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After the Albuquerque conference in 1992 (see the opening article in this book) and the publication of its papers the following year, Bill Miller suggested to me that perhaps the best way to get some important points across would be to write an article jointly. Since most viewed Miller as a critic of A.A. and me as a friend of the fellowship, we hoped that the mere conjunction of our names would draw attention to the piece. It did, as this became one of the most requested reprints in our experience. The article appeared in the Journal of Studies on Alcohol *55(2): 159-166 (1994), as William R. Miller and Ernest Kurtz. "Models of Alcoholism Used in Treatment: Contrasting A.A. and Other Perspectives with Which It Is Often Confused."*

Models of Alcoholism Used in Treatment:

Contrasting A.A. and Other Models with Which it is Often Confused

William R. Miller, PhD and Ernest Kurtz, PhD

In January of 1992, we participated in the first national conference on "Research on Alcoholics Anonymous: Opportunities and Alternatives," jointly sponsored by the University of New Mexico and Rutgers University (McCrady & Miller, 1993). Among the insights that emerged during that meeting was the realization that the essential nature of an A.A. model of alcoholism and recovery is often misunderstood. In particular, key elements of three other models are often confused with, mistakenly attributed to, or blamed on A.A. (e.g., Heather & Robertson, 1983; Miller & Hester, 1989; Peele, 1985).

Drawing on a survey of alcoholism treatment professionals in New Mexico and California, Moyers (1991) examined the factor structure of

beliefs about alcoholism. A strong first factor blended endorsement of items drawn from A.A. publications with non-A.A. items reflecting *genetic* ("A person's genes determine whether he or she will become an alcoholic"), *personality* ("The denial of alcoholics is so strong that it is often necessary to use very strong confrontation to get them to accept reality"), and *moralistic* beliefs ("Drinking alcoholics are liars and cannot be trusted"). Two other relatively unrelated factors embodied social learning theory and a view of alcoholics as a heterogeneous group with different needs and problems. Simultaneous endorsement of disease and moralistic beliefs seems to be the norm (Moyers & Miller, 1992). Milam and Ketcham (1983) have decried this dominant confusion of moral, spiritual, personality, and biological models.

As the treatment of alcoholism becomes increasingly professionalized, and as interest in research on A.A. grows, it will be important for treatment and research professionals to have a clear, accurate understanding of the essential nature and tenets of A.A.. At an experiential level, there is no substitute for attending A.A. meetings, and we believe that professionals in this field should do so. In thinking through the relationship of A.A. with treatment (Brown, 1985) or the design of new research in this area (McCrady & Miller, 1993), it is also helpful to have a sound conceptual grasp of how A.A. historically has understood alcoholism and the process of recovery. We seek, in this article, to offer a step in that direction by distinguishing among core A.A. precepts and other beliefs peripheral or even antithetical to A.A., with which it is often confused.

Four Models of Alcoholism

Many different descriptive and etiologic models of alcoholism have been proposed (Chaudron & Wilkinson, 1988; Miller & Hester, 1989; Paredes, 1976; Tarter & Schneider, 1976). We will focus here only on four which have been blended in current U.S. beliefs about alcoholism.

Volitional-Moral Model

The oldest model of drunkenness, which long predates Huss's (1849) coining of the term "alcoholism," saw it as volitional, the result of personal choice (Keller, 1979; Sournia, 1990). The ancients at times honored this choice, but the understanding that drunkenness was chosen, that people become intoxicated by their own willful actions, moved most in later times to pass negative moral judgment on such drinkers (Trotter 1778, as quoted by McCarthy 1958). In this view, social sanctions (punishment, loss of status or freedom) are appropriate responses to drunkenness. If adherents to this model adverted to any "loss of control" on the part of chronic drinkers, it may be interpreted as further evidence that drunkards are generally of weak and depraved character – an understanding furthered by temperance movements (Lender & Martin, 1987; McCarthy, 1958; an entertaining treatment may be found in Lender & Karnchanapee, 1977).

This perspective – that alcoholism is a matter of choice – is very much alive. Civil and criminal courts in the U.S. continue to show a reluctance to hold defendants blameless for actions committed under the influence (e.g., toughening laws on impaired driving). The U.S. Supreme Court has ruled that alcoholism can be regarded and treated as "willful misconduct" (Connors & Rychtarik, 1989). An assumption of freedom of moral choice lies behind all "Just say no" campaigns.

Personality Models

A second view emerged with the rise of psychoanalysis around the turn of the century. Alcoholism here is assumed to be a symptom of an underlying personality disorder, a disturbance of normal development. Though varying in specific content, writings in this area generally cast alcoholics as immature, fixated at an early childish level of development (Strecker, 1937). Thus arose the notion of the alcoholic personality – the idea that alcoholics share a common set of (undesirable, immature) traits which *precede* and continue or worsen with the development of drinking problems. Despite the elusiveness of such a personality in hundreds of studies of alcoholics (e.g., Miller, 1976; Vaillant, 1983), the belief strongly persists that alcoholics have a consistent and abnormal personality. Current popular manifestations include: (1) the notion that alcoholics characteristically overuse primitive ego defense mechanisms such as denial; (2) the belief that alcoholism in particular and addictive behaviors in general are results of growing up in dysfunctional families, and (3) the idea that there is a pervasive personality disturbance (e.g., co-dependence) which characterizes all people with addictions as well as those who live with them. The treatment, it follows, is psychotherapy, or some other process of working through, reparenting, etc.

American Disease Model

Within U.S. society, a third view emerged in the 1930s and 1940s, growing rapidly in popularity after World War II (B. Johnson, 1973; Wilkerson, 1966). Inspired by the observations of Dr. Benjamin Rush at the end of the 18th century, some 19th-century scientists had investigated the senses in which "inebriety," as chronic drunkenness was then generally termed, might be a disease. By century's end, however, the pressures of Prohibitionist political correctness had forced the abandonment of such research. With the repeal of Prohibition in 1933, a new "alcoholism movement" appeared in the United States, soon revealing itself to be dedicated less to research than to propagating the view not only that alcoholism is a disease, but that it is a particular *kind* of disease (B. Johnson, 1973). This model is succinctly set forth in one of the most popular and representative books of this movement (Milam and Ketcham, 1983).

Four core assumptions underlie the American disease model:

1. Alcoholism is a unitary disease entity that is qualitatively distinct and discontinuous from normality. As with pregnancy, there are no grey areas; one either is or is not alcoholic.

2. The causes of alcoholism are solely biological, rooted in heredity and physiology. Behavioral, family, and personality disturbances are merely symptoms of the underlying physical abnormality in how the body reacts to alcohol.

3. The definitive symptom of developed alcoholism is an inability to control consumption after the first drink. This is an inexorable reaction to the chemical ethanol, resulting from the physical abnormality.

4. This condition is irreversible and cannot be cured, only palliated.

In this view, alcoholics bear no responsibility for the development of their problems. They are, in fact, viewed as incapable of making rational decisions, warranting social intervention to coerce them into treatment. The therapy of choice consists of detoxification, education about the disease, admonition to abstain from all psychoactive substances, and medical procedures to alleviate related physical problems such as nutritional deficits (Milam & Ketcham, 1983). Psychotherapy is contraindicated, but referral to A.A. is seen as helpful for follow-up support. Nonalcoholics, on the other hand, are seen as able to handle alcohol normally, and thus in need of no treatment: "Alcohol is an addictive drug only for the minority of its users who are physically susceptible" (Milam & Ketcham, 1983, p. 24).

Alcoholics Anonymous

Alcoholics Anonymous is fundamentally a spiritual program. It is not a treatment, but a way of living and being. Though its sole purpose is to help alcoholics become and stay sober, the program attends to much more than the mere imbibing of alcohol. Only the first of A.A.'s Twelve Steps even names alcohol. The rest are concerned with spiritual processes: knowledge of and relationship with God or a Higher Power, self-searching, confession, openness to being changed, amends, prayer, seeking God's will, carrying

the message to others (Kurtz, 1979; Kurtz & Ketcham, 1992). Alcoholic drinking is seen as a reflection of the human need – gone wrong – for spiritual life and growth. Abstinence, then, signals only embarkation on the A.A. way of life, which is seen as a continuing journey toward wholeness and serenity (Alcoholics Anonymous 1953, Wilson 1967). Spiritual experience is not a byproduct, but the means by which an alcoholic recovers. Many A.A. writings in fact question whether it is even possible to recover by nonspiritual means.

In the A.A. understanding, the core of alcoholism, the deep root of alcoholic behavior, lies in *character* (which is not to be confused with personality). "Selfishness – self-centeredness! That, we think, is the root of our troubles" reads a key passage of A.A.'s delineation of "How it works" (A.A. 1976, p. 62); and A.A.'s members habitually use the vocabulary of faults ("defects of character") such as grandiosity, resentment, defiance, dishonesty, and obsession with control. Practice of the twelve steps brings a recovery characterized by growth in such character traits as acceptance, honesty, humility, and patience.

Points of Departure

Physiologic Factors

Because of its spiritual focus, A.A. is by nature inclusive rather than exclusive. It is therefore easier to say what A.A. *is* than what it is not. For example, although the primary focus of A.A. is on spiritual factors in etiology and recovery, A.A. writings explicitly leave room for physiological, psychological, and social factors, and for whatever new knowledge may emerge through scientific inquiry. Thus A.A. cannot be represented as saying that alcoholism is *not* caused or influenced by a particular factor. A.A. specifically refuses, by its traditions, to take any stand on such issues.

It is entirely out of character with A.A., however, to assert that alcoholism is caused only by a physical abnormality (or, for that matter, by any single factor). To do so is to deny the spiritual, psychological, and social aspects of alcoholism and of humanity, and A.A. consistently names, includes, and examines such influences. Its encompassing implicit model might be called spiritu-bio-psycho-social.

This is one way, then, in which A.A. differs from the American disease model. Milam and Ketcham (1983) specifically deny any except physiological causal factors, and criticize A.A. for being "a powerful obstacle to accepting the otherwise overwhelming evidence that biological factors, not psychological or emotional factors, usher in the disease" (p. 141). A.A., in contrast, does not "take any particular medical point of view" (A.A., 1976, p. xx), asserts that "the main problem of the alcoholic centers in his mind, rather than in his body" (p. 23), and consistently describes alcoholism as an illness with many dimensions. "Of necessity," the book *Alcoholics Anonymous* notes early in its "There is a solution" chapter, "there will have to be discussion of matters medical, psychiatric, social, and religious" (A.A., p. 19).

The absolute, black-or-white tone in which the American disease model is often expressed is likewise at variance with the character of A.A.. Bill Wilson's writings consistently allow for exceptions, referring to "most alcoholics" and "many of us." Even on the disease model's anathematic issue of controlled drinking, a term introduced in the original 1939 A.A. "Big Book," Wilson wrote: "If anyone who is showing inability to control his drinking can do the right-about-face and drink like a gentleman, our hats are off to him." Even in the midst of observations that "demonstrated again and again: 'Once an alcoholic, always an alcoholic,'" the tone of A.A. remains one of openness, inquiry, and allowance for differences. For though "Physicians who are familiar with alcoholism agree there is no such thing as making a normal drinker out of an alcoholic," Wilson recognized in the next sentence that "Science may one day accomplish this, but it hasn't done so yet" (all quotations from Alcoholics Anonymous 1976, p. 31).

Alcoholic Personality

On the question of whether alcoholics have a consistent personality, Wilson expressed some support for the idea:

> When A.A. was quite young, a number of eminent psychologists and doctors made an exhaustive study of a good-sized group of so-called problem drinkers. The doctors weren't trying to find how different we were from one another; they sought to find whatever

> personality traits, if any, this group of alcoholics had in common. They finally came up with a conclusion that shocked the A.A. members of that time. These distinguished men had the nerve to say that most of the alcoholics under investigation were still childish, emotionally sensitive, and grandiose. . . . In the years since, however, most of us have come to agree with those doctors. . . . We have seen that we were prodded by unreasonable fears or anxieties into making a life business of winning fame, money, and what we thought was leadership. So false pride became the reverse side of that ruinous coin marked "Fear." We simply had to be number one people to cover up our deep-lying inferiorities (A.A., 1953 p. 127).

Wilson did offer other generalizations about alcoholics' *character*. As always, he carefully allowed for exceptions, but after 17 years of sober experience with A.A. members, Bill depicted alcoholics as "largely a band of ego-driven individualists (p. 150), "bankrupt idealists" and perfectionists (p. 160), and "certainly all-or-nothing people" (p. 165).

Yet it is doubtful that Wilson thought any of these to be *uniquely* the characteristics of alcoholics, distinguishing them from other people. Both his published writings and his many letters (to individuals both alcoholic and non-alcoholic) exude the sense that A.A.'s co-founder is writing about general traits of humankind. It is not surprising, then, that recent years have seen A.A.'s twelve-step program applied to many different problems by a wide variety of people. Immersion in A.A. literature indeed suggests a parallel with John Milton's comment on the word "presbyter": the "alcoholic" is simply a *human being* "writ large" (quoted by Haller, 1963 p. 180). There is no sense that alcoholics are peculiarly weak or fallen, wicked or malicious – and this is one very large way in which A.A. departs from a moral model.

On the now popular notion that alcoholics have universal defense mechanisms, Wilson had little to say. The language of defense mechanisms is from psychoanalysis, not from A.A., and the word "denial" does not even appear in Wilson's major writings. He characterized alcoholics as resistant to pressure, and reluctant to admit alcoholism while drinking, but no implication is made that alcoholics as a group – before, during, or after drinking – are characterized by generally primitive defensive styles. This

idea, and the notion of "breaking down" defenses, are concepts of psychotherapy, and characteristic of confrontational programs such as Synanon, rather than of A.A. Although Synanon was pioneered by an A.A. member, Charles Dederich started Synanon precisely because there seemed no room in A.A. for the confrontation he deemed essential (Yablonsky 1965).

Coercion

With the rise of a treatment industry, it became increasingly acceptable for alcohol-impaired people to be coerced into treatment by the courts, employers, and planned family interventions – an uncommon practice in most of medicine and psychology. Vernon Johnson (1973) opined: "The primary factor within [the alcoholic] is the delusion, or impaired judgment, which keeps the harmfully dependent person locked into his self-destructive pattern. . . . The alcoholic evades or denies outright any need for help whenever he is approached. It must be remembered that he is not in touch with reality" (p. 44). Milam and Ketcham (1983) similarly argued that alcoholics "are sick, unable to think rationally, and incapable of giving up alcohol by themselves. Most recovered alcoholics were forced into treatment against their will" (p. 14).

Members of A.A. might well disagree with such a view. As their stories make clear, no one really comes to A.A. "freely," but the coercion described is more internal than external. "I finally got sick and tired of being sick and tired," runs one common explanation of why a member first came to A.A. The idea of externally coercing an alcoholic to do *anything* is utterly foreign to A.A.'s way. The guidelines set down by Wilson in 1939 for "working with others" have never been revised:

> If he does not want to stop drinking, don't waste time trying to persuade him. You may spoil a later opportunity. . . If he does not want to see you, never force yourself upon him (p. 90). . . Be careful not to brand him an alcoholic. Let him draw his own conclusion (p. 92). . . He should not be pushed or prodded by you, his wife, or his friends. If he is to find God, the desire must come from within (p. 95).

Contrast this with the following excerpt from an "intervention" with an executive, presented as exemplary on page one of the *Wall Street Journal* (Greenberger, 1983):

> They called a surprise meeting, surrounded him with colleagues critical of his work and threatened to fire him if he didn't seek help quickly. When the executive tried to deny that he had a drinking problem, the medical director . . . came down hard. "Shut up and listen," he said. "Alcoholics are liars, so we don't want to hear what you have to say."

As the stories that continue to appear in *The A.A. Grapevine* attest, for over 50 years members of A.A. have generally continued to intervene in the supportive, listening, and patient manner suggested by their Big Book – a style that differs radically from the aggressive, confrontational methods sometimes advocated to "break down defenses" (Miller & Rollnick, 1991).

Willful Misconduct

While A.A. writings clearly support alcoholics' right and ability to choose their own way, Wilson was clear in his understanding that drinking was not a willful choice for true alcoholics. Here A.A. differs from a volitional-moral model, which regards drinking a matter of will and decision:

> But what about the real alcoholic? . . . At some stage of his drinking career he begins to lose all control of his liquor consumption, once he starts to drink (A.A., 1976, p. 21). We know that while the alcoholic keeps away from drink as he may do for months or years, he reacts much like other men. We are equally positive that once he takes any alcohol whatever into his system, something happens, both in the bodily and mental sense, which makes it virtually impossible for him to stop (p. 22).

The A.A. understanding is evident in Wilson's description of his first meeting with co-founder Dr. Bob Smith. Speaking to Bob, Bill "bore down heavily," using the words of Dr. William Duncan Silkworth, "describing the alcoholic's dilemma, the 'obsession plus allergy' theme" (A.A. 1957, p. 69).

"Obsession" clearly implies that the alcoholic's lack of control extends to *taking the first drink*. In a 1966 letter reprinted in *As Bill Sees It: The A.A. Way of Life*, Wilson delineated his understanding of the alcoholic's power of choice: "As active alcoholics, we lost our ability to choose whether we would drink. . . Yet we finally did make choices that brought about our recovery. . . . we chose to 'become willing,' and no better choice did we ever make" (Wilson, 1967, p. 4).

In Jellinek's (1960) terminology, members of A.A. were thus understood by Wilson to be both "gamma" (unable to stop) and "delta" (unable to abstain) alcoholics. The hopelessness and powerlessness of this picture – unable to abstain, and unable to stop once started – provides a context to understand the need for help from a higher power. A.A. was meant, from its inception, as a last resort, when all else had failed. The lack of control is not limited to the second drink, or even to the first drink, but is described as a condition of the alcoholic's prior life in general. *Life* had become unmanageable.

Responsibility

Even a cursory examination of the twelve steps reveals A.A.'s sense of the alcoholic's responsibility to act: to admit, ask, accept, confess, pray, etc. The power to transform is not the alcoholic's, but God's – as members delight in reminding careless observers: "A.A." is not a self-help program: we tried that, and it didn't work. A.A. is a God-help program." Yet it is the alcoholic who must take the initiative for recovery, who must, by choice, "become willing."

The A.A. way differs from the American disease model in its sense of responsibility for actions prior to sobriety. Milam and Ketcham (1983) argued that A.A. "fixed the blame for contracting the disease squarely on the victim" and "has mistaken the psychological consequences of alcoholism for its causes" (p. 140). They warned that "The alcoholic should be assured throughout treatment that his personality did not cause his disease and that he is in no way responsible for it" (p. 156). They further advised that the fourth step of A.A. – making a searching and fearless moral inventory – should be based only on actions *after* treatment, not on what the alcoholic did before sobering up.

A.A., in contrast, advocates acceptance of responsibility for one's own actions, period. It is difficult to imagine an A.A. meeting at which someone claims, "I am not responsible for anything I did before I quit drinking." In the fourth through seventh steps, members specifically take responsibility for examining their past lives, recognizing and acknowledging their shortcomings. In the eighth and ninth steps, this responsibility is extended to making amends for past wrongs. Only then does the "from here on" advocated by Milam and Ketcham enter. A.A.'s final three steps are often referred to as "the maintenance steps." They assume a clearing away of "the rubbish of the past," not ignoring or denying it. Thus, the sense of avoiding moral responsibility for one's condition – a criticism sometimes leveled at A.A. – is characteristic of the American disease model, but clearly not of A.A.

Unitary Condition and Unitary Treatment

The American disease model is notably binary: either one is an alcoholic (and needs treatment) or a nonalcoholic (and needs no treatment). It was this very unitary disease model against which Jellinek (1960) cautioned.

There is much in A.A. writings to indicate an early, pre-Jellinek recognition of different types of alcohol problems. Phrases such as "seriously alcoholic," "not too alcoholic," "true alcoholic," and "real alcoholic" imply variations, as does Wilson's evident caution in using qualifications such as "most alcoholics" and "many alcoholics." Although the term *alcoholic* is manifestly used in different meanings in Wilson's prolific writings, it is clear that he consistently distinguished A.A. alcoholics from other types of drinkers, including "hard drinkers." Neither A.A. literature nor A.A. members speak as if there were one and only one type of alcohol problem. A.A. simply takes no position on anything except the experience of alcoholism described in its Big Book, by its members, for it is with this experience that potential new members must identify.

In describing a "model treatment program" (Milam's own), Milam and Ketcham (1983) prescribed a set of essential ingredients for success including an unnegotiable abstinence goal, education about the exclusively

physical cause of alcoholism, and nutritional counseling. Other approaches to treatment (e.g., medications, psychological therapies) were specifically denigrated as ineffective or detrimental, and inferior to their American disease model treatment.

Bill Wilson's writings, in contrast, describe A.A. not as the one only way, but as only one way: the way its members had found to be effective for alcoholics "like us." As the foreword to the second edition (reprinted in the third edition) of *Alcoholics Anonymous* states: "Upon therapy for the alcoholic himself, we surely have no monopoly" (A.A., 1976, p. xx). Even in the essential area of "the spiritual," the Big Book's instructions for "working with others" cautioned from the very beginning: "If he thinks he can do the job in some other way, or prefers some other spiritual approach, encourage him to follow his own conscience. We have no monopoly on God; we merely have an approach that worked with us" (A.A., 1976, p. 95).

According to A.A.'s Tenth Tradition, "Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy" (A.A., 1953, p. 180). As both Bill Wilson's writings and a variety of articles in the *A.A. Grapevine* have consistently made clear over the years since the Yale Clinic confusion in 1944, modalities of treatment and other approaches to recovery are "outside issues" (Kurtz, 1979, p. 118). For diverse reasons, over the same years, some in both the treatment and the research fields have forgotten or ignored that fact. Yet like any entity that claims to be "spiritual," A.A. eludes capture. The exploration undertaken here, we hope, will aid understanding not only of that reality, but of why it is so.

Conclusion

In sum, A.A., as reflected in its own literature, differs in several important respects from the volitional-moral, personality, and American disease models with which it is commonly confused in current public and professional conceptions of alcoholism. These differences are summarized in Table 1, which schematizes the foregoing discussion. Assumptions derived from these other models have been grafted onto A.A. concepts to form the opinions that dominate both treatment and research in the U.S. alcoholism field. Yet key constructs from these models are incompatible and contradictory, as reflected in current confusion about the nature, causes, and treatment of alcoholism. Is it a binary condition, a continuum, or a group of subtypes? Is it a moral problem? To what extent are alcoholics responsible for their actions? Is there only one way to recover?

Table 1
Summary of Points of Agreement and Divergence

	A.A.	Disease	Moral	Person.	Behav.
What Causes Alcoholism?					
Moral/Spiritual Factors	Yes	No	Yes	No	No
Biological Factors	Yes	Yes	No	No	No
Psychological Factors	Yes	No	No	Yes	Yes
Social/EnvironmentalFactors	Yes	No	No	Yes	Yes
Prime Causal Emphasis	Spir	Physiol	Voliti	Dvpmntl	Psych+
What Is Alcoholism?					
Disease/Illness	Yes	Yes	No	Yes	No
Unitary Entity	No pos.	Yes	No	Yes	No
Personalty Irrelvant	Char	Irrelevant	Wkwill	Immatur	
Moral Issues					
Choice About Drinking	Earlier not Later	No	Yes	Yes	Yes
Responsblty for Past	Yes	No	Yes	Yes	Yes
Responsblty to Recvr Change	Dn't Drink; Work Steps	Accept Tx	Behave	Accept Tx	
Coercion acceptable Recovery	No	Yes	Yes	Yes	Yes

Source of Healing	God	Medical	Morality	Psychthrpy	Psych.
Helping Style	Empathic	Expert	Exhort'n	Confrntatn	Educ
Attitude To Moderatn	Skeptical	Prohbitve	Permissv	Variable	Variable

"The only requirement for A.A. membership is a desire to stop drinking" (A.A., 1953, p. 143). One aspect of A.A.'s claim to be "spiritual rather than religious" is that it imposes no creed, no dogma. It is important to remember this, at a time when pressures imposed by political and economic interests, some of which at least give the impression of reflecting A.A. thinking, promulagate views that go far beyond the "experience, strength and hope" described in A.A.'s own literature.

Several of the most contentious political-economic issues within the U.S. alcoholism field do not arise from A.A., but from an amalgamation of the viewpoints outlined above. A.A. writings do not assert: (a) that there is only one form of alcoholism or alcohol problem, (b) that moderate drinking is impossible for everyone with alcohol problems, (c) that alcoholics should be labeled, confronted aggressively, or coerced into treatment, (d) that alcoholics are riddled with denial and other defense mechanisms, (e) that alcoholism is purely a physical disorder, (f) that alcoholism is hereditary, (g) that there is only one way to recover, or (h) that alcoholics are not responsible for their condition or actions. These assertions involve outside economic, political, social, moral, legal, and disciplinary issues on which A.A. takes no stand (although A.A. members, as individuals, and political organizations such as the National Council on Alcoholism, do so).

It would be helpful for treatment and research professionals to separate these issues from A.A. itself, and to understand the essential nature of A.A. as a spiritual program of living. Therapists can, for example, better choose and prepare their clients for A.A. referral if they have a clear understanding of how A.A. differs from other models and approaches. Well-informed designers of needed research could, for example, better choose process and outcome measures appropriate to reflect progress through the program, as A.A. understands itself.

Perhaps more than any other reality born in modern times, Alcoholics Anonymous has become the proverbial elephant described by unsighted examiners. Immersion in the literature on A.A. indeed suggests that as with

the classic Rorschach inkblots, those who tell about A.A. may reveal more about themselves than about the fellowship and its program. That *caveat*, of course, also applies to us. We have sought to respond to its warning by staying as close as possible to A.A.'s own literature. We hope this will encourage those who continue this discussion to be as cautious in claims that are made using the name of Alcoholics Anonymous.

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