ABOUT A.A.

...a newsletter for professional men and women

Winter 1980

How Three Simple Steps Can Smooth Life With A.A.

A.A.'s gratitude to the professional community grows daily, because we continue to grow at an ever faster rate. Much of this increase occurs because so many treatment professionals refer more and more problem drinkers to A.A. for the long-term, never-ending aftercare it furnishes. This pattern was fixed in A.A.'s earliest days, 1935-40, in Ohio and New York, and has become ever stronger.

Some problems have arisen. But, in A.A.'s 45 years, almost every difficulty experienced in A.A.'s cooperation with the professional community, or even within A.A. itself, has yielded to one of the following three remedies.

(1) Face-to-face communication *before* problems take root

Both professional alcoholism workers and A.A. members highly recommend mutual get-acquainted visits as a way of avoiding misunderstandings or tensions, and of easing those that inevitably occur. For example, one summer evening a few years ago, a small A.A. group (15 members) on the Eastern seaboard had just begun its weekly meeting when the door burst open and 20 patients bussed from a community mental hospital were marched in by a uniformed attendant. The attendant had never been to an A.A. meeting before; he was just following orders. None of the A.A.'s present knew the mental hospital had just started an alcoholism program.

The evening was counterproductive when it could have so easily been helpful to both the group and the hospital patients (and staff).

Clearly, if a large party of, say, student nurses, or prospective new members intends to show up at an A.A. meeting, some advance communication can help. Is it an *Open* meeting? How many "visitors" can be accommodated (chairs, refreshments, etc.)? Will the influx disrupt or change the character of the meeting? Would some other way of exposing the visitors to A.A. meetings be preferable, such as a meeting specially set up, perhaps at the treatment center?

In most population centers in the U.S. and Canada, a telephone call can arrange an exploratory get-acquainted session. A.A. "service" entities can be helpful, such as the local A.A. central office or intergroup; a local institutions, public information, or cooperation with the professional community committee. (If you have any difficulty contacting members locally, call or write this office.)

(2) Clear recognition of the differences between professional treatment and Alcoholics Anonymous

First priority is to understand the important distinction between being a "professional" in the field of alcoholism and being an A.A. member.

Taught by 45 years' experience with hundreds of thousands of alcoholics and thousands of professional treatment agencies, A.A. has a single, simple part to play in the recovery process: *sharing our own experience as alcoholics.* Perhaps the best reading for professionals who wish to understand A.A.'s "differences" is Guidelines for A.A. Members Employed in the Alcoholism Field. We can furnish you as many as ten copies, free.

To enlarge understanding, many A.A. pamphlets are helpful, such as "Twelve Traditions Illustrated"; "A.A. Tradition – How It Developed"; "If You Are a Professional"; and "How A.A. Members Cooperate." If your nearest A.A. group is out of them, ask us for a sample.

But the books are the best source for clarification. They include: "Twelve Steps and Twelve Traditions" and "A.A. Comes of Age."

(3) Sensing the limitations of A.A. on problems other than alcohol

"Pills" was the title of one of the very first A.A. pamphlets (1942). It went out of print over 30 years ago. But the problems endure.

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No matter how much we in A.A. might want to help narcotics addicts, compulsive gamblers, or compulsive overeaters, our primary responsibility is to alcoholics. It would be presumptuous of us even to try to perform tasks we are not qualified for.

One of the great agreements among A.A. members is that we share our *drinking* experiences and perhaps one of our most important strengths is that we stick to the one malady — alcoholism.

Our program is available to all who wish to pick it up and use it in whatever ways they choose in their own lives. (Nonalcoholics in the Al-Anon Family Groups and Alateen have done this.)

We have heard of scores of programs based on A.A., or modeled after it. Those that succeed and survive have always been the ones that looked at our material, but then adapted it to fit their *own* experience, and their own needs.

Some A.A. members also have pill, weight, gambling, and other problems in addition to their alcoholism. But the unifying force for all of us is the *drinking* experience we had. *All* of us had that. Therefore, some A.A.'s feel uncomfortable if a newcomer insists on talking *not* about our common bond, alcoholism, but about "dual addiction," "chemical dependency," and the like. A.A. unity, so paramount in our recovery, seems threatened when these nonalcoholic conditions become the focus of a meeting. Our efforts become diffused, and so does our effectiveness.

With this newsletter you'll find "Problems Other Than Alcohol," a reprint of an article by our co-founder Bill W., which covers the topic at greater length.

How Local A.A.'s in Five States Help Professionals Help Alcoholics

A.A. members in five states have worked out original mechanisms for cooperation with professionals in the alcoholism field.

In **South Carolina**, members of 15 A.A. groups in six counties met recently with members of their county commissions on alcohol and drug abuse. In two other counties, members of six A.A. groups meet bimonthly with commission personnel. Both the recovered alcoholics and the professionals reported learning a great deal about each other and about common concerns.

Oklahoma A.A.'s last year started a pilot program called "Bridging the Gap Between Treatment Facilities and A.A." It began when local A.A.'s went to two large hospitals and expressed concern that many alcoholic patients, upon release, never got to A.A.

Hospital directors and A.A.'s set up for patients facing discharge a weekly meeting chaired jointly by a hospital staff person and an A.A. member. The A.A. talks with each patient and establishes an A.A. contact for each in his or her home community upon the first day of release. Even out of the state, A.A. members have been enthusiastic when asked to be such contacts. Twenty members are involved in the A.A. program.

In **California**, the staff of the Bay Area affiliate of the National Council on Alcoholism met with the local A.A. Public Information and C.P.C. committees to explain the council's purposes and functions. It was useful to those present to explore why A.A.'s Traditions are valuable to the Fellowship, but not binding on N.C.A.

In **Nevada**, the A.A. General Service Committee held a one-day seminar on "Bridging the Gap" between professionals and A.A. groups. Rural counties' mental health entities sent social workers, members of the clergy, psychotherapists, nurses, and alcoholism counselors to the sessions.

In **New York**'s Suffolk County, the A.A. Committee on Cooperation With the Professional Community writes letters to employers, offering A.A. help for employees with a drinking problem. Since A.A. does not run or devise employee assistance programs, the emphasis is on A.A. as a community resource. The results have been gratifying.

Perhaps A.A. members in your community would like to follow those examples, or improve on them.

Triennial A.A. Sobriety Census Taken

During July and August this year, the every-third-year A.A. membership survey (our fifth) in the U.S. and Canada was conducted under the auspices of A.A.'s General Service Board. Results will be announced in a future issue of this newsletter.