groups because of the greater focus on the specifics of working the program. In social groups, on the other hand, struggles with not drinking and the stressors of daily life tend to be more of the focus of conversation inside the meeting. It often simply sounds like people openly sharing their problems. This is easier to relate to. Whether or not we have problems with alcohol we all experience stress, we all get angry or agitated. After repeated observation there are, therefore, subtle differences in what you hear in meetings of the two kinds of groups. The focus on common problems, my research and experience suggests, brings forth the most appealing aspects of social groups: a sense of belonging and new friendships that do not revolve around drinking. I discuss these issues in the next section.

The Benefits of Social Groups

Members of both social and structured groups place tremendous value on developing a new network and a sense of belonging. One of the "Three Legacies" of the program is unity (the other two being service and recovery, the latter of which highlight working the Steps with a sponsor). In AA, unity highlights the "fellowship" aspects of the

program. Fellowship centers on developing friendships and a sense of community and belonging with the other members of the group and program. Members describe the Three Legacies as a three-legged barstool, each equally necessary for an individual to "stand" in abstinence. Friendships and belonging are, therefore, perceived to be an integral aspect of working the program. While structured groups are no stranger to fellowship, fellowship is a key focus in social groups, and it is for this reason that I label these groups *social* groups.[6] I argue that social groups are best defined by their primary emphasis on fellowship (i.e., on bringing people together and making them feel welcome and a part of) and therein lies their appeal.

Eric I. grew up in a rural part of the country where alcohol was not legally available. Instead, people in his county relied on bootleggers. He said, "…as long as you had money and knew somebody that had a car you could drive up to the window and buy whatever you want." He started drinking at the age of 13 and he and his friends camped out a lot so they could drink uninhibited. Eric I. drank for decades and at one point it got so bad that he, like many others, hid his drinking from his spouse. He explained, "…on the sly I started mixing the wine with 101 proof vodka. Vodka and red wine still looks like red wine so nobody was the wiser." As time went on, he said, "I'd hide it in shampoo bottles in the shower, in the wheel well of the car, anywhere. And, uhh, at night, when my wife was fixing dinner I'd fix one glass of red wine and I would go in the basement, pull out the bottle in the wheel well and just chug-a-lug as much as I could then go back. Or I'd have it hidden somewhere in the bedroom or bathroom." As he entered later life and his drinking progressed, and because he hid his drinking, his family began to worry

[6] While structured groups is a self-designated term there does not seem to be a standard name for what I refer to as social groups. Some members of structured groups referred to them as "unstructured" but this was rare and, furthermore, is not very descriptive.

for his health. He would call someone and not remember he called them five minutes later. He would stumble into walls. Was it Alzheimer's? Had he had a stroke? He had tests done that revealed no problems. Only he knew what the problem was but he had to play along lest the true problem be discovered. He explained that this went on for many years "until my wife, for once, came downstairs and caught me as I had the trunk open and a fifth of Wild Turkey turned up."

Eric I. is a member of "Serenity." Serenity is a social group that has been gradually increasing its degree of structure over the past year or more. It was, however, still quite social in nature during the interview period. During the course of our conversation I had the following exchange with Eric I.:

> "*Me: What would you say is the most important part of the program?*
> Eric: Fellowship. I think it's very important. Having someone, whether it be my sponsor, or a lot of people use their group.
> *Me: Does AA do more than just help you maintain abstinence?*
> Eric: (long pause) Well, uhh, it's given me a lot of new friends and acquaintances.
> *Me: Another way to think about this: Do you get more out of it than just not drinking?*
> Eric: Yeah, relationships with other people. I've been able to, that's one reason I like to come. There are people here that I think of as friends."

Eric I. immediately identifies fellowship as key to the program. Having someone to lean on and identify with is *the* reason he participates in AA and attends Serenity. Once Eric I. makes this point, I then try to push him to identify other aspects of the program, perhaps those that members of structured groups commonly point to as important. When members of structured groups were asked about the most important part of the program, they consistently identify recovery as most important (a point that I return to subsequently since it appears to be a key source of variation between group types). My repeated probes, however, fail to elicit any additional benefits. Eric I., after struggling to come up with something more, simply repeats his emphasis on developing friends as crucial to his

participation. He gives us a sense that the social aspects of social groups are the basis of their appeal.

Shawn G., early 30s, a lawyer, very gregarious, found the program at a young age. Growing up his father was involved in sales so he traveled a lot. Otherwise Shawn G. feels he had a very normal and happy childhood. He characterizes himself as very curious by nature. As an example he said that he remembers when the D.A.R.E. officer came to speak to his class and said something like, “If you use drugs you might hallucinate and see a tiger in the next room,” he was more interested than afraid. (After telling this story he is quick to point out that (a) he is in no way pointing the finger at D.A.R.E. and (b) “[He] understands today what it means to have hallucinations and be paranoid, and it's not fun.”) Shawn G. was only active in his addiction from ages 15 to 19 but by his senior year he said, “Man, I was hooked,” using every day. After graduating from high school he went to college that August. He was back in his parents’ home by October of that same semester. He went to a treatment center and then to AA meetings but it was not until several months later, when he was involved in a car accident while drinking, that he “finally made a decision to be real about AA.”

Shawn G., is a member of Recovery, a structured group. Recovery is his third home group. Early in his recovery he moved and the move forced him to switch from a different structured group to a social group. His experience as a home group member of both structured and social groups gives him valuable insight into the allure of social groups. He elaborates on Eric I.’s point helping to explain the appeal of the fellowship:

> “From what I know about AA one part has always been social: hang out with family and friends, not just always be real serious and study the literature. A lot of times we'll take newcomers with us to show them, ‘Hey, look, you can have fun and be sober. You don't just have to go to meetings all the time.’ Certainly the social aspect,

> ya know, one of the things I thought when I first got sober is that I'm never going to have any more fun. I only had fun when I was drinking or doing drugs. So it can serve a very good purpose. To let new folks know that abstinence is not all boring and glum, we have a lot of fun too."

Though addiction brought Shawn G. to a state of misery, he suggests that as a newcomer he struggle to imagine how he might enjoy himself without the use of alcohol, again the double-edged nature of the addiction expressed by Mindi H. Part of the explanation for this sentiment is likely because the alcoholic struggles to envision life without alcohol in general, while another part is likely because of alcohol's place as a "social lubricant." Regardless, here Shawn G. stresses the fact that AA does not have to be all work and no play. Members attend meetings and study the literature but they also engage in other, social activities with one another. Shawn G. associated drinking with fun and had a hard time understanding how someone could go into social settings and not drink. The social aspects of the program therefore enable the alcoholic to have fun without alcohol. It is a form of re-socialization that teaches the alcoholic how to engage others and have a good time without drinking.

Nina, late-20s, doctoral student, sober for seven years, had "two pretty insane parents" and switched schools a lot growing up. From age 14 to 16 her family life got really bad. During this time she was offered the opportunity to move to France and enroll in public school there so she took it, even though she had no knowledge of the French language. Her alcoholism, as with many other people in the program, progressed gradually but she says by the age of 15 she had already written in her journal, "I'm an alcoholic." It would, nonetheless, be a number of years and a co-dependent alcohol/crystal meth addiction before she found her way to AA.

Nina is an unusual case in my sample. Though part of a social group, "Willingness," she has strong ties to structured groups and works the program differently than many members of social groups. Prior to attending Willingness, Nina lived elsewhere and attended a more structured group. Her sponsor is also a member of a structured group in the area. In fact, she said she attends her current group because she sees it as an opportunity to be of greater service. She said she joined the group because she thought it needed her help; they "need [her] more." The group has come a long way since she joined. Despite these factors, Nina is thinking about joining a more structured group. Nina, echoes Shawn G.'s point, focusing on the sense of a community that she finds in her social group:

> "It gives me a community that I can exist in that doesn't revolve around going to bars. To go to a new place where you don't know anyone and your only friends are the people in your [graduate] program with you and they want to go to bars and drink and they want to do it all the time and that's how they're going to socialize, which is fine, I love going out with them and having a good time, but if that was my whole life I couldn't do that, no way. So it's nice to have this community that I can go to where I know alcohol is not going to be around and I know I'm not going to have to think about it. Nobody's going to want to go to a bar and hang out for 6 hours when you're not drinking. I gotta tell ya, when you go to a bar for 6 hours and you're not drinking it gets boring, really boring. You have to stand up the whole time, you get tired. I'm so old. Anyway, so that's a main thing, just community."

The sense of community was especially important to Nina as she transitioned to graduate school. It enabled her to find a network of like-minded individuals that she could socialize with in settings conducive to her interests and abstinence. If you were trying to maintain abstinence and your only social circle was a group that liked to frequent bars then your abstinence, or your participation in that social circle, would likely not last long.

Tara, like many other respondents, had a normal childhood. She described herself as shy, quiet, and insecure growing up. She said she "came from a very stable home." Her

parents were “always very supportive and nurturing and gave [her] a lot of opportunities so from that perspective everything always looked great.” However, as she described for me, “inside I always felt like I didn’t deserve any of it or that I wasn’t worthy of it or that I wasn’t the person they thought I was, that I was bad and that they were going to find out one day and not love me anymore.” Alcohol was her reprieve from herself, at least for a time. After years of extremely heavy drinking, one morning, at age 24, Tara decided to make a change.

Here is how Tara described it: “I think I had been drinking for 24 hours straight, it was 9 in the morning, I’d been up all night, and I had a meeting with the therapist at 10.” (Recognizing her misery, she started seeing a therapist many months prior but she had yet to be completely honest about the severity of her drinking.) As she drunkenly staggered home, she explained to me, “I didn’t want to go home to my apartment and face the reality of what my life had become. And so I knew that day I couldn’t do that again. I can’t, I can’t see that truth one more time. And so I knew that I was going to kill myself.” She continued, “But then I remembered that I had my appointment and my therapist said this day was going to come so I thought, ‘Why don’t I go to my therapist and talk to her about it?’ And I did. And, umm, I don’t know why. I was right at that fork in the road and I could’ve gone either way and I don’t know what made me go that way but I did.” She has not had a drink since that bleak time a number of years ago.

Tara is also an important case because she initially belonged to the social group Willingness but is now a member of a structured group, Big Book. Tara draws on her own experience with early recovery to make the case that developing a new social circle can be extremely important for maintaining abstinence. As she explains:

> "I spent my entire first year of abstinence in a relationship with a guy and I didn't make any other relationships outside of that relationship in AA in any way. And so when that relationship ended I realized how easy it would be for me to just slip away because I didn't have anybody. And that was a very dangerous place to be."

Luckily, Tara came to this realization before she relapsed, but the danger was nonetheless very real for her. By integrating herself more fully into the community and the social aspects of Alcoholics Anonymous, Tara found a buffer against relapse.

During the course of our conversation, Tara also spelled out the initial attraction of social groups while also giving a vague sense that something was missing:

> "Big Book wasn't my first home group. The group I used to go to is a really social meeting, a lot of young people go there, umm, but, well, and that's why I joined it. I was like, 'I can relate to these people and so I should join it.' I didn't look at what this group was about or how they were giving back that's not how I made the decision. I needed friends really, that's what I needed. It was the sort of environment where everyone would hang out outside before the meeting and then go in and have the meeting and then go back out and hang out some more and then go out together. It was very social. Umm, so it served its purpose."

Tara therefore emphasizes the important role that a social group played in her recovery yet she also hints that this role is limited in scope. She says the social aspects of Willingness were very appealing to her and provided her with a platform to make new friends. However, she concludes by saying "it served its purpose." The social, in Tara's view, is therefore only one piece of the puzzle. Despite clear reasons for the attractiveness of the social aspects of AA, Tara suggests that the social aspects alone are not enough.

Last is David I. Like Shawn G, he took to the program at a very young age. There were a lot of young people in the program in the area in which I studied, more than in most places I suspect, but the number of young persons in AA continues to expand, as

does the total membership.[7] Though only in his early 30s, David I. has nearly 16 years of abstinence. David I. started drinking at age 12 whenever he could get his hands on something. Once he entered high school and access became less of an issue, his drinking "progressed really quickly." By age 16 he was skipping school regularly and staying out until all hours of the night. Sometimes he would never come home. It was around this age that his mother, father, and stepmother had an intervention and gave him an ultimatum: He either had to get evaluated for alcoholism or he was on his own.

David I. is also an important case. He began his AA career in a structured group then when he made a geographic change he joined the social group "Surrender." At the time of our interview, David I. was planning to leave Surrender and join a more structured home group. David I. adds additional weight to the point made by Tara regarding the initial attractiveness yet insufficient scope of social groups:

> "[AA's] a great place to meet people and develop friendships. I feel like I can move to anywhere in the country and probably the world and have a group of people to associate with right off the bat and be able to develop good friendships with some of them in a very short time. So there's a fellowship aspect to the program as well and I think a lot of people that show up at AA, I think that's what they focus on first. And I think it's important but to me the main focus of the program is the recovery part."

David I. states point-blank that the fellowship is attractive but inadequate. As David I. and Tara both make clear, the social aspects of the program are often the initial stimulus that draws people in and commands their attention. They add to this point, however, that while the social aspects of AA serve a purpose, there is more to the program. David I.

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7 Young people in AA are also networked through ICYPAA (pronounced like "Icky-pa"), the International Conference of Young People in Alcoholics Anonymous, which at present has conferences in 43 states (according to their website, www.icypaa.org). State conferences not only provide an opportunity for young people in AA to come together at an annual conference but also host other events, such as potlucks and retreats, and thereby serve as a means to bring young people in AA together.

puts a label on this when he suggests that the main focus of Alcoholics Anonymous is recovery, i.e., working the Steps.

This section therefore suggests that social groups play an extremely important function in the recovery process. As members first enter the program and seek to gain a foothold in abstinence, social groups offer participants a new network of peers that they can socialize with while avoiding the pressure of drinking as well as positive reinforcement and a sense of belonging. The fellowship aspects of the program, which social groups take as their primary purpose, appear to be vital to early abstinence. That said, in the next section my respondents make the case that the social aspects of the program are not the key ingredient when trying to assess the mechanisms that might account for variation in long-term abstinence across groups.

Moving Beyond on the Social

Members of AA see the social aspects of the program as a key element of Alcoholics Anonymous. In fact, they perceive it as one of the three most important aspects of the program. The social aspects of the program draw in the newcomer providing him or her with a new social circle devoid of negative influences, and enable him or her to develop new friendships that can act as new sources of social support, particularly with regards to maintaining abstinence. Members repeatedly emphasize how important this is to their abstinence, particularly during early recovery when avoiding circumstances that might tempt the alcoholic to drink are most crucial, and when the need

for social support is at its highest. This point cannot be understated. In my data the social support functions of AA seem to play a particularly important role in abstinence, just as other research suggests.

However, my data suggest that perceived social support varies little between group types. As such, it cannot explain the differences between types of groups. If we want to understand the underlying processes that account for these differences then we must look elsewhere. In the previous section, members began to point us in another direction, giving us a sense that there is something more; the social support aspects of the program, in and of themselves, are not the distinguishing feature between group types. In what follows, my respondents suggest that while the social may be attractive initially, other differences matter more.

Viv C., introduced above, belonged to a social group before moving to Recovery. She follows up on the point made by David I. in the conclusion of the previous section:

> "[My previous group] brought me the connection. I liked them people, personally. And the stuff we did talk about, I felt like that or, you know, I've done that. But I was not learning about the Big Book, the root of AA. AA's in the Big Book. I went a long time not even reading the Big Book… I need that structure. I went to a home group that didn't have structure, didn't have abstinence, didn't have a business meeting. Relapsed. Then I started at a Recovery after the relapse. I want to learn about how the program works, what am I supposed to do with it. I was out there lost and I would talk to the old timers, the people that had a lot of abstinence, and I needed somebody to guide me. I was just kinda lost there, you know, whatever. It was just a kinda free for all kind of thing... My other home group was like, 'Oh, I'm gonna go here tonight so I can see this person, that person, because they're funny, they're fun.' But the Book is where it's at, the instructions."

Viv C. begins to give us a better sense of the inadequacies of the social aspects. She suggests that she was not learning about the Big Book in her social group. Through her social group she found people she enjoyed the company of, changed her social circle to eliminate negative influences, and found something to do besides go to a bar (as Nina

discussed previously). However, while in the social group she was not learning anything. She developed a support system, undoubtedly of benefit, but had little active work to put the support system toward. In essence, she had a network of people to encourage her, but no knowledge of how to carry out her abstinence and effectively manage her alcoholism and the compulsion to drink.

Within 48 hours of one another, Stan and his immediate boss both reported problems with alcohol to their superior. Stan now has almost 25 years of abstinence. He was once a part of a social group, during which time he came very close to slipping. At the time, he had almost 10 years of abstinence, but he described himself as miserable. He claims he felt worse than he did when he was drinking. The group he is now a part of, "Traditions," emerged as the result of a split with his previous group. Stan explains what occurred:

> "The group we were at, there was issues about some of the people, how they were doing their abstinence, and there was just uneasiness about some of that. It turned out to be more of a social and dating club than people wanting abstinence so a bunch of us left to have a group that would stay focused on trying to stay sober and follow the principles of AA rather than worrying about a social club."

Stan tells a story that I came to see as typical. In his previous social group, he was not focused on the principles, i.e., the Steps, and, even though he had been sober for a number of years, he felt almost as bad as he did prior to his abstinence. He was what people in the program refer to as a "dry drunk," miserable but sober. Put differently and prefacing the analysis to come, Stan was not drinking but he was also not managing the underlying stressors that led him to drink. Stan, like Viv C., found that the mere existence of social support was not enough. He came dangerously close to relapsing as a result. Instead, he and several other members left the social group and started a new, structured

group. After nine years with Traditions, the quality of his life has improved tremendously and his abstinence continues unabated.

Mindi H. was very candid in her assessment of what transpired in her social group, Willingness, before moving to Big Book:

> "Where I got sober it was just, we would talk about stuff that didn't have anything to do with AA: somebody cut me off in traffic so here let's have a big bitch session about stuff that makes you mad.… I got all caught up in it. You know, who are you sleeping with, new tattoos and body piercings that people were getting, just stuff I did not need to be focusing on in early recovery. When I was there I didn't know any better, I didn't know any different. And that works fine for a while but once I found this group I saw the difference and knew I needed that structure to stay sober."

As Mindi H. makes clear, the social group was very attractive early on because it provided a new network of peers and a sense of belonging but, as time went on, she began to realize that it was not doing enough to help her stay sober. She had developed a new network of peers but there was little in the way of solutions to her problems. Notice her use of the word structure. She, like Stan, was not receiving the principles of the program, i.e., the Steps. She was focused on bonding around common problems and gossip rather than developing a repertoire for managing the triggers that led her to drink. Unlike some of the other respondents in this section, Mindi H. did not have to relapse to learn her lesson but she was quite clear during our interview that she, like Stan, felt miserable until she switched groups.

Ben, a member of the structured group Recovery, is a Physician's Assistant (P.A.). He nearly lost his license as a result of his addiction. Ben makes the same point made by the previous respondents. As he explains below, he was sober for 7 years before he relapsed:

> "I drank on the weekends, if I was off or not on call, and I'd take the pills if I had to be in the hospital. And that blew up in my face one day. So I was sober for 7 years. I

> went to treatment in '92, got involved in AA, and that's when I think I really truly figured out that I was an alcoholic. The guy that ran the treatment program had a really good attitude about the whole thing. He'd been in AA for a number of years. He said, 'My job is to educate you about what's wrong with you but my real job is to make sure you become a really solid AA member when you get out of here.' And I did that, I did it with great desperation and my life changed, it got much better. But the Steps absolutely terrified me, especially the 4th and 5th Step, and I kind of over-intellectualize things anyway. So I went to a ton of meetings and I could talk it, sound good, convince myself, and then I kind of picked and chose… I just kind of dilly-dallied around. It certainly helped to not drink but I didn't have any kind of good, quality abstinence in the long run. So I relapsed, drinking."

Ben draws a clear connection between his relapse and his failure to work the Steps of the program. More often than not, members identify the 4th Step, "Made a searching and fearless moral inventory of ourselves," as the key turning point in their battle with abstinence. As Ben suggests, going to meetings was not enough. Neither was availing himself of the social support offered in his social group. He "dilly-dallied" when it came to the Steps and after 7 years he relapsed. Ben therefore makes a strong case that attending meetings and reaping the benefits of the fellowship is simply not the primary mechanism of interest.

Carl M., has led a very unique life. He was a rugby player and a heavy partier in college, then became a welder, and then worked in a lab as a research technician. He also worked as a clown for 13 years and lived on a mountain in California at one point. While drinking he would often blackout and ride his motorcycle for hundreds of miles. He explains, "I used to drive motorcycles drunk. I'd black out for hours.[8] I'd drive hundreds of miles on motorcycles and not remember any of it." With a bewildered look on his face, Carl M. could only say, "By the Grace of God really," and then he moved on to a

[8] A black out is phenomenon typically associated with excessive alcohol consumption wherein the individual's memory is either impaired or they are completely unable to remember a large block of time. It is different from "passing out," which is strictly a loss of consciousness, in that the individual remains awake but has amnesia-like symptoms.

different point. Later in the interview, he shared a story with me that left an image in my mind that I will never forget. While clowning, Carl M. was in the throes of his addiction. After working an event, he would invariably pick up a case of beer and drive the long drive home to his house in the country. So at the mercy of his addiction, he would not even get out of his truck in order to begin to drink himself numb. There he was, a sad clown sitting in his old truck out in the middle of nowhere, alone, drinking. As he recounted this story, and this image, to me, which characterized a long period of his life, we laughed. Hysterically. It was, undoubtedly, the funniest moment in all of my interviews, and I am not normally one for schadenfreude. After the interview, and as I transcribed it, I imagined writing about the story and making the reader laugh hysterically as we did. Yet as I sat here trying to convey the humor of the story with my writing, I repeatedly failed in my efforts. In retrospect, I think laughing hysterically was the only course of action for me, and Carl M. as well. I did not remember this after the interview concluded but when I went back and listened to the tape, I noticed that at the end of the story he paused for a fraction of a second, let out a weak laugh, and sighed, "Pitiful." Then we moved on to a completely different subject.

Carl M. relapsed after being abstinent for 10 years. After relapsing, Carl M. found his way to the structured group "Unity." He adds an additional dimension to the familiar emphasis on the Steps and the Big Book:

> "So the long and short of it was that I was like well my mom's an alcoholic and she's the reason why I'm messed up so I went to Alanon.[9] And well, no, maybe it's the pot so I went to NA. And then it was like, well, it's really about the alcohol. And there was so much shame, so much shame. And this was in '89. So while I was there I went to NA and AA a *lot*. But basically all I did was go to meetings. I didn't get a sponsor;

[9] Alanon is a 12 Step program for relatives and friends of those suffering from alcoholics. It focuses on problems common to friends and family of alcoholics and how to manage relationships with active alcoholics in a person's life.

> I read the literature a little. Nothing went in though. So I went to meetings and basically got a drier brain."

Carl M. draws on the metaphor of a dry drunk that I used to characterize Stan. Like many others, Carl M. did not seriously read the literature or work the Steps. He adds to this the fact that he did not get a sponsor. In doing so he seems to add another key ingredient to the recipe. Carl M., like Ben, attended a lot of meetings and availed himself of the fellowship, but again this does not seem to be an important source of variation between groups.

Last is Todd H. He was in the Navy for a number of years but eventually he was discharged because of his alcoholism. He then struggled to remain employed and had marital difficulties as well. After years of barely managing to keep afloat, Todd H. entered Alcoholics Anonymous. He helps pull together all the pieces of what respondents have said throughout this section:

> "I actually stayed sober for about 10 years with AA. I was very active but I did not (pause) there's a big difference in the way I worked the program back then and the way I work it now. Having a sponsor is key. *(ME) So you didn't have a sponsor back then?* I did have a sponsor but we didn't sit down and read the Big Book and really study the text and to do exactly what the Big Book said. You know, do the list. It's really critical to do all the Steps. It is critical. A lot of people think if you go to a lot of meetings you're going to stay sober but really the crux of it is good sponsorship and working with other alcoholics."

Todd H. relapsed after 10 years of abstinence yet he went to a lot of meetings and even had a sponsor. Todd H. therefore suggests that it is not the sponsor itself, but what actually occurs in the sponsor-sponsee relationship that matters. It is an interestingly parallel to the point that the mere presence of social support is not enough. This time around Todd H. sat down with a sponsor, carefully read the Big Book, and worked through every single one of the Steps. He therefore draws together aspects of the program

highlighted by respondents throughout this section and suggests that it was only by leaving a social group and joining a structured group that he was able to take this integrated approach to maintaining abstinence.

Conclusion

Sam H., is a member of the structured group Traditions and has been sober for nearly 10 years. He was a very high functioning alcoholic; he managed to go back to school and obtain an advanced degree while active in his alcoholism. Sam H. put much of this chapter very plainly in a few short words. During the course of his interview, he said, “The Steps are extremely important but at first, for me, I needed the fellowship. I couldn't have gotten to the Steps without the fellowship first.” In doing so, Sam H. highlights the tension between social and structured groups. Social groups serve an extremely important function in the early abstinence and given the emphasis all groups place on newcomers their successes are to be lauded. However, as these newcomers move beyond the initial hurdles of abstinence, structured groups appear to become far more important. It is in structured groups where members appear to learn to maintain long-term abstinence.

I began this chapter with the basic point that the typical conceptualization of AA as a homogeneous entity exists for many reasons yet is ultimately misplaced. Instead, I suggested, AA groups appear to vary systematically along an important cleavage most easily indicated by amount of long-term abstinence and which I characterized in terms of structured versus social groups. This point can stand on its own merit. Virtually no

research has even pointed to the possibility of systematic differences among groups, much less tested for group-level effects. Though I discuss the implications of this point more fully in the concluding chapter when its importance is more manifest, it stands to reason that much of the research on Alcoholics Anonymous and its efficacy grossly oversimplifies its models and the assessment therein.

This point was, however, only the beginning. The overriding goal is to explain the underlying processes through which this group-level variation emerges. I want to explain the mechanisms by which groups have their effects on long-term abstinence. In order to do so, I first complicated the picture. I did so by suggesting that perceived social support, in and of itself, does not appear to account for the differences between group types. I then suggested that structured groups can be off-putting to many participants because of the heavier focus on working the Steps and reading the Big Book with a sponsor, and yet this appears to be the difference that matters when it comes to long-term abstinence. In fact, my analysis implies that when groups are characterized by a more explicit focus on social support and a sense of belonging (i.e., the fellowship), they tend to have less long-term abstinence. Furthermore, this suggests that the mechanisms leading to abstinence may shift over time, and again points to the need to consider how the needs of participants relate to the goings-on in the individual group in which they are participating.

As stated in the Introduction, the present ethnographic approach cannot make definitive claims about the association between group-level processes and outcomes. Nonetheless, in subsequent chapters I hope to spell out underlying mechanisms that offer theoretically compelling evidence in favor of the association between kind of AA group

and abstinence outcomes. In doing so, I hope to gain insights into the mechanisms through which social relationships have their effects.

In the next chapter, I attempt to delve more deeply into the role of working the Steps and reading the Big Book with a sponsor. In this chapter, I gave a cursory overview of these aspects of AA and did so strictly in the service of trying to identify what might underlie the differences in long-term abstinence among AA groups. The next chapter is therefore dedicated to fleshing out working the Steps, reading the Big Book, and sponsorship. It is an attempt to better understand what these processes imply and thus how and why they might be the mechanisms that matter for long-term abstinence. Key to the next chapter will be the link between these processes and coping, and how this pertains to how social relationships, and AA, work to have their effects.

Table 1. Characteristics of AA Groups in Sample

Group Name	Years in Existence	# of members	Mean support (total; close)	# of members long-term abstinent (years)	% of active long-term (10+; 20+)	Group type
"Rigorous Honesty"	6	12-15; 10-12 active	20; 3	5-6 (10+); 4 (20+)	42%; 33%	structured
"Unity"	25 (approx.)	30; 20 active	24; 4	10-15 (10+); 6-7 (20+)	50%; 33%	structured
"Recovery"	16	30-35; 20-25 active	25; 3	10-15 (10+); 7-8 (20+)	40%; 28%	structured
"Traditions"	9	40-45; 30 active	26; 4	20 (10+); 6-7 (20+)	66%; 20%	structured
"Big Book"	9	20; 10-12 active	20; 3	6 (10+); 2 (20+)	50%; 17%	structured
"Serenity"	17	30-35; 20 active	25; 4	4-5 (10+); 1 (20+)	20%; 5%	social
"Willingness"	12 (approx.)	10-12; 7 active	20; 4	1-2 (10+); 0 (20+)	14%; 0%	social
"Surrender"	30 (approx.)	15; 8 active	22; 3	1 (10+); 0 (20+)	13%; 0%	social

CHAPTER 3

WORKING THE PROGRAM

Introduction

In Chapter 1, my analysis suggested that social groups serve an important function in the world of Alcoholics Anonymous groups because of processes typically associated with social support. Social groups excel at drawing in the newcomer and appear to do so because they focus on helping the newcomer develop a new network of peers and provide him or her with a sense of belonging. At the same time, these groups appear to foster long-term abstinence at lower levels than structured groups. My analysis suggested that structured groups, on the other hand, may be less welcoming to the newcomer. Structured groups therefore sacrifice some of the emphasis on "feel-good" support, though by no means forsaking it, in order to stress areas other than attending meetings and availing oneself of the social aspects of AA (i.e., the "fellowship").

As I first familiarized myself with the population, attending meetings and interviewing members, I suspected that informal processes outside of the meetings would be of central importance in identifying the mechanisms underlying long-term abstinence outcomes. It seemed only reasonable that given the obvious similarities between all AA groups, as discussed in Chapter 1, things occurring outside of meetings would be what

distinguished among groups. This hypothesis proved correct, though not in the way I anticipated. As I began to explore the informal interactions that occurred outside of meetings I noticed the nature and extent of "extracurricular" activities was remarkably constant across groups. Most members actively participate in outside activities with other members and tend to do so with regularity. Members grab a cup of coffee, play golf, go hiking, watch sports, etc. just as "normal" friends do. The groups themselves rarely organize such activities and members of all groups almost unanimously think that the one area where their group suffers is that it does not organize activities more. In fact, the one interesting piece of data I collected based on this false lead was the realization that groups rarely organize activities for members and yet collectively imagine other groups that do so with regularity.

As I realized my hypothesis about informal processes was a dead end, it became apparent that the differences that mattered were formal in nature. As discussed at the end of Chapter 1, structured groups differ from social groups in that they relegate the social aspects of the program to a subsidiary role instead focusing on reading the Big Book and working the Steps with a sponsor. The purpose of this chapter is to spell out in greater detail why it is that reading the Big Book and working the Steps with a sponsor might be connected to better long-term abstinence outcomes on the part of structured groups. That is, I want to understand the underlying processes through which these social relationships might do their work.

My analysis suggests that these non-meeting yet formal activities can be conceptualized as a means to transmit coping strategies to members. At the heart of their success, I argue, is the fact that structured groups give members tools to manage stressors

that might threaten their abstinence and lead to compulsive drinking. In what follows, I focus on working the Steps and sponsorship, bringing in the role of the Big Book throughout the discussion. I then attempt to tie these dimensions together into a package and suggest that these processes give members tools to moderate the triggers that lead to compulsive drinking and thereby promote long-term abstinence.

My analysis focuses on AA members that are or were a part of structured groups. The reason for this is quite simple: My interest is in explaining how it is that the relationships that characterize AA are conducive to long-term abstinence and it is in structured groups where you find long-term abstinence (as suggested in Chapter 1). I therefore take as a point of departure that AA has worked for these people. The question, in turn, is how: How is it that the culture of structured groups is conducive to long-term abstinence? How is it that members actually achieve long-term abstinence?

If we want to answer these questions then it is necessary to focus on an insider account of how members that achieved long-term abstinence (i.e., members of structured groups) did so. This is not to suggest that my analysis is the only way to make sense of the program, nor the only way for participants to approach it. Chapter 1 makes clear that there are two basic approaches to Alcoholics Anonymous. Rather, the present analysis is an attempt to understand how those that successfully achieve long-term abstinence do so as to understand how the relationships work to have their effects.

Underlying this analysis is an attempt to flesh out the processes through which social relationships have their effects. My analysis is meant to explore how the substance of our relationships actually works to influence our health (behaviors) by detailing how the differences between groups matter in substantive terms. In essence, I seek to explain

mechanisms through which social relationships pattern health by connecting the work of structured groups (i.e., reading the Big Book and working the Steps with a sponsor) to the patterning of coping strategies. This chapter sets the stage for the Chapter 3, wherein I analyze how it is that the Steps work as coping strategies to have their effects and thereby give us both a better sense of how coping strategies are employed and how the work of structured groups produces coping strategies that can be put to use.

Working the Steps

Tim N., whose alcoholism brought him to an extended period of homelessness, is a member of the structured group Big Book. He gives us an introductory assessment of the program and helps pick up where the discussion left off in the previous chapter. Tim N. said, “Well I think at the heart of AA is the 12 Steps. That's the pinnacle… AA is a society of alcoholics in action. That's what our literature says we're supposed to be. Meetings are just one thing that we do.” He, too, stresses that meetings are not the defining feature of Alcoholics Anonymous. (After hearing this repeated by roughly a dozen different people, I started to wonder why I ever thought meetings were important. As discussed previously, they are iconic.) Tim N. says the “pinnacle” of AA is the Steps and learning to put them into action. Vanessa, I turn to in more detail subsequently, was even blunter: “The program is the 12 Steps. Not the fellowship. I think people get that confused. Working the program, for me, means that I am actively engaged in the 12 Steps myself.”

One of the unwritten norms in AA is the expectation that when a newcomer first joins AA, he or she will attend 90 meetings in 90 days ("90-in-90" it is generally called). Given the early importance of developing a new peer network, as well as the difficulty of the early days of withdrawal, it is easy to see why this expectation exists. If nothing else, it gets the addicted person out of the house and gives them something to do, an alternative to going to a bar or drinking at home. Ben offers a useful analogy, drawing on this expectation, to underscore the centrality of the Steps:

> "I've also learned that it's not all about going to a couple meetings. I think the meetings are important, they're a place to meet people, to be supportive, to help others, but I heard this guy say one time, 'You can stand me in a garage for 90 days straight but I'm not turning into a car.' You can make good on 90 meetings in 90 days but you're not necessarily going to be a recovered alcoholic if you don't give me the Steps."

As Ben states, there are a number of positive features of attending meetings, including the peer network and support functions that Chapter 1 suggested are important in early abstinence, and so is more even-handed than Tim N. and Vanessa. Nonetheless, Ben believes working the Steps is pivotal for long-term abstinence.

Noah Y. is a physician. He attends the structured group Rigorous Honesty. Noah Y. nearly ruined his carrier with his substance abuse. He was fired from his residency, had to pursue a different specialty, and almost had to give up practicing medicine entirely as a direct result of his dependence. Abstinent for 7 years, he did not have his first drink until his senior year of high school. His drinking accelerated quickly and he began binge drinking regularly. During college his binging gradually escalated. Though it lessened when he first entered medical school, he said it worsened "as the stress accumulated." Noah Y. recapitulates the sentiment expressed by Ben:

> "This is a point I really try to drive home with my patients and with my sponsees is that going to meetings is good but it's really not enough. A person really needs to change and it doesn't happen just from going to meetings. It doesn't happen from just hanging out and drinking coffee. The change comes from working the 12 Steps. The most fundamental essence of working the program is actively working the 12 Steps of Alcoholics Anonymous."

Noah Y. sees change coming from the 12 Steps. In order to achieve long-term abstinence, he suggests, it is necessary to actively work the 12 Steps. It is, then, not simply reading through the Big Book with a sponsor and working the Steps, but learning to put them into action routinely.

Kalvin I. grew up a child of little means in the Deep South. His parents were sharecroppers and his family "never had much." Perhaps because of this, Kalvin I. said he liked "the excitement that came with drinking." As his drinking progressed, his life became over-filled with "excitement" and he ended up in prison, where he would spend many years of his life. It was in prison that he found Alcoholics Anonymous, and he credits AA with turning his life around. He has been sober for over 30 years and now has a wife, children, a good job, attends church, and is back in prison. Except now he is a visitor and comes in order to bring AA meetings to the currently incarcerated. Kalvin I. is a member of the structured group Big Book. He stresses the action component in very simple terms, "The 12 Steps, ya know, that's just something on a piece of paper... You can say all this stuff about the 12 Steps and the 12 Traditions and relationship with God and all this stuff but all this stuff is just words. Everything about this requires some kind of action, you gotta be doin' somethin'."

Returning to Ben, once again, we find slightly more precision:

> "And so part of the whole deal is as you move on through those Steps and hit [Steps] 10, 11, and 12, and you're practicing those principles in all your life, or you should

> be. If you're not you're missing the boat. I think that's how AA helps. I mean, it's given me a set of principles to live by and a way to enact those things in my life."

Here Ben claims that the key is to practice the Steps "in all your life." He says that failing to apply the Steps in a general sort of way is "missing the boat." Ben helps clarify the focus on "taking action." Achieving long-term abstinence is about applying the Steps to your life, he and Kalvin suggest.

Diane achieved some abstinence through attending meetings at various social groups but eventually she relapsed. She says she never worked the Steps prior to her relapse. She is now a member of the structured group Recovery. Diane came to the U.S. from a foreign country after falling in love with a G.I. stationed in her country. She says she wanted to escape. She hated her mother and always looked to men for fulfillment. She echoes Ben's point, saying, "[AA] shows me a way of life. You see, one reason why I always drank is because I didn't know how to live differently. AA actually shows me, with the Steps, a different way of life. AA is a way of life. It does it by applying the principles of the Steps." She goes a step further than Ben claiming that AA is a "way of life." AA gives members a new way of life by offering them a set of principles, the Steps, that they can put to use on a daily basis.

Holly B., who spent many years living the lifestyle of the party girl, and many more years bouncing from social group to social group struggling to maintain abstinence, drives this point home. I asked her, "What does it mean to work the program?" She responded, "It means to live the program. It means to take the Steps and integrate them into your life and have a routine where you use several of the Steps on a regular basis such that it becomes a regular part of your life, a part of who you are. It's way of life." Here Holly B. is quite specific. She says the purpose of AA is to integrate the Steps into

your daily life, on a routine basis. Members, through working the Steps, learn to apply the Steps to their life in general. They are actively employing the Steps as a means to maintain abstinence.

Sponsorship

In this section, I attempt to build on the insight that working the program is about learning to put the Steps into action on a daily basis such that it becomes routine, or a way of life. Here I focus on the importance of sponsorship in working the Steps and maintaining long-term abstinence. This brings us closer to the goal of trying to understand how it is that structured groups, with their focus on reading the Big Book and working the Steps with a sponsor, actually work to promote long-term abstinence. It sets the stage for the final section, where I attempt to pull it all together in order to understand why working the Steps, which seems to presuppose reading the Big Book with a sponsor, may be so conducive to long-term abstinence.

Laura, a member of the structured group Recovery, has an autistic child and has been in the program for just under 20 years. She was one of the calmest and most peaceful people I have ever met. It was hard to believe her when she told me about her drinking days. She sounded like she was quite the hell-raiser. Laura starts us off with a basic function of the sponsor:

> “They had the experience, they actually know and could put words on to what I was feeling because before then no one could understand me. I don't think anyone can understand it unless they live through it, which you can say about anything. I mean, you can't understand being a mom until you are one, and you can’t understand having

> cancer and what it's like to go through having cancer unless you have it. But for alcoholics it's such a mental twisted spiritual thing you really, really need another person that's been there and walked the path and can say this is my life, this is what I did, and look I still got sober."

Much like the broad function of social groups, Laura suggests that the sponsor offers a point of identification for the recovering alcohol. The sponsor is someone that can understand what the alcoholic has been going through. They are able to relate to his or her experience with experiences of their own. Many members describe this identification as relieving some of their guilt by giving them an "I wasn't so bad" feeling.

Kathy T., mid-40's, was a member of Surrender, a social group, when I first met her, but by the time I interviewed her she had switched to Rigorous Honesty, a structured group. She is a self-described "military brat" and grew up with an authoritarian, abusive father and a mother who she says over-compensated for her father, which had the effect of being extremely controlling. Kathy T. said she first began drinking in college, but not alcoholically right away. The progression occurred fairly quickly nonetheless. She describes herself as a functional alcoholic; she explained that she created rules to help "manage" her drinking. For years she was always on the verge of losing control yet narrowly managed to keep her life in order. That is, until one day she broke down screaming and crying, hysterical, threatening to kill herself for hours on end and experienced what she refers to as her "I'm fucking beat moment." She took the role of the sponsor a step further, saying the role of the sponsor is "To be the riverboat guide... To say this is what I did to stay sober, this could potentially work for you, particularly if they've never had any interaction with AA at all." She suggests that sponsors are not only there to provide a sense of understanding but also guide the recovering alcoholic through the act of maintaining abstinence.

Carl M., a member of the structured group Unity, was introduced in the previous chapter as the sad clown that used to ride motorcycles while blacked out. He further elaborates on the point made by Laura and Kathy T.:

> "They're not a shrink. I use my sponsor to get me through the Steps. The sponsor is someone that can show me that my stuff isn't so bad and bring me through the Steps and show me what the program is so I'm not doing Bob's program, I'm doing it the right way. To answer questions, to guide me to places to go, to introduce me to other alcoholics, to lead me to service positions, some times to do social things with. It's kinda like, uhh, (at which point he pauses, then in a hippie-stoner voice he says) my dealer man (laughter ensues). It's a conduit in."

Carl M., like Laura and Kathy T., suggests that the sponsor serves a number of purposes. Echoing Laura's point, he says that the sponsor "can show me that my stuff isn't so bad." When he suggests that the sponsor acts like a "dealer" or is a "conduit in," Carl M. reinforces the "riverboat guide" analogy used by Kathy T. In addition to reiterating these previous points, Carl M. adds that the sponsor's primary purpose is to take the sponsee through the Steps.

David I., who was working the program before he finished high school and was in the process of completing the transition from structured group to social group then back to structured group when I interview him, put this succinctly saying, "The main job of the sponsor is to take someone through the Steps. Most people do a pretty horrible job of trying to work it by themselves. The main focus of the sponsor is to help take you through the Steps correctly." Carl M. and David I. thus help clarify that among all the functions that the sponsor might serve, their chief function is to walk the sponsee through the Steps.

Rick I., late 30s, physician, soft spoken, describes his mentality growing up as "work hard, party hard." His drinking progressed gradually throughout college and then

when he entered medical school he toned it down initially. Like Noah Y., as the stress of medical school increased, so too did his drinking. After playing with fire for a number of years, he had his medical license suspended. That served as his wake-up call and he was quick to give credit to AA for his recent reinstatement. A member of Serenity, which has been gradually transitioning from social to structured, Rick I. says "If my home group hadn't grown, I probably wouldn't be attending this meeting." As he elaborated subsequently in our interview, by grown he means become more structured. During our interview, he was adamant about the role of the sponsor in long-term abstinence:

> "I kind of came up with this saying based on the saying, "The patient who treats himself has a fool for a doctor." Well the alcoholic who works the 12 Steps alone has a fool for a sponsor. If you don't have a sponsor you're screwed. That's what I think. *(ME) Why is that?* Because we're crazy when we get into the program. And you can't, like I said, I couldn't do a self-study of the 12 Steps. I had to have someone lead me through... you can't see it when you're, when you haven't been practicing the principles long enough. You can't sponsor yourself, it's not possible. Everyone who relapses said they didn't make it past the Third Step and you need a sponsor to do the Fourth Step. So, uhh, no sponsor, no abstinence."

Here Rick I. claims that without a sponsor, long-term abstinence is not possible. Though surely an exaggeration, among the members that I interviewed that had relapsed at one time, they all followed Rick I. in identifying Step 4 as a critical turning point. All either said they never worked any of the Steps, stopped at Step 3, or did not take Step 4 seriously. In effect, Rick I. lends weight to the evidence suggesting that sponsorship and working the Steps are connected to long-term abstinence outcomes. In the previous chapter, I noted that structured groups tend to engage in these activities more. Here, Rick I. makes the link directly. In making this claim, he also reiterates the point that the sponsor plays a critical role in helping the sponsee to work through the Steps. Though he puts it in vague terms, Rick I. further suggests that it has something to do with helping

the recovering alcoholic see how he or she can “practice the principles,” a point that becomes clearer in the next section.

Ben, the P.A. that nearly lost his license as a result of his alcoholism and is a member of structured group Recovery, adds another important dimension to the role of the sponsor. Like Carl M., he sees the sponsor as potentially serving a number of purposes:

> “Well I think the meetings are important but I think sponsorship is absolutely critical. It would be like going to the Amazon and trying to do it with a map but no guide, something like that. I just, I mean I don't know where I'd be without a good sponsor. There's a lot of things that pass for a sponsor. Obviously I had a sponsor when I tried this before and they were the kind that were like, you know, give me a call, read this, read that, we'll talk about it, blah blah blah, and that may work for some people but that didn't work for me. Good sponsorship is where you sit down and read the Book together… And then that person also kind of, I think initially, is kind of like a connection to AA. They introduce you to other people so that your network of support broadens and deepens, and they make sure you get to a variety of meetings, stuff like that.”

The sponsor can serve as a connection to AA, helping broaden a recovering alcoholic’s support structure, much as social groups do in general. Ben stresses that this is particularly important early on, just as we saw in the previous chapter. A new peer network and sense of belonging are undoubtedly important in early abstinence. More importantly, however, Ben connects the sponsor to reading the Big Book. He draws on the analogy of the sponsor as a guide and suggests that the sponsor’s job is to sit down with the sponsee and walk him or her through the Big Book

Nikki I., mid-20s, describes her early childhood as “great.” She said she was raised by two loving parents who taught her morals and the value of hard work. Her parents were “kinda hippies” (and it shows in her manner of dress–you would never guess she was once in the Navy). The first time she drank she did not tell anyone she was

with that it was her first time because she had already lied to them and told them she had drank many times in the past; she wanted to look cool. She says that she blacked out the first time she drank and "thought it was normal" as a result. She was 14 and she loved it. Her drinking progressed rapidly – she did black out and love it the first time she drank, as she pointed out – and pretty soon she was chasing it, always trying to find where people were drinking. After high school she joined the military. She describes the early stages of the military as her "golden years" where she was drinking, partying, and having fun while not getting into any trouble. Eventually she was thrown out of the military with a general discharge under honorable conditions, which is just below an honorable discharge in terms of prestige. She says it should have been a lot worse but they just wanted her out. Her life spiraled downward after this and though she managed to string three months of abstinence together at one point, she continued to go in and out of AA for over a year. Then, one day, for no particular reason, enough was enough and she decided to make a change. Due to a geographic move, Nikki I. switched between structured groups, moving from Big Book to Unity. Nikki I. helps weave together the disparate threads of sponsorship into a more coherent whole:

> "I get the one-on-one help with the Steps. I can't work the Steps by myself, I don't know how to, so it's helpful to have someone that's done them before because I don't know how to do them by myself. Reading the Big Book with a sponsor. That's how you get the Steps; you work the Steps doing that."

Nikki I. builds on Rick I.'s point that you cannot do the Steps alone. Members often point to Step 5 (Admitted to God, to ourselves and to another human being the exact nature of our wrongs.) as a clear sign that sponsorship is a necessary component of working the program. The sponsor need not be the other "human being" in Step 5 but, based on my knowledge, it always is. Nikki I.'s quote is particularly instructive, however, because it

ties together reading the Big Book, sponsorship, and working the Steps. She suggests that through individual sponsorship, where the sponsor guides the sponsee through the Big Book, the sponsee learns the Steps. She gives us the sense that it is a package deal: The role of the sponsor is to take the sponsee through the Steps, which is done, in part, by reading the Big Book. Later during the interview, Nikki I. returned to the subject of Big Book adding, “The fact that it says it’s our basic text at the beginning means a lot to me. You know, like, if I’m taking geology I’m going to use the geology textbook not the astronomy textbook so that means this is what I need to read if I want to stay sober.” The textbook analogy is quite common and members often refer to the Big Book as their “basic text.”

What stands out most in my mind about Vanessa, is her describing how much her world “shrank” as a result of her alcoholism. Isolation is a common part of the alcoholic’s story. My observations suggest that this is usually both because the alcoholic drives other people away with their errant behavior and because they deliberately avoid other people. Vanessa described how her entire world became her apartment, her job, and the bar, all of which were within walking distance of one another. During one particularly bad period of her alcoholism she wasted months and months of her life wearing down a path between the three. Those three places completely defined her existence for months on end. Vanessa, a member of the structured group Rigorous Honesty, made Nikki I.’s point exceedingly clear saying, “The Book is the program. That's where the program comes from. The Book is how we learn to do [the Steps]. It has the instructions. The Big Book is the recipe.” She sees the Big Book as the source of the Steps, which is where they

literally originate from, and suggests that learning how to do the Steps requires reading the Big Book.

Holly B., 8 years sober, bounced around social groups for a number of years. It "took [her] a long time to get sober" and it was not until she settled into Unity, a structured group, that she managed to achieve the long stretch of continuous abstinence that she now enjoys. Holly B. had a horrible childhood. She grew up with everything she "needed physically but nothing emotionally." Her dad was a doctor and very abusive. As she reached young adulthood, she said she used to stay home and "just cry and cry." Her escape was going out and partying and "getting ripped." She was in a very dysfunctional marriage for a number of years and has generally had "complicated" relations with men. After a lifetime of struggle, she has finally found some measure of happiness. Expressing a sentiment I heard repeatedly, she says her life continues to improve as she continues to work the program. Holly B. spells out more clearly how the Big Book is put to use in teaching the Steps:

> "What I do with my sponsees is read the Big Book with them. I show them where what I'm saying is in there so that the language that it's using can be articulated in modern day language because when I first opened it I didn't get it. So it's like, for instance, 'Look at this page. Do you see that? This is what it means. Do you get it?'"

Just as other members claimed that it is not possible to do the Steps alone, Holly B. "didn't get" the Big Book when she first read it. Working with a sponsor, as she now does with her sponsees, helped her understand it. In order to do so it was necessary to walk through the Big Book page by page. It really is very much like studying a text. Together sponsor and sponsee pick apart sentences and paragraphs and make sense of them. Crucial to this process is demonstrating to the sponsee how the Steps actually work

and what it means to work them. The sponsor teaches the sponsee how the Steps function and what it actually looks like to apply them.

In the final quote of this section we turn to Ben, the P.A. that nearly lost his medical license, once again. Ben helps summarize the various points made throughout this section and sets the stage for the next section, where the focus turns to pulling together sponsorship, reading the Big Book, and working the Steps and understanding why these processes may be central to long-term abstinence:

> "The beauty of the sponsorship I have is that we sit down and read the Book together, like face-to-face. So it's like even though I've been in AA before and exposed to a lot of stuff it just didn't sink in... The program is in the Book and if I work through that with someone then I can change. I think it gave me a road map to do the things, um, that need to be done… When I work with others it's about what's in that book, understanding what alcoholism is, understanding what the solution is, and probably most important of all, it's not about sitting in meetings and all that, that's important, that's good stuff, we need to do that, but it's about action because I'm the kind that can sit and mentally masturbate all day long. I can sit and talk up a storm and sound good. Anything I have now it's because I was willing to get up off my butt and follow some direction... it's not about sitting in meetings… it's about taking action, it's all about action."

Ben highlights, as many others in this section have done so, reading the Big Book with a sponsor as the vehicle for working the Steps, which he sees as the foundation of long-term abstinence. He also makes the point, as others have done in this chapter and as was suggested in Chapter 1, that meetings are not the key to long-term abstinence. Much like Rick I., who suggested that the sponsor's primary purpose is to help the sponsee learn how to "practice the principles," Ben says the core purpose of the sponsor is to walk the sponsee through the Steps so that they can understand "what the solution is" and learn about "taking action." In this way, he takes us back to the previous section, where members stated that the key to the Steps is learning how to put them into practice routinely, as a way of life. We thus get the impression that the sponsor instructs the

sponsee on how to put the Steps into action (or practice) through a careful reading of the Big Book.

Why Working the Steps with a Sponsor

The analysis thus far has suggested that reading the Big Book and working the Steps with a sponsor is vital to maintaining long-term abstinence. It placed particular importance on working the Steps, by which members mean learning how to actively apply the Steps in their daily lives. What this leaves unanswered is why learning to put the Steps to use would actually be of benefit when it comes to maintaining long-term abstinence. Why might this translate into long-term abstinence? What is it about the Steps, and putting them to practice, that might lead to long-term abstinence? How is it that these relationships actually matter for abstinence outcomes? In this final section, I discuss to what end members read the Big Book and work the Steps with a sponsor. I pull together the previous sections and attempt to give a clear statement about why reading the literature and working the Steps with a sponsor may be the processes through which members achieve long-term abstinence. I attempt to highlight an underlying mechanism through which these processes might produce outcomes.

Natalie Y., late-40's, exuberant, originally belonged to Big Book, a structured group, and is now a member of Serenity, a social group; however, at the time of our interview she was giving serious consideration to leaving Serenity for a more structured group. Natalie Y. describes herself as having had a good home life growing up. She says

she was very happy as a child and teenager, her life filled with friends and laughter, which is not uncommon among my respondents.[10] The first time Natalie Y. got drunk, she was around 14 years old and it was thanks to the assistant leader in her Girl Scout troop, a 19 or 20 year old girl. She nonetheless avoided alcohol for most of her childhood and it would be her senior year of high school before she started to drink with any consistency. Though she hid her drinking from others, often sneaking drinks and hiding bottles, and suffered from profound emotional struggles, her alcoholism would be functional for the next 25 years. Though she maintained a marriage, had children, held a job, etc., she was miserable for much of this time. When she first quit drinking, she said she felt even worse than she did while she was drinking. This is a common experience among recovering alcoholics, the reasons for which will become apparent shortly. Natalie Y. said she got meaner when she first quit. She said it was during this period of her life, abstinent and ornery, that her husband said, "I'm so glad you've stopped drinking. I've missed you." She responded, shocked, "You'd rather have this bitch than that kind of half zoned-out woman?" He replied, "Oh my God yes!" Natalie Y. gives us greater perspective into the function of the Steps and the role of the sponsor:

> "When I first came in I was trying to get sober without a sponsor because I went a whole summer from June 1st to probably mid-August without a sponsor and I would drink and then not drink for a couple weeks and then I would drink and then I went without a drink for 30 days and I was just miserable because I was not drinking and feeling all this stuff that I had always run away from and thinking all the crazy

10 Though there is a tendency to focus on the traumatic and dysfunctional, both in Alcoholics Anonymous and in studies of alcoholism, particularly in Sociology where we tend to think about how a negative environmental might explain a poor outcome (an urge I admittedly suffered from early on in my research as I attempted to look for environmental commonalities shared among all of my respondents as an explanation for why alcoholism occurred only to be frustrated by the diversity), many of my respondents describe their childhood as similar to Natalie Y.'s. This is not to discount environmental explanations entirely, as the majority of my respondents do have in common a number of negative environmental characteristics (and I am a sociologist after all); rather, my point here is to caution against reading too much into early-life experiences and upbringing as a determinant of alcoholism. That said, in my view the answer is to be found in gene-environment interplay.

> thoughts that I always thought without any solution to deal with them because my solution was always to just drink. It wasn't until I got a sponsor that someone was able to sit down with me and tell me well this is how I did it, this is what I needed to do, just really takes you by the hand and shows you by sharing how they worked the Steps and gives you direction on how to stay sober based on what they did. I mean the group is great but, you know, you just can't go to the meetings. There's some things you should just really talk to about with your sponsor. The group is there to support everybody but the sponsor is where, is the most help in working the Steps and the Steps really helped me stay sober."

With this statement, Natalie Y., like many other respondents, says that AA is not just about the meetings; rather, the Steps are the key to recovery. She also notes the importance of sponsorship in working the Steps. Underneath these points, she clarifies why it is that working the Steps with a sponsor helped her achieve abstinence. She says that alcohol served as a "solution." By this, she elaborates, she means that she believes she used alcohol as a coping strategy for dealing with life stressors. Working through the Steps with a sponsor enabled her to develop new coping strategies. It gave her new solutions. Natalie Y. thus gives us a much deeper sense of how it is that the Steps function as a solution. She points us toward mechanisms. The Steps are literally a means of coping with stressors. The repeated claims about "putting the Steps into action" are therefore a coded way of talking about actively using the Steps as coping strategies.

Unlike Natalie Y.'s happy home life, Taylor Y. did not have a very pleasant childhood. She described her father as a dry drunk and said he left the family when she was about five years old. The family struggled financially after that and her grandparents were responsible for a lot of her upbringing. They discouraged her from drinking because of the history of alcoholism in her family but she said that just made her run toward it. She experimented with drugs quite a bit but alcohol was always the constant. She also had serious mental health issues. On more than one occasion she spent time in a mental

institution. Among all of my respondents, Taylor Y. broke down the function of the Steps the most clearly:

> "I feel like if you're not working the Steps then you're not really working the program. The whole point of even going is to stay sober and I think without the Steps you can be sober but not necessarily "happy sober." *(ME) Why is that?* Just think of the Steps as alcohol. We don't have alcohol any more so we use the Steps instead. It's a replacement for alcohol. *(ME) How does that work? Why is that a good analogy?* Okay, so, a lot of our drinking is about being able to deal, right, so when you take away the alcohol we don't have anything to deal. So the Steps, the tools, the program, are introduced as a way of dealing with the things that you used to use alcohol as a way to deal with. So when something comes up instead of drinking you do a Step… It's a replacement for alcohol because it's a solution."

Taylor Y. drives home the point Natalie Y. made about using alcohol as a coping strategy and thinking of the Steps as an alternate means to cope with stressors. She says that alcohol was a way to deal with problems and the primary reason why alcoholics struggle to maintain abstinence (apart from the early physical dependence) is that they used alcohol as a means to cope. The Steps therefore function as a replacement for alcohol giving members new ways to cope with stressors that they face. The Steps are tools for moderating stressors; they offer a "solution" to the need to use alcohol as a coping strategy functioning as a way to manage stressful situations.

Nina, who enrolled in French public school without any knowledge of the French language, helps clarify the coping function of alcohol in the alcoholic's life. When I asked her how she sees herself during her days of alcoholism from her current vantage point she said, "I see myself as really scared, really confused, and then I took actions I needed to take in order to get a solution and it's just unfortunate that that solution involved hurting tons of people and, like, you know, fucking up my family life and my own life in such drastic ways." Here Nina uses the exact same language that members used previously when talking about the program of Alcoholics Anonymous to describe

her drinking. Her drinking was taking action in order to get a solution. Like Taylor Y., the Steps and alcohol are interchangeable. Both offer a means of coping, of moderating life stressors. As Nina also makes clear, alcohol functioned as a very negative form of coping, but it was a coping strategy nonetheless. The Steps serve the same purpose; however, they do so through more positive means. Tim N., whose alcohol dependence brought him to homelessness, put this in other terms. He said the point of working the program is to "...learn about AA principles and apply those principles to problems in your life and power them down." The term "power them down" has stuck with me. It suggests precisely the same mechanism. Applying the principles of the program in your life is a means of moderating the problems in your life. This helps explain why Natalie Y., and many others, were miserable while abstinence. They had abandoned their old means of coping with stress but had failed to find a replacement. The were thus left to suffer the harmful effects of stress without recourse to moderating resources that would alleviate their suffering.

Finally, Noah Y., the physician that nearly lost his ability to practice medicine and had to change specialties as a result of his alcoholism, helps tie the Steps back to the Big Book:

> "I think [reading the Big Book] is essential because the 12 Steps are outlined in the Big Book. Basically the Big Book is the manual for getting sober. The big thing with AA, I think, is that we share this common solution and the common solution is the 12 Steps as outlined in the book *Alcoholics Anonymous*."

Noah Y. says the Steps function as a solution. By this, he means they offer an alternate means of coping with life stressors. They help the alcoholic maintain abstinence by alleviating the need to drink in order to moderate stress. They give the alcoholic an alternate set of tools, or coping strategies. This is done by having the sponsor walk the

sponsee through the Big Book and teaching them how to use the Steps. The purpose of the sponsorship and reading the Big Book is to learn how to actively apply the Steps on a daily basis to your life as a means to moderate stress.

Conclusion

In Chapter 1, my analysis suggested that structured groups better promote long-term abstinence and pointed to the role of reading the Big Book and working the Steps with a sponsor as a likely reason for their success. In this chapter, I explored more carefully the role of these processes, attempting to understand why it is exactly that they might be responsible for long-term abstinence. My analysis suggested that reading the Big Book and working the Steps with a sponsor is critical to long-term abstinence outcomes because it transmits to members coping strategies for managing life stressors. Members suggest that reading the Big Book with a sponsor is the vehicle through which they learn to actively apply the Steps to problems in their lives. In effect, members are socialized into how to use the Steps as a repertoire of coping strategies that members employ to moderate stress. They see alcohol as a negative means of coping and the Steps as a replacement.

I undertook this analysis as means to better understand how the social relationships in structured groups actually matter for outcomes so as to gain insight into the underlying processes through which social relationships have their effects. The previous chapter suggested that though the social support functions are a critical

component of early recovery, they are not the primary agent of long-term abstinence. This chapter suggests that coping strategies are at the heart of the matter. Rather than focusing on social support processes, my analysis indicates that structured groups better promote long-term abstinence because they teach members new coping strategies that can be used to moderate stressors. It is through developing new coping strategies that members are able to achieve long-term behavioral change. This suggests the need to pay much closer attention to how the substance of social relationships patterns outcomes with specific attention to coping resources as a key link in the process. Particularly in the case of AA, it suggests the need to turn attention to heterogeneity among groups when thinking about long-term abstinence outcomes, especially with regards to the extent to which members realize the goal of utilizing the Steps as coping strategies.

Thinking about this case more broadly, I take it to suggest that social support, in and of itself, is not enough to achieve long-term behavioral change. In order to have a lasting impact on health outcomes, individuals need tools to actually carry out the change. Social support may be an important component, but it is not the difference that matters, at least as it is typically conceived. In the case of abstinence from alcohol, for example, support with achieving abstinence may be beneficial, but it does not appear to be the crucial ingredient for long-term abstinence. It begs the question of how it is that one would even achieve abstinence simply with support. What is it that should be supported? Is it simply the act of not engaging in the problem behavior? Certainly that is important, particularly early on when the shear compulsion to engage in the behavior can be overwhelming (e.g., when the person is still physically dependent), but it is essentially a passive conceptualization of support that is typically conceived of when using the term

support. What I mean is that thinking of support in this way neglects the need to empower the individual with tools that they can actively draw upon when dealing with the negative behavior and stress that comes with attempting to change that behavior. Such support does not help the individual employ coping strategies; it is not a direct replacement for the problem behavior. My analysis suggests that when it comes to problem behaviors, at least, coping strategies may be the key. Individuals need support that involves actual instruction in how to cope, both because they need a means to manage the stress that arises from attempting behavioral change and because changing the behavior means abandoning their go-to coping strategy.

Furthermore, I would maintain that the processes used to transmit coping strategies in Alcoholics Anonymous are generalizable beyond AA. Reading the Big Book and working the Steps with a sponsor has no immediate parallel in the everyday. The processes in AA are highly formalized and therefore, at first glance, may seem like exceptional cases. Once AA is cast in terms of a program for teaching members new coping strategies; however, it becomes surprisingly similar to other treatment modalities such as CBT and MET (see the Introduction for more on these methods and their efficacy relative to 12-Step-based approaches to treatment), as well as other non-12 Step models of recovery (e.g., Rational Recovery or SMART recovery). This suggests to me that it may be necessary to read the Big Book with a sponsor in order to learn the Steps and how to apply them to one's life as coping strategies but that such processes are not necessary for learning new coping strategies more generally. Instead, activities such as those in AA are a case of the kind of deliberate, focused, long-term work that is necessary to transmit to individuals coping strategies, and for these coping strategies to become routine. It may

seem like excess, but recall from the Introduction that behavioral change is extremely difficult and long-term success rare; inertia is the norm. It therefore may require an "excessive" amount of deliberate work such as that found in AA to learn the coping strategies that will enable an individual to manage the excesses that characterize problem behaviors. This finding (i.e., that groups that place large external demands on members may be the best poised to induce behavioral change because of their deliberate focus on transmitting new practices to members) also speaks to a larger tradition in sociological theory on the role of external costs in individual outcomes and the good society, a point to which I return in the concluding chapter.

In order to more fully make the case that the Steps are what matter for long-term abstinence because they function as coping strategies, Chapter 3 addresses the use of the Steps directly. In the next chapter, I draw on numerous accounts of how members of AA actually use the Steps as a means to cope and thereby moderate the stressors in their lives. Ideally, this chapter will give a much clearer sense of how it is that the Steps are put to use as coping strategies and thus have their effects. My goal is to illuminate why it is that the Steps may be so vital to long-term abstinence, and therefore why structured groups, where working the Steps is paramount, may better promote long-term abstinence. In doing so I hope to gain some insight into underlying mechanisms through which social relationships in AA have their effects.

CHAPTER 4

COPING STRATEGIES

Introduction

In Chapter 1, I argued that, rather than treating AA groups as homogeneous, groups can be divided into two types, structured and social. I then suggested that amount of long-term abstinence is a key indicator of the differences between these two types of groups. I also made the important point that levels of perceived support appear to be constant across all groups and that my data suggest social groups are better for newcomers whereas structured groups are better for achieving and maintaining long-term abstinence. Finally, I took an initial glimpse into some of the contours of these two types of groups in an attempt to point he way toward processes that might account for their differences. I suggested that structured groups appear to focus more deliberately on reading the literature and working the Steps with a sponsor whereas social groups are more preoccupied with developing a new peer network and providing a sense of belonging, though these aspects are not exclusive to social groups. This suggested the need to investigate the work of structured groups more closely if I wanted to get a better sense of how such groups are particularly conducive to long-term abstinence.

In Chapter 2, I attempted just that, conducting an analysis of reading the literature and working the Steps with a sponsor. Respondents described in close detail the value they see in these activities. Central to their claims was the view that these processes help members develop a repertoire of coping strategies. Members suggested that reading the literature and working the Steps with a sponsor not only socializes members into the program in a general sense but also teaches them coping strategies that members can then employ to manage stressors that threaten their abstinence. In effect, these processes give members new tools to moderate the triggers that create the compulsion to drink, which is the function that alcohol used to play in their lives, however negative it might ultimately be.

In this chapter, I build on the previous two chapters analyzing how members actually put these coping strategies to use to effectively manage stressors. My goal is to understand how the coping actually operates to produce beneficial effects. Much of my preoccupation in this chapter centers on detailing the various ways in which members put these tools to use in their daily lives. I draw heavily on examples given to me by the members themselves. Importantly, much of their discussion has little to do with alcohol itself. Instead, members describe using what they learned through reading the literature and working the Steps with a sponsor as a means to manage the stressors of everyday life. In doing so they drive home the point that they are learning a repertoire of coping strategies for the management of stressors, which is intimately related to their ability to maintain abstinence.

In the examples that follow, I attempt to give a brief treatment of how a number of the Steps function as coping strategies that are useful in a variety of contexts. Much as

with Chapter 2, I again rely on members of structured groups. I almost wholly ignore members of social groups because members of social groups are not reading the Big Book and working the Steps with a sponsor and therefore are not developing the repertoire of coping strategies that is the subject of this chapter. Members of structured groups are the ones using the Steps as coping strategies and by looking at how they do so I hope to reveal how it is that the relationships in AA promote long-term abstinence. Critical to this chapter is to understand how it is that members actually employ the Steps as coping strategies so as to connect the culture of structured groups to substantive processes that ought to pattern health outcomes.

Putting Coping Strategies to Work

Tim N., who has over 30 years of sobriety after having been brought to an extended period of homelessness by his alcoholism, leads off:

> "If all I could, if I had stayed the same way as when I was drinking, or first quit drinking, I would've blown my mind, I couldn't have lived with that. Hence the person either returning to drinking or killing himself. Your life gets worse after you quit drinking because you can't take the edge off. When you drink the pressures off. Well it might still exist but when you're drunk you get some relief from that, you forget that the world exists. When you quit drinking, I had a guy call me – I've spent most of my life sponsoring the homeless or people in the penitentiary or mental institutions – now he's 50 years old, called the other morning at 6 o'clock crying because he had a toothache. Well it's his first major pain without having a drink. It's sad really. The guy don't know how to do nothin'."

Tim N. does not give us a clear sense of how, exactly, the Steps actually operate as coping strategies; rather, the example he draws on sets the stage for subsequent analysis wherein members detail specific ways in which they use the Steps as coping strategies.

Importantly, as suggested by Tim N., members articulate doing so in ways that appear to extend well beyond the immediate context of stressors that are directly connected to not drinking. In doing so, they give us the sense that the Steps can be thought of as a repertoire of coping strategies that members employ in virtually any context as a means to moderate the impacts of stressors on their lives.

Laura, a member of the structured group Recovery, has an autistic child and has been in the program for just under 20 years. She gives us an initial sense of how members put the program to use, specifically the First Step, in a very general way:

> "[AA] is living. It's, uh, it's kind of like, it's almost like a classroom to just go to. To go to school to deal with life better because the steps are put in such a beautiful way that they can help you with every single aspect of your life. It's not just being powerless over alcohol. You're powerless over people, places, and things. So, umm, when things happen to you where you're powerless you are able to find some peace: Okay, I'm powerless over this, ya know."

Laura suggests that the coping strategies in AA might be thought of as a genuine repertoire because they "can help you with every single aspect of your life." She gives us an idea, albeit only in a vague sense, of how the tools of the program function in this capacity. She suggests the emphasis on powerlessness in Step 1 ("We admitted we were powerless over alcohol—that our lives had become unmanageable.") transcends the context of drinking to "people, places, and things." Laura says that by learning to let go of control in situations where she is powerless, she finds her life is much easier. In essence, Laura suggests that Step 1 functions as a meaning-focused coping strategy (see the Introduction for more detailed information on coping strategies). It enables her to positively reappraise and reinterpret a situation and come to understand it in a way that makes it more tolerable, or less threatening. She found the tools of the program extremely helpful when her son was first diagnosed with autism.

During the course of Nina's interview, the graduate student that enrolled in a French public high school without any knowledge of the French language, she started listing various ways in which she uses the tools of the program to manage the stressors in her life. As part of this process, she discussed Step 4 (Made a searching and fearless moral inventory of ourselves.):

> "Taking inventory. So, umm, writing down people who I've harmed, what my part in it was, people that I'm angry at more often than not, and what my part in it was. So that's something I'm doing constantly. And it's really helpful. Especially since I'm working on my Tenth Step and trying to be consistent about cleaning up my part in things. And that's been a really helpful tool. Because like I'll forget, I'll forget that someone made me really angry and I'll bottle it up and then it'll build and build and build and this is like a way of flushing out my system."

Nina describes Step 4 in very concrete, practical terms and draws on a "bottle-of-emotions" metaphor to do so. By regularly taking inventory (i.e., looking at who she has harmed and what her part in it was), she finds that it helps her deal with her emotions in a more constructive way. Rather than bottle up her anger and then unleash all hell on some poor, unsuspecting soul, taking inventory enables her to acknowledge the anger and then let go of it. (And, apparently "all hell" is no exaggeration. She described for me the fits of anger she used to have and they were no-holds barred: screaming, cursing, throwing things, etc.) Taking inventory, as a tool, can therefore be extremely therapeutic by acting as a safety valve for anger and other unhealthy emotions. In this sense, it connects directly back to Step 1 and the use of the Steps as meaning-focused coping strategies. It also functions as a meaning-focused coping strategy in another sense because it enables her to reappraise a problem situation and see the part that she might have played in it. In doing so, it helps her better manage her emotions and therefore can operate as an emotion-focused coping strategy as well. Nina therefore sees Step 4 as an extremely

important coping strategy and gives us a sense of how she puts it to use in her daily life suggesting that it too transcends the drinking context and has wide applicability.

Natalie Y., who was a functional alcoholic for 25 years and was in the process of making the unusual transition from structured group to social group then back to structured group, describes how Step 4 helped her with a situation at work:

> "I just had this incredible, well it wasn't incredible, but something at work happened that was making me crazy and I was able to look at what's really going on here, what about me is going on here. Because inevitably anything that happens is a reflection of me and how I'm thinking about it so I need to change my thinking. That's one of the biggest things I've gotten: what about me needs to change, not what about this person needs to change, because that person is not going to change, I don't have any power over that person. But I can change the way I think about it or the way I respond to it which is in effect going to have some kind of effect on the situation. And so that's what I get today, I can approach every situation, approach every situation objectively and say, 'Okay what's going on and what do I need to do differently OR do I just need to accept it.'"

Though Natalie Y. gives us little detail about the situation at work, she gives us a great level of detail regarding how the program helped her to deal with her problems at work. By using Step 4, she was able to quickly take inventory of the situation and assess how she was playing a part in the problem. One such way, as Natalie Y. suggests at the end, is to accept the problem, i.e., to acknowledge her powerlessness over the problem and let go of control. As she points out, this is critical because it is a waste of effort to attempt to change the other person. Instead, she can look at herself and how she was responding to that person, reinterpret the situation to make it less threatening or seem less like an attack on her person (meaning-focused coping) and then either respond to the issue directly (problem-focused coping) or accept it and move on (emotion-focused coping). Many members refer to this as "living in the solution" or as "focusing on the solution." By this, they mean precisely the process just articulated. In fact, members of structured groups

often refer to their group as “solution-oriented.” This suggests that structured groups, with their deliberate focus on reading the literature and working the Steps with a sponsor, are oriented toward learning to use the program in the manner articulated by Natalie Y (i.e., as a repertoire of coping strategies that can be used to moderate stressors).

Kathy T., the “military brat” who described her nervous breakdown as her “beat moment” and is a member of the structured group Rigorous Honesty, gives a brief summary of how Step 4 helps her with relationships in general and with romantic relationships in particular:

> “You know I wrestle with the relationship thing. I’ve been in a relationship with a guy for over 5 years. When I get really resentful and angry toward him, I do an inventory to clear up my side of the street, to clear up the blockage between us in the relationship. So that can help my relationships, my relationship with my family, with my friends. It’s great.”

The story here is incredibly similar to Natalie Y.’s story, except Kathy T. focuses on a different domain of her life where she finds Step 4 can function as a useful coping strategy. She does not give us a good sense of how Step 4 translates into a specific kind of coping strategy but in each instance a “spot-check” inventory is taken that enables the individual to “clear up my side of the street,” a phrase that is often repeated by members of structured groups, so that he or she can be “part of the solution.” The present discussion suggests this can mean different things depending on the situation. At times, it may entail reinterpreting the situation (meaning-focused coping) or identifying and dealing with the emotional turmoil caused by a stressor (emotion-focused coping), or it may reveal the need for direct action (problem-focused coping). Furthermore, Kathy T. not only describes how Step 4 can be applied to relationships but also connects this point to the fact that working the program has a positive impact on her life in general because it

actually improves her relationships with others. In this respect, developing and refining coping strategies actually has an impact on her network.

To give another example, Noah Y., who is a member of the structured group Rigorous Honesty, has 7 years of abstinence, and nearly lost his license to practice as a physician as a result of his alcoholism, discussed how he used Step 4 to help deal with a particularly stressful situation at work a couple months prior to our interview:

> "More recently I had a bad outcome with a patient who ended up dying. Part of [what upset me] was certainly things I could've done different, or wish I would've done differently, and of course I felt bad that the patient died. But really what was kind of unsettling to me was the fear I had that all these outside things were going to happen to me. That I was going to get sued, that my colleagues, physicians, and the nurses, and social workers, weren't going to think well of me… So I took my inventory and talked to my sponsor about it focusing on my part in it and what really was my part and what really was not and more importantly what my part was in the fear of how people were going to think about me. Turning to the Steps and my sponsor really helped me work through that stuff."

Noah Y. therefore sees the Steps, in particular Step 4, as a means to manage the stressors of situations at work. By taking his own inventory, Noah Y. was able to identify the underlying issues that were giving rise to his stress and thereby find some relief. Step 4 allowed Noah Y. to gain some critical distance, or a sense of perspective, on the issue and, in a sense, functioned as a meaning-focused coping strategy. He was able to reinterpret the situation in a new light and reduce the threat of the situation.

Kathy T. went into more detail subsequently in our interview, breaking down what a spot-check inventory looks like and tying together several of the various threads that have run through the discussion of Step 4:

> "Umm, I think like AA gives you, uhh, a lot of tools to question yourself as you go through life. So for me what I'm like now, as far as my actions are concerned, I'm more concerned about why am I agitated or why am I doing something that I'm doing, why am I afraid at this very moment? So it's pretty interesting because I can get into situations during the day and I feel myself getting pissed off at something

> somebody's done at work and I will immediately be like, 'Why are you so concerned about that?' like, 'What does this say about you? What's being hurt here? What outcome are you afraid of happening?' So I think that's one of the biggest things is just being able to assess things really quickly and then let go and see what happens. Like a spot-check inventory in the 12-12."

Like Natalie Y., Kathy T. finds that Step 4 works well in conjunction with Step 1 and in a work context, just as Noah Y. suggested. Both of these points make sense. If Step 4 is about acknowledging how your thoughts and behaviors are not helping the situation then the next logical step is to figure out a solution. Many times the individual is able to turn to Step 1 as that solution and simply let go of his or her desire to control the other person, or the outcome. Admitting powerlessness, rather than being defeatist, actually serves as a powerful meaning- and emotion-focused coping strategy. Letting go acts as a sort of preventive measure, or as a moderating resource. Stress and anger are not pent up and then unleashed on others, or on the self through compulsive drinking. This applies to the work context, as Kathy T. points out, and perhaps to any other situation that involves relations with others.

Kathy T. reiterated this point subsequently during the course of our interview, broadening from Step 4 to Step 4 through Step 7, which represent the entire process of taking inventory, sharing of the inventory with another person, and admitting powerlessness much like in Step 1 (see Appendix A for a list of the 12 Steps). According to Kathy T., these Steps are particularly useful because they isolate how you tend to cope with stressors while also giving you new coping strategies:

> "Yeah, and the other thing is that [Steps] Four through Seven really just give you how you react to life. Your character defects, how do you react when you're threatened, when you're fearful, when you're trying to get what you want. That's actually really good. You have this assessment, 'This is who I am and this is how, these are the actions that affect my life.' So it gives you a clear picture of what you should be working on."

As Kathy T. suggests, Steps 4 through 7 are particularly important because they give you an assessment of how you normally react. This is particularly important as members seek to develop healthy coping strategies. Taken in conjunction with the previous point, Kathy T. suggests that Step 4, in particular, is extremely important because it both gives you an assessment of how you tend to cope using unhealthy coping strategies and provides you with tools for the development of healthy coping strategies. This is then applied to any given situation. The member identifies the stressor, isolates its source, and then attempts to address it (i.e., cope with it) using any number of tools (i.e., coping strategies) at their disposal.

That said, this idealized scenario does not always play out according to plan. Sometimes even the sharpest tools do not get used. Alcoholics Anonymous acknowledges this fact of life and builds it into the program. As the Big Book states, "No one among us has been able to maintain anything like perfect adherence to these principles. We are not saints" (Alcoholics Anonymous 2002: 60). So what happens when a member fails to put the tools into action and employ the coping strategies outlined above? It is here that Step 9 ("Made direct amends to such people wherever possible, except when to do so would injure them or others.") becomes relevant. My respondents suggest that it is a key problem-focused coping strategy.

Nina shares precisely this sentiment:

> "I don't react to situations with near the same intensity that I used to. I still have a temper, I still can throw things. But I have the ability to apologize today. I never had that. I couldn't say I was sorry like to anybody ever because that would've been like admitting that I'd done something wrong or that I was a bad person. Like I think if I would've apologized to anyone during that period it would've been like I was apologizing for everything. Now I'm sort of able to say like okay this is an apology about one little tiny piece of myself."

She spells out very clearly that she is far from perfect, both as a person and at working the program, but through working the program she has made tremendous progress in learning how to effectively manage stressors. Now she uses the tools of the program to apologize, undoubtedly a problem-focused coping strategy, which as hard as it might be to believe, she says she was never able to do in the past. Amends may also extend beyond an apology. When members make amends it is implied that they will generally do whatever the other person deems appropriate compensation for the harm done. Heartfelt apologies and pledges to correct future behavior, along with sincere effort to do so, are the norm. Paying back monetary debts accumulated during the course of drinking is very common for the newly abstinent.

Kathy T. applies the emphasis on amends to the context of work:

> "The other thing is, uhh, I've had to make amends to people and once you make amends to people at work, particularly people who work for you, I have found myself literally like getting ready to get in the same situation and it'll click for me, 'Don't go there, do something different this time' and therefore I have a better relationship with my coworkers."

Making amends has served as a learning experience for Kathy T., enabling her to have better relationships with other people as a result. The stress of strained relationships is moderated through making amends. This suggests that Step 9 serves as a problem-focused coping strategy because it resolves, or diminishes, stress-inducing conflicts and relationships. Making amends (Step 9) and letting go of control (Step 1) therefore seem to function as bookends to Step 4. If negative behavior is spotted before it occurs, Step 1 can used as a meaning-focused coping strategy to lessen the perceived threat of the situation and thereby avoid problem behaviors or responses. If, on the other hand, a stressor provokes some sort of negative response, Step 9 can be used to remedy whatever

wreckage might have been created so as to prevent additional stress accumulating from the unresolved problem situation. This can be said for relationships with coworkers, significant others, friends, etc. and because of their wider applicability to relationships in general such tools have a profound impact on the quality of life for members of the program in ways that extend beyond the immediate context of struggles with alcohol.

Nick K., early 30s, is a member of Surrender, a social group, but was planning to leave the group, most likely for Unity, a structured group in my sample. Nick K. was a bright kid with a tragic upbringing. He grew up in an environment where both of his parents were active alcoholics, abusive and controlling. Based on his story, I got the impression that Nick K.'s father used him as a means to enable his parents' dependence. When describing his childhood, Nick K. said he constantly struggled to fit in and do normal kid things, be it staying over at a friend's house, playing sports, or participating in marching band, but could never achieve any of these things because Nick K.'s father had him do everything around the house and often would not allow him leave the house simply to demonstrate that he was in control. Nick K. said most of his childhood is a blur, which he presumes is a means to cope with the difficulties he encountered. I do not need to refer to my interview transcript to remember that at the conclusion of a long soliloquy about his childhood, he summarized by saying, in a hauntingly emotionless tone, "So my childhood was really lousy in the main." Nick K. joined the military after graduating high school, but was allowed to enroll in a Junior College for a year before attending basic training. When asked how he started drinking, he responded, "Quickly." He went to school three weeks prior to the start of the semester in order to attend band camp. He said he became an alcoholic before classes even started despite his intention to never drink

because of his father. After one year of heavy drinking and nearly failing out of all of his classes, he left for the military. He hated it. One "benefit" to his experience in the military is that he learned to "control" his alcoholism, i.e., to cease experiencing external consequences. As a result, he was able to complete his service, maintain a job, and get a degree from a well-respected university graduating with high marks. After graduation, in the span of a year, he went "from having what seemed like the world in front of [him] to being in a deep well." It was at this point that he joined AA.

Nick K. is an affirmed atheist yet he has very positive things to say about prayer and meditation, the focus of 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.):

> "I pray in the morning and I pray at night and I pray simply because I was told to pray. I have no idea what I'm praying to and I have no idea what, no expectation that something is listening. But I know there's something therapeutic in the act of prayer… I know that it gets me thinking about stuff. And if that's all it does for me, honestly, that's quite a lot… I certainly feel like I have a tremendous amount to be thankful for and I don't always think about that. It's really easy for me to get pissed off about my work situation and I can spend a lot of time feeling sorry for myself but if it doesn't stop before then it generally stops then because I spend a little time thinking about, you know, what I have to be grateful for."

Nick K. connects the act of prayer to enhancing his life in a general way, much as previous respondents have with other aspects of the program. He sees prayer has helping him get outside himself and "thinking about stuff." He clarifies this point, saying that at the heart of it is finding things to be grateful for. Doing so serves as an additional safety valve allowing him a positive means of releasing stress and anger, which in turn also improves his relationships with other people and can make his work situation easier. The emphasis on gratitude therefore functions like a meaning-focused coping strategy. It

enables him to reinterpret his life focusing on the positives rather than the negatives and to thereby diminish the importance, and thus stress, of those negatives. When an atheist finds benefit and meaning in prayer, it is hard not to see how the tools of the program can be put to use to cope with the stressors of life.

Stepping back from the individual tools, the final two examples help broaden our perspective. These examples summarize the various points made as I worked through specific examples and attempted to elucidate how the Steps function as coping strategies and what the act of putting them to use actually looks like for members of the program. Ben, who nearly lost his P.A. license as a result of his dependence, stresses the point that incorporating the principles of the program into your life is an active process and he repeatedly refers to AA as a "program of action," a sentiment he shares with many of my respondents:

> "I mean, it's given me a set of principles to live by and a way to enact those things in my life. Ya know, a lot of people go to church and have wonderful things happen; I went to church and it was fine. That's one of those things where you can go and sit there for an hour and leave but if you don't take whatever principles and put them into action in your life then nothing is going to happen, nothing is going to change."

Ben is explicit about seeing the program as a set of tools to be actively employed in his life and compares it to religion in order to make his point. He stresses action because he sees integrating the tools into one's life as an active process. One has to work at it perpetually in order for it to become perpetual. If behavioral change, in this case abstinence, is the goal, then Ben suggests that one must continually work at using the coping strategies to manage the stressors in one's life. It is a gradual, active process of learning and then becoming proficient at taking the Steps of the program and using them

to moderate stressors that might lead to compulsive drinking. It is a replacement for drinking, which functioned as an alternate, maladjusted, form of emotion-focused coping.

Lastly, we return to Natalie Y., who played the part of the tormented yet functional alcoholic for decades. She is very clear about the link between the program, the Steps, and abstinence:

> "Well just understanding why I drank. That, umm, and what I was running away from. And those things still exist in me, ya know, those things that I would run away from, they didn't go away when I stopped drinking, so what AA has helped me do is to respond differently to those things, to address them and give me relief from those things without drinking. It's far more, far more. It's freedom, freedom from those things that caused me so much pain that I drank. Ya know, so much discomfort that the only solution was for me to drink and, ya know, once I started I wasn't going to stop."

Just as with many other respondents, Natalie Y. believes a critical feature of the program is its attempt to find new strategies for coping with the things that alcoholics are "running away from," i.e., from the stressors in their lives that alcoholics use alcohol to moderate.

Nina made a similar point during the course of our interview. Speaking about how she sees her former self, Nina said, "I see my [former] self as really scared, really confused and then I took actions I needed to take in order to get a solution and it's just unfortunate that that solution involved hurting tons of people and like you know fucking up my family life and my own life in such drastic ways." It thus becomes clear that members see alcohol as one coping strategy and the Steps as an alternate coping strategy. Relating this notion to Natalie Y.'s previous point about how she uses the tools of the program in a work context, we get a much clearer picture of how the program can be thought of as a repertoire as well. While at work, she quickly performed a Step 4 spot-check inventory and then used the Step 1 emphasis on powerlessness to let go of her desire to control the situation. That is, she took the tools of the program and their function

of moderating the stressors that incite compulsive drinking and dealt with the problem in a positive way. She used Step 1 as a meaning-focused coping strategy. Natalie Y. therefore gives us a very concrete example of how and why the program acts as a repertoire. It is a set of tools that become internalized and deployed in a variety of contexts for the purposes of moderating the stressors in one's life.

Conclusion

In this chapter, I sought to build on the work of the previous two chapters. In Chapter 1, my analysis suggested that structured groups differ from social groups in that they focus primarily on reading the AA literature and working the Steps with a sponsor. In Chapter 2, I investigated these processes more closely, paying particular attention to the function that reading the literature and working the Steps with a sponsor might serve for individuals in structured groups as a means to explain the differences in long-term abstinence. I found that underlying these processes is an effort to transmit the Steps as a repertoire of coping strategies that members can employ to manage stressors that threaten to activate their compulsion to drink. In this chapter, I investigated the processes underlying the use of the Steps as coping strategies. My goal was to understand how it is that members actually employ the Steps as coping strategies. In other words, I wanted to explore what the act of applying the Steps as coping strategies looks like in an everyday sense so as to gain a better understanding of the mechanisms through which processes

characteristic of structured groups might actually translate into long-term abstinence outcomes.

The main focus of the foregoing analysis was how the program functions as a set of coping strategies that members use to address stressors and how, over time, these tools become a way of life. My respondents suggested that this is what it means to "work the program": to integrate the tools of the program into your daily life so that they can be utilized as coping strategies in a variety of contexts. As one does so, the program becomes a repertoire (i.e., a persistent pattern of thinking and acting) that members deploy automatically, as second nature. My analysis suggests that, in the end, the primary purpose of reading the literature and working the Steps with a sponsor is to internalize the tools of the program such that they become an ingrained, almost non-deliberative process that is implemented virtually devoid of context. This is, of course, only true in the ideal-typical scenario. The adage in cultural sociology that people "have more culture than they use" is undoubtedly applicable to the case of recovered alcoholics. Interestingly, however, members are conscious of the imperfect fit between coping strategies and the effective management of stressors and institutionalize shortcomings with an emphasis on "progress not perfection" when it comes to employing the Steps.

As I have argued here drawing on in-depth interviews with my respondents, the Steps are designed with the express purpose of dealing with the stressors of life in general. My respondents describe how the tools of the program carry over into daily life, being useful in virtually every situation they encounter throughout the day. As they become recovered alcoholics, making the program a way of life, the thought or desire to drink becomes almost non-existent over time. Members do so by developing the Steps

into a repertoire of coping strategies, which can be translated directly into terms familiar to the stress process literature.

Many of the members I interviewed described a danger in this loss of obsession/compulsion. The absence of compulsion can lead to complacency and/or a belief that the alcoholic is cured, which can lead to relapse. A number of my respondents who relapsed early in recovery described precisely this process. In this sense, alcoholism and the program operate as though they are mutually exclusive repertoires. To drink is one approach to coping. It is to, in effect, use a temporary coping strategy that brings about no resolution to the stressors and is accompanied by increasingly severe side effects. To work the program is another approach. Rather than cope through an emotionally unhealthy avoidance strategy, members learn to cope through emotionally healthy channels (even if this includes emotion-focused avoidance strategies such as those institutionalized in admitting powerlessness). My respondents suggest both are not possible simultaneously. It is perhaps because of these clashing approaches to coping that members of AA view recovery and the program as fundamentally incommensurate with drinking.

My respondents also make clear that it is not enough to simply not drink for them. This is precisely the reason why the term "dry drunk" exists in AA. To simply not drink is only an absence. It is not a positive state of being.[11] Coping strategies are merely removed, which can actually leave the alcoholic in worse shape than before. As such, alcoholics enter the program looking for a way to stop drinking and they find much, much more. They find in the program a repertoire of coping strategies that transcends the

[11] It is very much like the term "mental health," which is often treated, at least implicitly, as nothing more than the absence of illness.

drinking context seeping into virtually every aspect of the recovered alcoholic's life. The program of Alcoholic Anonymous is therefore more than a tool for maintaining abstinence. It is a generalizable set of tools, a persistent pattern of thinking and acting that transcends context; it is a repertoire. Kathy T. summarizes nicely this point: “It’s freakin’ amazing! You come here not to drink and you rearrange your whole interaction with life and all you really thought was, ‘Oh someone’s gonna teach me how to not drink.’” This is what is implied in the Step 12 missive to “practice these principles in all our affairs.” Nina is equally illustrative: “It gives me these amazing tools. All I have to do is call my sponsor like what am I going to do about this situation and it turns out, oh yeah, I'm gonna pray and write a fear list. Duh! It gives me these amazing tools and I feel better after I do them.” It gives members a set of tools that they can use to deal with stressful situations and by applying them to their life, a member can moderate the harmful effects of those stressors.

In the final chapter, I attempt to spell out the contributions of the chapters individually and as a whole, particularly as they relate to the larger goals set out in the Introduction. Of utmost importance will be to relate the foregoing analysis to the question of how social relationships have their effects. I hope to suggest that this work contributes a great deal to such an understanding since it gives us both a sense of how social relationships can pattern coping strategies and how the coping strategies themselves might actually work to affect health.

CHAPTER 5

CONCLUSIONS

At the outset, I noted that research has consistently documented a causal relationship between social relationships and health while simultaneously neglecting to gain a detailed understanding of the underlying processes through which social relationships have their effects. For over three decades, researchers have pointed out the need to assess how it is that social relationships actually work to have their effects yet such research has not been forthcoming. This absence is particularly striking because the stress process paradigm offers a number of compelling mechanisms such as social support, self-efficacy, and coping strategies that are thought to moderate the harmful effects of stress. This suggests the need to both connect these coping resources to the social relationships-health link and to spell out how it is that these resources actually operate in the moderating process. The preceding analysis attempted to fill this void.

It did so through an ethnographic examination of alcohol abuse and dependence (AAD) and Alcoholics Anonymous (AA), an area where this same problematic has recently come to light. This separate yet related body of research is primarily concerned with treatment, where comparative efficacy research has been the norm. In recent years, researchers have begun to explore the underlying mechanisms through which various forms of treatment have their effect and thus have embarked on an agenda

complementary to the issues long outstanding in the broader social relationships literature. Targeting AAD and AA therefore offered an important empirical starting point for conducting research on the underlying processes through which social relationships pattern health. It enabled a lens into a very large problem and grounded the research in a specific case.

Chapter 1 introduced the AA groups studied within this research project. It immediately departed from other studies of AA by calling attention to significant heterogeneity among the groups and attempted to classify these groups into two types: social and structured groups. I suggested that social groups are characterized by their intense focus on the social aspects of AA, which include social support, developing a new network of peers, and providing a sense of belonging. Structured groups, on the other hand, are characterized by their intense focus on reading the literature and working the Steps with a sponsor. My data suggested that social groups shine in terms of incorporating newcomers whereas structured groups are characterized by considerably higher levels of long-term abstinence.

The finding that structured groups have higher levels of long-term abstinence led me to investigate why it is that the social relationships in structured groups, with their attendant focus on reading the literature and working the Steps with a sponsor, might be especially conducive to long-term abstinence. This was the purpose of Chapter 2. In Chapter 2, I turned my attention to structured groups and assessed what it is about reading the literature and working the Steps with a sponsor that might link these groups to better outcomes. My analysis suggested that these processes can be understood as transmitting to members a repertoire of coping strategies. Through reading the literature

and working the Steps with a sponsor, members of structured groups learn tools to moderate the stressors that might lead to compulsive drinking and alcohol abuse. Underlying this point was the realization that alcohol functions as a moderating resource in its own right, albeit an unhealthy one that members become overly-dependent on, and thus the work of structured groups can be understood as offering a replacement for the place of alcohol in their lives.

Then, in order to fully connect social relationships through the repertoire of coping strategies known as the Steps to outcomes, I attempted to isolate how exactly it is that members put these coping strategies to use in Chapter 3. In this chapter, I drew on a variety of examples of ways in which members use the Steps as various kinds of coping strategies to moderate stressors that they encounter in their life. Members repeatedly detailed how a number of different Steps can be implemented as tools for effectively managing stressors. Members spoke of the Steps in terms of meaning-focused (e.g., taking inventory), problem-focused (e.g., amends), and emotion-focused (e.g., letting go of control) coping strategies and explained how they are substantively put to use in order to produce positive outcomes.

Throughout these chapters, my overriding goal was to assess underlying mechanisms through which social relationships pattern health. My analysis as a whole suggests that the actual substance of relationships matters and does so because of the socializing functions that relationships play in the development of coping resources, specifically coping strategies. The choice of home group brings with it a certain kind of affiliation and this has an important bearing on outcomes. Most critically in the case of long-term abstinence, my analysis suggests that relationships influence an individual's

coping repertoire and thereby impact subsequent health. I therefore see coping strategies as a key mechanism through which social relationships have their effects. Given the links between these findings and the religion-health literature, the above analysis may help us gain a better understanding of the more general process concerning the link between social relationships, how and why they work through stress moderating resources, and with what effects.

In the Introduction, I was careful to point out limitations of the present research, specifically the fact that I could not isolate these processes as causal. My data are simply not of a kind that lend themselves to "proving" a causal connection between type of group and outcome. There is little need to convince that coping resources act as moderators in the stress process, nor that social relationships pattern health. What has been missing is an understanding of the underlying processes through which coping resources actually operate to have their effects. It is here where my analysis shines. The data that have been used to establish a causal connection between social relationships and health simply have not been amenable to articulating in clear detail the underlying processes that are the focus of the present ethnographic approach. One approach's strength is another's weakness. The close attention to detail in the preceding analysis has attempted to offer a careful accounting of how it is that these processes actually occur by looking at how variation in the substance of social relationships, i.e., the culture of the group, leads to differences in coping strategies and thereby outcomes. I have attempted to provide clear and compelling mechanisms at work by explicitly tracing the link from AA group to coping strategies to actual stress moderating on the part of individuals.

Why is it that coping strategies are so central to my analysis? One substantive implication of my argument is that it may be particularly important to target coping strategies when thinking about behavioral change. In part, this is simply because other coping resources were relatively constant across groups. Social support, social control, sense of belonging, and mattering, all important moderating resources, are present in both groups. There can be little doubt that social influence and social control act as forms of behavioral guidance helping members to maintain sobriety. Members model and encourage behaviors for newcomers. In fact, this is an important component of the sponsor-sponsee relationship, which I have argued is at the heart of structured groups. The emphasis on fellowship, or unity, as one of the "Three Legacies" in AA also makes clear the importance of belonging and companionship. These resources are not absent from structured groups; rather, they take a secondary role to what is the primary focus of social groups. Structured groups therefore contain all the things that social groups have yet they sacrifice some of what makes social groups so attractive in order to make room for deliberate focus on the transmission of coping strategies. Ecologically, it seems like a natural division of labor. Social groups catch members early on, make them feel welcome, and absorb them into the fold in their early struggles with abstinence, and then structured groups give them the tools to achieve long-term abstinence.

If anything, then, the current analysis suggests that these other moderating resources are either less important predictors of long-term abstinence, or the situation is more complex than what is generally captured with the strategy of apportioning variance that typifies quantitative analysis. One such example may be the role of self-efficacy in abstinence. Perhaps self-efficacy predicts abstinence because coping strategies increase

feelings of self-efficacy. By teaching an individual how to better cope with stressors, it boosts their sense of mastery, and thereby leads to abstinence. In this sense, coping strategies answer the question, "Where does self-efficacy come from?" Another example may be the peculiar fact that perceived support is an important predictor of outcomes yet actual, or received, support tends not to be. The preceding analysis suggests that the kind of support matters. Availability and provision are not enough; social support, in and of itself, is not enough to achieve long-term behavioral change. In order to have a lasting impact on health outcomes, individuals need tools to actually carry out the change. Social support may be an important component, but it is not the difference that matters, at least as it is typically conceived. In the case of abstinence from alcohol, for example, support with achieving abstinence may be important, particularly early on, but it does not appear to be the crucial ingredient for long-term abstinence.

In this sense, the emphasis on coping strategies raises the question, "How is it that one would actually achieve abstinence simply with support?" What is it that should be supported? Is it simply the act of not engaging in the problem behavior? Certainly that is important, particularly early on when the shear compulsion to engage in the behavior can be overwhelming (e.g., when the person is still physically dependent). But this is essentially a passive kind of support. It does not empower the individual with tools that they can actively draw upon when dealing with a problem behavior. It does not help the individual employ coping strategies; it is not a direct replacement for the problem behavior, which Chapter 2 suggested was critical when thinking about how coping strategies work to affect behavioral change. Individuals need support that involves actual instruction in how to cope, both because they need a means to manage the stress that

arises from attempting behavioral change and because changing the behavior is like abandoning their go-to coping strategy. It is a particular kind of support that matters, one that helps the individual employ coping strategies. Thus the present analysis may also help refine our thinking about how various coping stress moderating resources operate, perhaps through their influence on coping strategies, to have their effects. It suggests the need to think through more complicated models of how effects might be said to occur.

I hope that the present research also has lessons regarding AA, in particular. My research suggests that Step work may not be important early on; rather, social support functions are central. Subsequently, however, Step work, which is achieved through reading the Big Book with a sponsor, may become crucial for the goal of long-term abstinence. In the process, it also suggests that groups ought not to be treated as homogeneous entities. Effects likely depend on the individual group and the match between the individual and the group. Sending a newcomer to a structured group may lower their chances of success; not sending someone to a structured group after they have had a chance to reap the benefits of social groups may also lower their chances of success.

An important corollary is the need to distinguish between attendance and involvement in studies of AA. Anyone can attend an open meeting of Alcoholics Anonymous. But to attend does not mean that one is reaping the benefits of the program. I regularly attended meetings of AA for an extended period of time and had personal contact with many of the members but I would hardly consider myself to have participated or belonged. If you ever want to see how easy it would be to attend meetings and not become involved then visit a few. Unfamiliar faces often enter just before the

meeting begins and leave as soon as it ends. It is easy to do. Ben best captured the difference between attendance and involvement when he said, “You can sit me in a garage for 90 days but I’m not going to turn into a car.” It is therefore necessary to pay attention to the actual contours of these relationships: What is it that people are actually doing? What is the substance of these relationships?

The present research also suggests the need to study longer-term outcomes. Studies almost always focus on changes in alcohol-related behavior at 1, 3, and 6 month intervals. 1 year is unusual. And yet permanent behavioral change is notoriously difficult to achieve. Is our goal 6-month change? Is that the basis upon which an intervention should be deemed successful? This suggests the need to focus on the factors that lead to lasting change, as I have attempted to do here.

An important concrete implication for AA also arises from my observations. Given the important functions that the two kinds of groups serve for different phases of the recovery process, it may be possible to house both needs within the same group and therefore better facilitate the transition from social group to structured group. One way of doing this might be to incorporate “beginners meetings” into structured groups. Though the substance of beginners meetings varies, one model stands out. In this model, a chair or discussion leader will briefly discuss a topic at the core of AA (for example a Step) and then members take turns speaking as normally occurs in an open discussion meeting. In this way, the social support functions are emphasized initially but it also gives some exposure to the coping resources that become important subsequently. Most importantly, it creates an environment that welcomes newcomers while also linking them to members with longer-term abstinence that can serve as the kind of sponsor that will focus on

reading the Big Book and working the Steps. It would essentially institutionalize the path that many members tread more precariously by linking newcomers to the resources that will be most beneficial to them during various stages of the recovery process.

An interesting tension internal to AA, and possibly generalizable beyond the context of AA, also emerges from the present research. My data suggest that the kind of the group matters for long-term abstinence yet the underlying processes through which members achieve long-term abstinence happens primarily outside the group through one-on-one sponsor-sponsee interactions centered on reading the Big Book and working the Steps. Why, then, does the culture of the group matter if the mechanisms that produce long-term abstinence occur outside the group? The answer, I believe, lies in the fact that the group is ultimately the site through which the member connects him or herself to others and therefore the choice of home group sets one on a path. This path necessarily circumscribes the possible and creates an opportunity structure. Groups are a place to get networked and the kinds of networks that people develop matter, as suggested by a substantial body of research on the link between social relationships and health that was reviewed in the Introduction and by the preceding analysis. The present research extends beyond this insight though and helps explain why it matters. In a social group, you simply are not as likely to find the kind of sponsorship that transmits the AA repertoire of coping strategies through reading the literature and working the Steps. The would-be recovered alcoholic faces a problem of supply and demand. The lack of emphasis on the kind of sponsorship I argue matters for long-term abstinence creates a problem of demand because the recovering alcoholic cannot demand what they do not know. The lack of the kind of members that would be able to sponsor in a way that transmits these

coping strategies creates a problem of supply because the members of social groups have not done it themselves.

Additionally, in Chapter 3 my research suggested that developing and refining coping strategies actually has an impact on networks and I read my research as evidence in favor of the compelling work suggesting culture drives networks.[12] In the case of AA, it seems to me, a taste for the low-hanging fruit of belonging offered by social groups drives members to their initial participation; however, over time their tastes shift. Members begin to realize that they need something more, i.e., their tastes develop, and this leads them to select out of their social group in favor of a structured group and thereby they forge a new network. In short, and in the context of AA, tastes tend to shift over time and drive network membership.

I also hope that current research extends beyond the case of AA to treatment in general. AA may be exceptional in that, relative to other treatment modalities, it offers a broader repertoire of coping resources. The nature of the organization may make some coping resources, e.g., the sense of belonging and motivation that are particularly important early in recovery, more easily realizable. But the important point is that these processes are not mysterious or unique to AA. They are generalizable to other forms of treatment. Attending meetings, sponsorship, reading the literature, and working the Steps are all ways to transmit coping strategies (the Steps), enhance self-efficacy (e.g., by giving members coping strategies so that they can become proficient at dealing with problems on their own), network change ("fellowship"), motivation (e.g., by hearing the stories of others and providing a source of meaning and purpose through service such as sponsorship), etc. The difference, in my view (other than the fact that it is far cheaper and

[12] Lizardo 2006; Vaisey and Lizardo 2010

more widely available), is simply that AA bundles all of these into a single package. Unfortunately, this is often lost, or at least more difficult to obtain, with the division of labor that exists between social and structured groups.

Underlying this insight, and as mentioned in Chapter 2, is the fact that AA functions similarly to any number of cognitive behavioral therapies (e.g., Motivational Enhancement Therapy and Rational Emotive Behavior Therapy; (see the Introduction for more on these methods and their efficacy relative to 12-Step-based approaches to treatment) as well as other treatment methods that are typically posed as alternatives to AA (e.g., SMART Recovery and Rational Recovery). In every case, it is possible to interpret these programs as attempts to transmit to individuals a set of coping strategies for disrupting a dysfunctional cognitive-affective-behavioral process. In every case, treatment involves learning coping strategies to manage the stressors thought to lead to the compulsive behavior and, over time, to develop a new pattern of thinking and acting as a result. Of course how these processes unfold (i.e., their actual substance) varies widely among treatment modalities. Their underlying mechanisms, however, are remarkably similar, particularly given the antagonism that sometimes exists between these alternative models.[13] This suggests to me that it may be necessary to read the Big Book with a sponsor in order to learn the Steps and how to apply them to one's life as coping strategies within the context of AA but that such processes are not necessary for learning new coping strategies more generally. Instead, activities such as those in AA are a case of the kind of deliberate, focused, long-term work that is necessary to transmit to individuals coping strategies, and for these coping strategies to become routine. It may

[13] Here I mean the one-sided antagonism of Rational Recovery toward AA. Rational Recovery is often framed as alternative, superior program and actively discourages attending any kind of recovery group.

seem like excess, but recall from the Introduction that behavioral change is extremely difficult; inertia is the norm. It therefore may require an "excessive" amount of deliberate work such as that found in AA to learn the coping strategies that will enable an individual to manage the excesses that characterize problem behaviors.

Though not the primary focus of the present research, this finding also speaks to a larger tradition of thinking at the origins of sociological theory. It suggests that social environs that enforce rules more strictly, or perhaps make more demands of their participants, may be a better means of fostering the kind of community that brings long-term benefits to members of that community. Early sociological theory proposed an opposition between Gemeinschaft (i.e., face-to-face, intimate, and enduring social structures characteristic of tightly-knit communities) and Gesellschaft (i.e., modern, anonymous, impersonal social relations).[14] This work argued that Gemeinschaft places large external costs on the individual but seems to have largely positive benefits because it binds individuals together, whereas Gesellschaft tends to create greater room for the self-interested individual but at the cost of the larger social fabric. Similar themes emerge in other early theory, including the risk of a breakdown in social norms and the loss of community with the shifting division of labor in the industrializing world[15] and in the modern metropolis.[16] This line of thinking extends throughout the history of social thought into the present day.[17] In essence, sociological thinking has a long tradition of seeing the heavy external demands of a close-knit community as a positive force that

[14] Tonnies [1887] 1957.

[15] Durkheim [1893] 1933.

[16] Simmel [1908] 1950.

[17] See, e.g., Davis 1949, Elias 1978, Giddens 1991, Merton 1968, and Wirth 1938.

binds people together. Durkheim's seminal work on suicide stands out as an exemplar of this thinking and is perhaps the most proximate example to the present work.[18] In this work, Durkheim argued that greater external demands by a community tend to have a positive influence on risk of suicide (so long as they are not too extreme, one obvious example being Jim Jones and the Peoples Temple). There is, therefore, a close parallel between Durkheim's work, and many subsequent scholars', and the present analysis, which suggests that structured groups may better promote long-term abstinence because of the greater demands that they place on their members. By incurring additional costs above and beyond social support, members of structured groups find a new repertoire of coping strategies that can be used to better achieve behavioral change. The present research therefore taps into a larger tradition of research on how groups bind people together and with what effects, hopefully helping to make sense of the underlying mechanisms through which these processes occur.

In order to make the case that coping strategies are central to the relationship between social relationships and health, I have also borrowed insights from cultural sociology. The emphasis on microcultural processes (i.e., at the level of the individual group) led me to take a novel approach to the study of AA. In turn, I found the concept of cultural repertoires to be a useful heuristic. Structured groups appear to transmit to members a persistent pattern of thinking and acting that brings with it a set of tools for managing problematics (i.e., stressors). Members are learning a package of coping strategies. In this way, the present research helps bring together cultural sociology and the sociology of health and illness by helping us think about how cultural mechanisms

[18] Durkheim [1897] 1997.

underlie the stress process. Culturally-shared ideas, meanings, and mental representations undoubtedly pattern coping resources.

Typically, cultural repertoires are thought to be emergent in interaction and it takes considerable work simply to unearth the core meanings shared by a group of individuals, much less how these meanings inform their behaviors, and especially health behaviors. It is perhaps for this reason that cultural sociology and the sociology of health and illness are uncommon bedfellows. With AA, however, these processes are on the surface, institutionalized and codified. The repertoires, once understood as repertoires, are laid out in the Big Book and transmitted via sponsorship. The study of AA therefore allows for a unique source of leverage. It makes it easier to "see" how meaning-making processes transpire and with what effects. To use an analogy, the site of AA as a study for meaning-making might be thought of as akin to the use of radioisotopes in nuclear medicine. To describe briefly, such a procedure involves injecting an easily traceable chemical into a person's body so that a physician can more easily capture how the body is functioning improperly. As the body processes the chemical in a manner divergent from the norm, it is possible to isolate where the chemical was processed improperly. In the case of Alcoholics Anonymous, the program itself functions much like those radioisotopes. Because we know what is to be processed, i.e., because the Steps are institutionalized, it allows us to more easily trace how they move in interaction, come to constitute the substance of social relationships, and with what effects.

Two other points seem particularly pertinent. First, the focus on cultural dimensions also offers a complement to fundamental causes research,[19] which focuses on the material sources of health disparities. It turns our attention to the non-material factors

[19] See Link and Phelan 1995.

that pattern health. Second, though a detailed discussion is beyond the scope of the present work, there should be clear parallels between the current research and religion. David I. makes this point explicitly in Chapter 3. I have suggested that many of the same processes that occur in AA extend to other treatment modalities and perhaps to social life more generally. Religious groups are likely the most immediate extension beyond other forms of treatment. The conclusions drawn from AA therefore may help us understand some of the underlying processes through which religion patterns health, a stream of research in its own right. Though it seems inappropriate to speculate on the details, it is possible that much of the underlying processes identified in AA are directly transferable to the context of religion.

In sum, I hope that the present research has made a number of important contributions. Most importantly, I hope that it has given some insight into the underlying processes through which social relationships affect health, an area of research that has long been absent from the study of health and illness. The social and health sciences are among the last to abandon a Newtonian view of causation that focuses on simple deterministic and linear causal effects. The "hard" sciences have long since moved on and yet we cling. I read the multiple-decade call for mechanisms underlying the social relationships-health link as an acknowledgment that this classical approach is inadequate. As I see it, this approach has gotten us to the point where we have identified causal relationships but fail to understand the underlying processes. This suggests, to me, the need to move beyond this antiquated notion of causality in order to understand not just causal relationships but the underlying mechanisms. I believe that research will be

profitably advanced by embracing complexity and contingent causation.[20] I hope that the present research stands as an example of how research can be moved forward through such an approach and thereby serve as a signpost along this path. This is not to say that present research suggests or demonstrates that the prevailing approach is "bad" or "wrong" or "unnecessary," simply that it is insufficient. Along the way, I hope that the present research has also contributed to our understanding of AA, alcohol abuse and dependence, behavioral change, treatment, coping resources and the stress process, and cultural processes underlying these diverse topics.

[20] This is not an argument concocted out of thin air. Glass and McAtee (2006), among others, make this argument well. In fact, I read the entire thrust of mechanisms-based research, which was touched on briefly in the Introduction, as, at the very least, an implicit acknowledgment of the validity of this argument. There are, however, myriad forces standing in opposition to such a shift. The first that come to mind are norms of scholarship and merit (most especially in terms of what is likely funded) and ease (complexity and contingent causation are undoubtedly more difficult to assess and model, particularly given prevailing analytic strategies).

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

- 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.

INTERVIEW SCHEDULE

[Introductions and verbal informed consent (see Appendix C)]

Section I: Basic information

- Your first name & last initial please?
- What is your DOB?
- Sex/Gender?
- Race/Ethnicity?
- Are you married? Have you ever been married?
- What is the highest level of schooling that you have completed?
- *IF STRUGGLING, PROMPT: some high school, high school diploma/GED, some college, college degree, more than a college degree...

Section II: Background information on sobriety, meeting attendance, support

- What is your sobriety date?
- What step are you currently practicing? Worked through the 12 steps?
- Do you have any sponsees? How many?
- What is the name of your home group?

- How often are meetings offered at your home group?
- How often do you attend meetings at your home group?
- Do you regularly attend groups other than your home group? Names? How often attend?
- If you had to take a guess, how many meetings would you say you've attended in the last year?
- How many AA members would you say you can turn to for support? How many would you say you regularly turn to?
- How often would you say you are in contact with these key people?
- Do you keep in contact with many of the people that you knew prior to entering AA and are not members of AA?
- *IF YES, Are any of these your old drinking buddies? What kind of relationship do you have with your old drinking buddies?

Section III: The meaning of being an alcoholic

- Looking back, prior to when you started drinking, what was your life like?
- *PROMPTS: Family life? Childhood in general? Where you lived?
- What were you like? Who were you before you started drinking?
- Do you think AA has helped you understand that time in your life differently? How so?

  Can you describe for me how you moved from being a person who didn't drink to

being a person who did?

- Looking back, how do you see yourself while you were drinking, that is, as a practicing alcoholic? Who were you before you stopped drinking?
- Do you think AA has helped you understand that time in your life differently? How so?
- Can you describe for me how you moved from being a person who drank, a practicing alcoholic, to being a person who didn't drink?
- How do you see yourself now?
- Do you think AA has helped you understand yourself differently nowadays? How so?
- How do you think your view of alcohol and alcoholism has changed since joining AA?
- What have been some of the most important things you've learned in AA?
- Could you briefly described to me what you think are some of the most important aspects of AA?
- How do you see AA as helping you maintain sobriety?
- Does AA do more than help you maintain sobriety? How?
- Can you give me specific examples? Related to not drinking? To everyday life?
- *Prompts: When you want to take a drink? Problems with coworker? Family? Etc.

Section IV: How respondents selected a particular group as their home group

- Why have a home group?
- How long have you been a member of your home group?
- How long has your group been in existence?
- About how many home group members would you say there are in your group? Of those, how many would you say are active?

- How many members of your group would you say have long-term sobriety in your group?
- Why did you select this particular group as your home group and not another group?
- In a given 6-month period, how many newcomers would you say enter your group but do not stay and get sober?
- How would you say your group is in comparison to other groups when it comes to helping newcomers achieve long-term sobriety?
- If your home group were to shut down suddenly, what would you do?
- *PROBE: How would you go about selecting a new group? Would you choose one of the other groups you attend [refer to list]? Why or why not?
- On a scale of 1 to 10, where 1 is worst and 10 is the best: All things consider, how would you rate your life in general these days?
- How would you say your overall life satisfaction compares to other members of your group?

- *IF STRUGGLING, PROMPT: better, worse, or about the same?
- How about your group in general in comparison to other groups?
- *IF STRUGGLING, PROMPT: better, worse, or about the same?
- What would you say is most important to your maintaining sobriety in terms of what goes on in the group?

Section V: The nature and extent of AA-related activities

- What does it mean to work the program? What is it that one should do in order to achieve sobriety?
- *Prompts: What does it look like? Can you describe what these things are? How do they operate? How are they beneficial?
- Do you think it's important to regularly attend meetings? Why? What purpose do they serve? Do you do so?
- Do you think it's important to get a sponsor? Why? How is it beneficial?
- What is the nature of the relationship with one's sponsor? What happens in that relationship? How is it part of working the program?
- Do you think it's important to read the Big Book? Why? How is it beneficial? Do you do so?
- Do you think it's important to get involved in service work? Why? What purpose does it serve? What kinds of service work are you involved in?
- How often would you say you participate in activities with other AA members

outside of formal meetings?

- Prompts: coffee/food, picnics, Alano clubs, parties (e.g., New Year's party, dances), other AA group-based clubs (e.g., a group motorcycle club), camping, softball, group clean-up-fix-up days
- During these activities, how much of the time would you say you spend talking about things specifically related to AA (e.g., the Steps, animosities, recovery, etc.)?
- How often would you say your group sponsors/organizes such activities?
- Have you always participated as much as you do currently?
- IF NOT, Why the change?
- Why is that you participate in these outside activities?
- Do you see them connected to AA in some way?

[Conclusion: Thank the participant for their time]

CONSENT SCRIPT

Hi! As you already know, my name is Andrew Payton and I am a doctoral student at the University of North Carolina at Chapel Hill in the Department of Sociology.

I am going to read a consent script and ask you to give verbal consent regarding your participation in this interview. I will ask only for verbal consent so that we can better protect your anonymity by not having to ever record your last name. Please take a copy of this information so you can follow along and also because there is contact information at the bottom in case you find yourself with any questions or concerns at a later time.

First, you should know that your participation in this interview is completely voluntary. If you do not wish to participate, you may say so now or stop at any time during the course of the interview. If you do not wish to answer a particular question, for whatever reason, simply say so and we will move on.

Second, you should know that your responses will be completely anonymous. Information such as your name, the name of your AA group, other AA members, etc. will not be included in anything that is written based on this interview nor will it be given out to anyone else. If you agree to give consent I might use direct quotes from you, but these would only be quoted as coming from a fictitious person with a fictitious name in a fictitious group.

Third, I want you to know that the purpose of this research is to better understand how AA groups help members maintain sobriety. You should know that I am paying for all the costs associated with this study. The interview averages about 1 and a half hours in length.

- Do you have any questions at this time?
- Do you agree to participate in this interview at this time?
- Do you agree to be audio recorded at this time?

If you think of anything else please feel free to contact me at [number removed] or via email at [email address removed]. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish, the UNC Institutional Review Board at [number removed] or via email at [email address removed].

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