An Alcoholic Forever?

A Critical Discourse Analysis of Alcoholics Anonymous Construction of Identity Development in Addiction Recovery

by

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Abstract

Alcoholics Anonymous (A.A.) largely dictates the treatment of alcohol addiction in the United States and Canada. This exclusivity for treating alcohol-related health issues has created problems among individuals who struggle with A.A.'s methods. This Critical Discourse Analysis (CDA) of A.A. texts and member accounts identifies ideological discourses that reflect cultural values and expectations of alcohol consumption. These discourses prescribe how individuals who are reducing alcohol use must behave in order to live successfully. Such behaviours include developing a religious practice, behaving in culturally appropriate ways, abstaining from alcohol, and encouraging other "alcoholics" to adopt their lifestyle. This analysis explores the implications of such identity constructions for individuals seeking to manage alcohol-related health issues.

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Introduction

"If you're an apple, you can be the best apple you can be, but you can never be an orange."
- Alcoholics Anonymous

Alcoholics Anonymous (A.A.) is North America's largest peer-support group for alcoholism. A.A. emerged after the U.S. prohibition and Temperance Movements in the late 1800s and early 1900s (Room, 1993) and is now the most popular, well-known alcohol treatment program in United States and Canada (Bloomfield, 1994; Young, 2011). Being the most dominant program for alcohol dependency, A.A. has been the focus of many research studies. Historically, many researchers supported A.A. as an optimal recovery option for people with alcohol use issues, but more recently scholars, journalists, and other media channels have increasingly begun criticizing A.A. and its components as an ineffective alcohol treatment method. One criticism is A.A.'s impact on personal recovery and sense of self. Literature has shown that A.A. influences identity development in ways that can be positive or harmful depending on member experiences and understandings of themselves. This study looks at how discourses in A.A. are closely connected to dominant ideologies of alcohol use in Canada and the United States. Ideologies in A.A.'s methods and principles may not be based necessarily on what is beneficial for member and individual health, but rather on powerful cultural ideals in Canada and the United States dictating what are appropriate, approved of behaviours, attitudes, and beliefs.

A.A. offers a space for individuals to connect with others as a way of addressing their alcohol dependency. According to Suissa (2003), much of A.A.'s success can be explained by the human and social solidarity it gives to people with alcohol use issues who are usually submitted to social and family isolation (p. 206). The program employs 12 steps designed by its

founders to help individuals overcome their alcohol dependency. The fellowship does not hold an official stance on a theory of addiction, but Young (2011) and Cain (1991) show that A.A. most closely aligns with a specific medical approach – the disease model – towards alcohol use disorders. Consequently, the disease model (Cain, 1991), prohibitionist attitudes (Boyd, 2014), and abstinence narratives (Thompson, 2012b; Tupper, 2008) are among the most accepted concepts governing addiction treatment and recovery today.

While A.A. may be effective for many people struggling with alcohol use, there are others for whom it may not be effective (Kitchin, 2002; Peele, 2012; Suissa, 2003; Thompson, 2012a). Yet, people cannot simply access another way of treatment. Due to the hegemonic views surrounding prohibition, addiction as a disease, and abstinence, A.A. is accepted as universal and absolute and is often portrayed as the only way to seek relief from alcoholism (Frank, 2011). Because personal change in alcohol use is often influenced by a specific set of discourses, identity and existence is often affected too (Cain, 1991; Young, 2010, 2011). Thus, identifying with dominant discourses such as prohibition, disease and abstinence is effective and positive for some and disadvantaging for others (Kitchin, 2002). Research has also shown that those who oppose dominant ways of thinking about alcoholism may face stigmas and negative stereotypes (Boyd, 2014), receive less support (Dutta & Zoller, 2008), and develop damaging identity narratives (Thompson, 2012b).

Challenging these dominant addiction discourses has been difficult in light of their popularity in U.S. and Canadian societies. Many people struggle to understand the various elements and nuances of addiction (Polander & Shalin, 2013) and, as a result, do not realize that issues surrounding alcohol use disorders are often maintained by widespread acceptance and trust in conventional beliefs (Tupper, 2008). This study examines A.A.'s discursive practices

through a critical discourse analysis (CDA) in order to find out how language within A.A. constructs member identities. As Blommaert (2005) and Fairclough (2010) show, it is simple to claim we are affected by the hegemonic beliefs surrounding us, but it is harder to show how such relationships might manifest themselves. CDA has the potential to reveal invisible power relations within A.A. discourse that maintain societal acceptance and reproduction of dominant discursive themes such as disease, prohibition, and abstinence. In order to observe such phenomena, this study analyzed A.A. literature and media and member excerpts within those texts. This process allowed for the identification of specific discursive strategies in A.A. discourse and observation of how they were interpreted and reproduced through social practice. This analysis helps understand relationships between social and societal practices, embedded and socially constructed beliefs in healthcare, and identity among individuals trying to transcend past alcohol use issues. By showing the influence of addiction recovery discourses specifically in A.A., this study intends to help people and society become more aware of dominant ideologies' potential effects on individuals with addictions. Such ideologies are maintained through daily social interaction and may play a significant role in society's inability to effectively address them. This study explores the potential of developing and encouraging a variety of ways to treat alcohol use disorders, rather than relying exclusively on the dominant model.

Literature Review

Alcoholics Anonymous and the Development of Addiction Discourse

The literature explored for this study includes a variety of perspectives regarding A.A.'s role in alcohol treatment. In addition to outlining the role A.A. has had in U.S. and Canadian healthcare, the literature reflects a clear divide among researchers regarding the fellowship's effectiveness. Since 1935, A.A. has progressively grown into the most widely used alcohol treatment program in the United States and Canada (Davis & Jansen, 1998). Bloomfield (1994), DiNitto (2002), Quinn, Bodenhamer-Davis, & Koch (2004), Room (1993), Suissa (2003), Thompson (2012b), and Young (2011) agree that A.A. has been a pervasive entity since its inception. The organization has become the most utilized form of treatment and recovery support in the US with over one million memberships in 1990 and over two million members in its 2014 survey (Alcoholics Anonymous, 2014a; Bloomfield, 1994, p. 23). Support for A.A. comes not just from its members. The organization has a tremendous influence on the public's view of alcohol dependency and the way it is treated (Suissa, 2003, p. 206). Room (1993) found a large portion of the U.S. population was familiar with A.A.'s practices, showing that the organization's influence is not limited to attendees (p. 3).

Due to its popularity, A.A. soon emerged as a popular research topic and also attracted critiques in regard to its religious affiliation (Mäkelä, 1991; Quinn, Bodenhamer-Davis, & Koch, 2004), its conflict with non-American and non-Protestant cultures (Morjaria & Orford, 2002; Vick, Smith, & Herrera, 1998), and, more recently, its dominance and exclusivity as an alcohol treatment agent (Mäkelä, 1991; Quinn, Bodenhamer-Davis, & Koch, 2004). Ideological constructions of medicalized discourses also came under critique. For example, Suissa (2003) explored the impacts of discourse in A.A. and the disease model and concluded that the

medicalization of alcohol and drug use behaviours raised important scientific, ethical, and social issues (p. 206). Research by Cain (1991), Davis and Jansen (1998), Frank (2011), Kitchin (2002), Polander and Shalin (2013), Sifers and Peltz (2013), Thompson (2012a), Wilcox (1998), and Young (2010; 2011) supports the notion that the recovery program an individual attends significantly influences his or her life. This scholarly literature offers a foundation for understanding the relationships among identity, alcohol and addiction discourses, and dominant beliefs visible in A.A. Studies on A.A., the medical (or disease) model of addiction treatment (Boyd, 2014), abstinence narratives (Thompson, 2012b), and prohibitionist attitudes (Frank, 2011) serve as foci for analyzing the role of A.A. discourses in identity development among individuals in recovery.

A.A.'s Ideologies

There are two main approaches to framing alcohol use: the medicalized model of alcoholism as a disease and a large spectrum of theories inspired by sociology, philosophy, psychology, and anthropology (Suissa, 2003, p. 201). For example, positive psychology approaches such as Meaning Therapy (Wong, 2010) are also established forms of treatment for individuals with addictions. These therapy and treatment forms focus on ways to transcend past addiction, rather than reducing addiction to a disease. While A.A. does not officially prescribe to specific treatment paradigms, Sifers and Peltz (2013) found 93.4 percent of 500 A.A. members surveyed described alcoholism as a progressive illness (p. 713). This large acceptance of the disease model suggests that this discourse is maintained and reproduced by A.A. texts. However, support for the disease model is not universal. Working for a private addiction treatment organization in British Columbia, Sunshine Coast Health Center (SCHC), I have witnessed many people struggle to make sense of addiction because of the predominant ways substance and

alcohol use are defined and perceived. SCHC programs adhere to a Meaning Therapy model, rather than the popular 12-step programs seen in most treatment centers. My time at SCHC has shown that popular ideologies such as addiction as a disease are not based on observed qualities in individuals, but a reflection of social values and rules defining acceptable behaviour (Suissa, 2003, p. 205). In sum, there is a noticeable disagreement within research regarding the effectiveness of A.A. and its narratives of drug use, addiction, and treatment (Sifers & Peltz, 2013; Suissa, 2003; Tupper, 2008).

Some researchers prefer A.A.'s approach and consider it effective. Davis and Jansen (1998), for example, describe A.A. as misunderstood when viewed through the dominant social science lens and incapable of being comprehended by outsider – "normal" – non-alcoholics. In addition, Sifers and Peltz (2013) share with A.A. a common belief that only former alcoholics can help other alcoholics get sober, highlighting a pre-existing and influential idea that those who have not experienced alcohol use issues cannot possibly understand the experience of achieving and maintaining sobriety. Lack of outsider understanding, however, is not the cause of A.A.'s breadth of criticisms. Instead, critics claim that referring to heavy alcohol use as a disease and abstinence as recovery creates limitations for those with alcohol use and dependency issues who do not adopt the medical discourse. Other researchers claim that abstinence narratives within the organization maintain an ineffective ideal for many people in, or in need of, recovery as it perpetuates common stigmas of addiction (Sifers & Peltz; 2013; Thompson, 2012b). As Suissa (2003) says, "there are no good or bad drugs, there are only good or bad relations to them" (p. 206). However, the disease model plays a central role in dominant discourses that describe certain substances as "bad" by defining alcohol dependency as a disease. According to Suissa (2003), the intention of the disease model is to promote acceptance of the illness status so that

persons have a better opportunity to get involved and be responsible in their rehabilitation. Consequently, this process of systemically labeling more and more behaviours as diseases leads to a biased conception of those with addictions (Suissa, 2003). Tupper (2008), similarly, criticizes that this conventional discourse is embedded with outdated prohibitionist attitudes and implies that only one correct and healthy way of substance use (in other words, abstinence) exists.

Some studies show A.A. contributes positively towards recovery identities. Davis and Jansen (1998) describe A.A. "as a safe harbour rich in stories and experiences that allow newly recovering alcoholics to reconstruct their life stories" (p. 173). They claim language in A.A. is easily misunderstood by anyone who has not lived the alcoholic experience or been a part of the A.A. fellowship (p. 172). Polander and Shalin (2013) observed both positive and negative alcoholism narratives among A.A. members depending on individual perceptions and the concreteness of their understanding. Personal experiences appear to play a role in how people with addictions adopt and interpret A.A. philosophies. Davis and Jansen (1998) also dismiss criticisms suggesting phrases/concepts such as "powerlessness" further disadvantage those already powerless in a dominant culture. They claim that the language of powerlessness should not be oversimplified and, instead, seen as a language of transformation. "It is a transformation of their identities from drinking non-alcoholics to non-drinking alcoholics" (Cain, 1991, p. 210), affecting how they understand themselves and interpret the world (Wilcox, 1998, p. 110).

Young (2010) shares Davis and Jansen's (1998) support for A.A. as a preferred addiction recovery program, agreeing that A.A. is a safe environment for creating new identities and for individuals who have been rejected by "normals" and are no longer willing to be isolated or identify with drinking alcoholics (p. 716). This social unity is the center point for A.A.'s success and support. It is said that the "addict" identity crisis stems from excessive uniqueness, which

prevents individuals with addictions from connecting with others and can only be resolved through anonymity in social situations (Young, 2010, p. 718). Such concepts align well with A.A. as it discourages individualistic qualities such as personal agency, autonomy, and confidence (Kitchin, 2002; Thompson, 2012b). It is more about the collective being than individual success. Cain (1991) asserts similar ideas, noting that the disease of alcoholism is part of oneself and that one can only change to a non-drinking alcoholic by attending A.A. meetings and finding identity through its members' shared stories. Newly recovering alcoholics must internalize and become emotionally attached to the non-drinking identity in order for effective recovery to occur (Cain, 1991, p. 218). Clearly, member identity plays a dominant role in A.A. discourse.

Once the alcoholic identity has been claimed, it is difficult to shed (Young, 2011, p. 216). According to Cain (1991), the A.A. member comes to see "not only his drinking as alcoholic, but also his 'self' as an alcoholic; the disease becomes part of one's self" (p. 214). Such findings directly conflict with research showing negative outcomes among those who attend A.A. and adopt the "alcoholic" identity. The mainstream conception of addiction adheres to the disease model and drug and alcohol users often internalize it (Thompson, 2012a, 2012b). Alcohol and drugs are invested with powerful social and cultural meanings that affect how people perceive, categorize, understand, use and react to them (Tupper, 2008). A common stereotypical view of individuals with addictions sees them as liars who are in denial, narcissistic, anti-social, and cognitively impaired (Thompson, 2012b). Such perceptions devalue human consciousness and personal agency of people with addictions. Frank (2011) observed similar outcomes among Methadone Maintenance Treatment (MMT) patients. Because MMT patients were considered to still be using a substance, they maintained "active addict" identities and, as a result, were

stigmatized through an abstinence lens. Again, identity development in addiction recovery can clearly be affected by the prevailing discourses used in A.A.

Societal Adoption of A.A. Discourse

Abstinence and disease narratives are the primary discourses in A.A., and their influence is evident in the program's popularity as an alcohol treatment program in society (Kitchin, 2002, p. 770). This popularity causes both people with and without alcohol addictions to embrace abstinence and disease narratives. Hegemony operates largely through discourse by representing things in ways that appear universal and natural (Benwell & Stokoe, 2006, p. 30), and laypeople's simplistic interpretations of addiction's complexity maintain the hegemony of disease and abstinence narratives (Polander & Shalin, 2013). Many people make sense of such information through narratives and figurative language influenced by personal psychosocial experiences (Polander & Shalin, 2013). Because dominant cultures construct personal experiences, it can be expected that popular discourses of abstinence will affect many people's interpretation of addiction since society is already susceptible to adopting the dominant war-on-drugs ideology that shapes contemporary policies (Tupper, 2008, p. 230). Boyd (2014) also shows that the dominant narrative has extended beyond individuals with addictions to the general public. In Boyd's (2014) research, radio hosts maintain conventional beliefs of addictions by describing such individuals as "victims" who are "without hope" (p. 211). Freedom from addiction would only be achieved through "finding redemption and achieving abstinence [in order to repair] their damaged natures" (Boyd, 2014, p. 213). Findings indicate that this medical understanding of addiction has become widespread among friends, family, and society (Boyd, 2014; Frank, 2011), with social institutions such as media reinforcing conventional health policies and regulations that lead to specific cultural understandings of how citizens may use and

maintain their bodies (Thomas, 2006, p. 10). This widespread maintenance of disease and abstinence discourses debilitates individuals in recovery as they begin to internalize these constantly reproduced definitions and experience reduced autonomy, self-efficacy, and personal agency (Thompson, 2012b).

Discursive Practices of A.A. Members

Benwell and Stokoe (2006) assert that identities are the product of dominant, available discourses, which may operate to produce social inequalities (p. 31). Discursive acts of identity include processes that people consistently orient to during accounts of themselves (Benwell & Stokoe, 2006, p. 18)**.** These processes are visible in identity development among people recovering from alcohol dependency in A.A. (Cain, 1991; Sifers & Peltz; 2013; Young, 2010, 2011). However, while many people adopt dominant beliefs maintained in A.A. regarding alcohol use and dependency, a number of Sifer and Peltz's (2013) participants indicated they disagreed with these engrained concepts used in A.A. Some members expressed concern with the ideal of "powerlessness" suggesting that it creates reliance on a higher power (part of A.A.'s spirituality component) or relieves responsibility for past behaviours (Sifers & Peltz, 2013, p. 717). Kitchin's (2002) analysis of traditional, in-person, and virtual A.A. meetings beget similar discussions and comments regarding A.A. philosophies and language. When comparing the discursive practices of in-person and virtual meetings, Kitchin (2002) noticed a dichotomy between how A.A. is supposed to be and how it is actually adopted by members (p. 750). While members may agree and adhere to A.A. philosophies during meetings, many held drastically different opinions surrounding their recovery once interacting on virtual forums. These experiences in virtual A.A. communities showed members go through times of liberation and benefits, but also of disempowerment (Kitchin, 2002). One user expressed that they felt "a very

real group pressure to conform or face personal ridicule, shame, and putdowns," and another said there was not much tolerance for opposition to A.A.'s practices and literature (Kitchin, 2002, p. 759). As Kitchin (2002) notes, it appears cyberspace provides safety and space for critiquing A.A. practices and philosophies. These are important findings to consider, as some scholars suggest that the dominance of A.A. ideologies and discourses may be the result of embedded power relations rather than the actual effectiveness of the program. For example, Tupper (2008) suggests that an absence of literature on drugs' therapeutic values is not a product of lacking scientific evidence on drugs' therapeutic values, but rather of ideological refusal to acknowledge evidence that is contrary to drug-war ideology (p. 233).

Similar to Kitchin's (2002) and Sifers and Peltz's (2013) findings, Thompson (2012b) highlights the harms of the dominant abstinence narrative and comparing it with positive motivation models. Thomas (2006) similarly observed the human condition and "whole person" experience receding into the background as healthcare became more science-based and focused primarily on biology and physiology (p. 41). Discourses that pathologize addictive behaviours can cause individuals with addictions to seem themselves as defective and in need of repair (Thompson, 2012a, p. 431). It is this type of discourse that individuals with substance use issues are most exposed to and most likely to draw upon (p. 249). Both Davis and Jansen (1998) and Thompson (2012a) find A.A. adheres to the medical model of disease, rather than strengths perspective of wellness and positive motivational models, which focus on individual motivation, meaning, and agency as ways to help people with addictions become aware of their full potential. Thompson (2012b) notes that researcher and professional projections of addiction theories also influence individual internalizations of such narratives. If researchers internalize the dominant narrative, then it is not surprising that those with addictions have also done so (Thompson, 2012b,

p. 41). This may be because the refusal to adhere to dominant addiction ideologies during research can mean professional isolation, less likelihood of publication in conservative peer-reviewed journals, and reduced chance of securing research grants from major federal funding bodies (Tupper, 2008, p. 230). It appears that specific discourse and underlying ideologies may dictate addiction recovery within A.A. rather than individually-driven behavior modifications. Exploring this discourse on recovery will help shed light on A.A. philosophies and the role of concepts such as abstinence and prohibition in A.A. communication.

Addiction Recovery Identity and Discourse

Identity repertoires are conditioned by unequal access to particular identity-building resources (Blommaert, 2005, p. 207). According to Blommaert (2005), people continually perform identity rituals in everyday life. This process only develops through social life participation (Benwell & Stokoe, 2006). According to Hall (as cited in Benwell & Stokoe, 2006), an individual's self-consciousness only exists in relation to "others" who serve to validate such existences (p. 24). Part of identity development also includes acquiring a particular ideological version of the world (Benwell & Stokoe, 2006). Because discourse is closely linked to identity development, it is theorized that dominant discourses in addiction recovery likely affect these new identities post-addiction. Currently, the disease discourse underlies many of the ways addiction is approached in both treatment and recovery (Suissa, 2003) and in education (Tupper, 2008). Many people new to recovery enter these dominant discourses when developing a new lifestyle and identity, because, despite changing individual needs and new healthcare methods available, "communication remains locked within repressive cycles that reinforce hierarchy of providers over patients" (Ellingson, 2008, p. 308). This negotiation of power and expertise between health-focused organizations, such as A.A., and its users/members directly impacts

member experiences such as identity development (Elilingson, 2008, p. 294). Analyzing the power of addiction discourses and their outcomes will provide valuable information to those working in the field or living in addiction recovery and create room for different, less popular, but potentially effective ways of recovery that may bring more success to those struggling in the current, dominant ideology.

Methodology

Fairclough (2010) refers to discourse as language and other symbolic forms that comprise the material forms of ideology. Using this definition, discourse is composed of three elements – social practice, discoursal practice such as distribution and consumption, and text – which contribute to the reproduction of existing discourses and power and social relations (Fairclough, 2010, p. 59). Blommaert (2005) makes similar assertions, noting that textual structures exercise a critical function in social production of inequality (p. 29). The question of this study, then, is in what ways does language within A.A. construct identity development for its members? I chose Critical Discourse Analysis (CDA) as the methodology because it allowed me to employ a critical paradigm in my examination of A.A. communication. Tupper (2008) found CDA to be an effective part of questioning and challenging taken-for-granted, status quo beliefs such as those found in popular addiction treatment narratives (p. 224). Frank (2011) also noted CDA to be a useful tool for uncovering and understanding the (re)production of power relations and inequality within language**.** I employed CDA using qualitative methods and drew on critical theory to situate discourses in societal contexts as a way to identify ideology and analyze the power relations and consequences stemming from those discourses (Brabham, 2012, p. 397). This methodological process helped to unmask apparently natural or universal aspects of alcohol treatment and recovery in A.A. discourses by revealing existing social construction and reproduction processes that reinforce them as such (Frank, 2011).

Dutta and Zoller's (2008) and Fairclough's (2010) use of critical theory guided analysis of the literature review data, as CDA is born out of its analytical framework surrounding ideology and power (Brookfield, 2014). The goal of the critical theorist is to expose taken-for-granted assumptions in discourse that mirror dominant perspectives and guide practice (Dutta &

Zoller, 2008, p. 16). As Fairclough (2010) notes, discourse and its relationship to ideological practices and social struggle must be emphasized and language/ideology problems should be confronted (p. 64). Structural inequality, the interconnection between power and ideology, and the exercising of dominant values in order to create hegemony and "common sense" beliefs are all focal points for critical theorists (Brookfield, 2014). I also considered Stets and Burke's (2000) perspective of individual identity and social identity theories to examine group thinking and behaviours of A.A. members. Many identity theorists believe that identity development is influenced by an individual's comparison of similarities with group members and contrasts with non-group members (Stets & Burke, 2000). The individual identity and social identity theory was helpful in analyzing member excerpts and how the reproduction of A.A. ideology is perpetuated between members and throughout the fellowship to influence and develop individual identity.

Concepts

Included in this section are definitions of key concepts guiding this research. *Addiction* broadly defined refers to a behavior considered out of control in some form (Centre for Addiction and Mental Health, 2010). *Self-help groups* consist of members who share a common problem such as a disease or, more commonly, an addiction and join together with the common goal of helping one another cope, heal, and recover (Ahmadi, 2007). *Alcoholics Anonymous* is the most well-known self-help group in the United States and defines itself as an international fellowship of people who want to do something about their drinking (Alcoholics Anonymous, 2014b). *Addiction treatment* in this research proposal refers to formal programming different from self-help groups. *Addiction recovery* is defined as a process of overcoming problems and issues associated with alcohol use and alcoholism. Because this thesis looked at dominant

ideologies in A.A. and speculated abstinence was one of the discursive codes, addiction recovery cannot be considered synonymous with abstinence. *Abstinence* literally, and for the purpose of this thesis, is defined as withdrawal from alcohol and substance use. Abstinence is one of the ways or methods in which alcoholism is treated, but not the only one. Not all groups or individuals define addiction recovery as being abstinent from substances. Finally, individuals examined and involved in this thesis are not referred to as "addict" and "alcoholic". Because this thesis focuses on identity, addiction, and power structures, I have refrained from using such terminology as many people with addictions and those working in the field consider these terms to be socially limiting (Peele, 2015). However, the terms "addict" and "alcoholic", inevitably, appears in the research since they are a common part of the vocabulary used in this field.

Data Gathering

Discourse in the tradition of CDA refers to language as a social practice or how language functions to establish identities, social relationships, and systems of knowledge and belief (Tupper, 2008, p. 224). Both Fairclough (2010) and Blommaert (2005) discuss three key aspects: discourse as text, discursive practice, and social practice. Because of these elements, CDA must go beyond only analyzing the texts producing and distributing specific discourse in order to observe and analyze ideological positions. In order to understand how discourses influence ideology, it is important to look at social and discursive processes in addition to text. It is not possible to only "read off" ideologies from texts; meanings are produced (Fairclough, 2010, p. 57). Critical discourse analysts use a critical stance when dissecting text while keeping the broader social context in mind as a way to expose and intervene in the discursive forms in order to create positive change (Brabham, 2012, p. 398). To effectively analyze the impacts of social practice in A.A. and the ways it may reproduce dominant discourse, I examined official texts and

member testimonies in literature and media circulated in the A.A. realm. I chose texts and media that are most well known and likely to be read and watched by both prospective and current members. In other words, these texts are most likely to play a large role in the construction and development of how members see themselves. *Alcoholics Anonymous* – or A.A.'s Big Book, *The 12 Steps and 12 Traditions*, the *A.A. Grapevine*, A.A.'s website, pamphlets, and images and videos within these bodies of text were the sites for observation and analysis. All of these texts and illustrations are available through A.A.'s website and regional offices. Principles, rules, and practice discourse were analyzed first in A.A.'s Big Book, *12 Steps and 12 Traditions*, and the following A.A. pamphlets: *A.A. Fact File* (1956), *Do You Think You're Different?* (1976), *How it Works* (2001), *Is A.A. for Me?* (1989), *Is A.A. for You?* (2008), *Is There an Alcoholic in Your Life?* (1976), *The A.A. Group* (2005), *The Twelve Concepts for World Service* (1986), *The Twelve Steps Illustrated* (1991), *The Twelve Traditions Illustrated* (1971), *This is A.A.: An Introduction to the A.A. Recovery Program* (1984), and *Understanding Anonymity* (2011). These materials were analyzed to identify ideological assumptions about identity. Member testimonies and narratives were analyzed in A.A.'s Big Book, the *Do You Think You're Different?* (1976) pamphlet, and eight A.A. Grapevine issues ranging from 2001-2004 provided by A.A.'s regional office in Victoria, BC. The A.A. Grapevine "is a lifeline linking one alcoholic to another and a source of information for A.A.'s many friends" (AA World Services, 2004, p. 8). By analyzing member-written excerpts, I was able to conclude whether the transmission and cultivation of A.A. discourse is maintaining and reproducing dominant disease and abstinence ideologies (Tupper, 2008). These excerpts became the crucial link between text and social functioning since they provide examples of how representations are consumed (Blommaert, 2005).

Data Analysis

In general, CDA requires researchers to use a multidisciplinary approach when analyzing data and theorizing findings (Jorgensen & Phillips, 2002). Therefore, in order to capture an understanding of A.A. members' identity development, the data analysis was approached through Fairclough (2010) and Dutta and Zoller's (2008) critical theory lenses with Stets and Burke's (2000) Identity and Social Identity Theory as a supportive theoretical perspective. Official texts regulated by A.A. were first analyzed inductively to see what discursive themes emerge. Any discourse observed within the images, books, pamphlets, and videos was recorded. Afterwards, the most prominent and frequently observed themes were selected and used to deductively analyze member excerpts in order to determine whether noticeable identity themes in A.A. texts were being interpreted and reproduced.

Ethical Challenges

Because no participants were involved in this study, I did not have to consider immediate ethical rights of anyone involved in this study. For member narratives and testimonies in the Big Book and A.A. pamphlet, *Do you Think You're Different?*, aliases and pseudonyms were already created for members in order to keep true identities confidential. In *A.A. Grapevine* issues, members submitted their stories with either only their first name or an alias to protect their identity. Because this study relied entirely on publicly available A.A. texts and these confidentiality measures were already in place, no direct or indirect harm was expected to come to the authors, deceased or living, of the testimonials analyzed.

Limitations

One limitation in using CDA for this type of research is its primary focus on language, discourse, and communication instead of overall cultural influences. Because the primary site for

this research is A.A., it is not transferrable to any other addiction recovery method, service, or self-help group. Findings should not be considered transferrable to other 12-step treatment programs such as Narcotics Anonymous, Al-Anon, and "Twelve Step Facilitation" (TSF) as their programming differs from A.A.'s, potentially creating different discursive practices and ideologies as a result. This analysis is further limited by its reliance on A.A. literature for examples of ideological discursive practices such social reproduction and maintenance as many of A.A.'s fundamental literature is decades old with some of it being created and significantly revised in recent years and others dating back to the 1950s. More substantial research is needed including studies that analyze actual current member accounts of their A.A. experience. Data that observes and compares perspectives of those who struggled with A.A. discourse with current member accounts will also be a beneficial addition to this body of research. A more in-depth historical and cultural study of A.A., discourse, and related ideologies in Canadian and American societies will broaden understanding of this topic even further by revealing any historical and cultural situations A.A. may have been born out of and which may be partly attributable for the fellowship's dominance and popularity today.

Results

CDA revealed patterns in discourses and social interaction within A.A. that undoubtedly affect the way members identify themselves. The following discursive main themes emerged during this initial analysis: religiousness, model behaviour, medical theories, social identity, and A.A. as the objective way to treat alcohol use disorders. These five themes may initially appear different and conflicting, but together they form a cohesive discourse that frames how alcohol is expected to be consumed and how alcohol use disorders and dependency should be prevented, treated, and avoided. Member testimonies and statements in *The Big Book, Do you Think You're Different?*, and *A.A. Grapevine* issues were analyzed. The intent of this subsequent analysis was to observe whether members reproduced and practiced the highlighted discursive themes in A.A. texts. As CDA looks for subliminal, hidden functions within language and communication that maintain ideologies in our cultures and societies, it would be within these testimonies that reproductions of the discourse and ideological themes would be illustrated.

Religion & Spirituality

All of A.A.'s texts are ripe with reference to spirituality and religion. This discourse is immediately visible in its official Steps – "Came to believe that a Power greater than ourselves could restore us to sanity" (AA World Services, 2005b, p. 25) – and throughout its texts – "That means we have written a book… and of course we are going to talk about God" (AA World Services, 2001a, p. 45). There are images such as a woman revealing eerie creatures in her closet to another woman that illustrate alcohol as an irresistible demon as well as a man who is freed without visible help from shackles, which suggests God removes the disease of alcohol (AA World Services, 1991, pp. 7-9). A.A. texts also contain more specific references to Judeo-Christian, monotheistic understandings of spirituality and religion with references to a singular

god such as "If the Creator gave us our lives in the first place…" (AA World Services, 2005b, p. 59) and "…for deep down in every man, woman, and child, is the fundamental idea of God" (AA World Services, 2001a, p. 53). Despite this apparent reliance on Judeo-Christian beliefs, A.A. states throughout its texts that religion is an individual choice and members can maintain their own idea of God (AA World Services, 2001a, p. 28; AA World Services, 1976a, p. 12). A.A. even goes as far as to declare it "is not a religious organization…" (AA World Services, 1956, p. 6).

Yet, in many instances A.A. portrays lacking faith and relationship with God, particularly among agnostics and atheists, as the cause of individuals' struggles with alcohol. Individuals who come to A.A. looking for relief from alcohol use are quickly told they were lacking a relationship with God. According to A.A., a lack of faith among alcoholics is a temporary one since one must reconnect with God in order to achieve recovery. The expectation that agnostics, atheists, and those lacking faith convert once belonging to A.A. is evident in excerpts such as:

- "We agnostics and atheists were sticking to the idea that self-sufficiency would solve our problems" (AA World Services, 2001a, p. 52),
- "But cheer up, something like half of us thought we were atheists or agnostics" (AA World Services, 2001a, p. 44), and
- "Yes, we had to look for our lost faith" (AA World Services, 2005b, p. 29).

Aversion towards individuals with lacking faith or who are agnostic or atheist is also visible among members. Individuals with these theological perspectives are seen to be incapable of recovery because of their disconnection with God: "If you think you are an atheist, an agnostic, a skeptic, or have any other form of intellectual pride which keeps you from accepting what is in this book, I feel sorry for you" (AA World Services, 2001a, p. 181). One member even describes

witnessing the repression of non-Christian experiences, specifically atheist, in a meeting (J. C., 2000, p. 48). It is apparent A.A. encourages Christianity and prefers members to follow this religious orientation as well.

While A.A. declares on a number of occasions that it does not require members to identify with their perspective/depiction of God (AA World Services, 2001a, p. 344, 366), there are many instances showing members have aligned with this Judeo-Christian understanding of God. For example, many members' narratives illustrate that their belief in God helped them successfully recover from "alcoholism":

- "All the credit belongs to God. On my own I could not have quit" (AA World Services, 2001a, p. 485)
- "I cried for joy as the realization came that God and the A.A. program had done for me what my own will could not" (W. B., 2004, p. 6)
- "God, has not only saved my life and restored me to sanity, but has given me a new way of life" (AA World Services, 1976b, p. 19)
- "…Because God and A.A. were able to do for me something I was unable to do for myself" (AA World Services, 2001a, p. 358).

A.A. clearly sees recovery as a re-connection with faith, preferably Judeo-Christian – or Abrahamic (Herbener, 2013) – denominations (AA World Services, 2001a, pp. 11-14, 52). Once those with alcohol problems adopt this specific type of faith, they receive the benefits of a relationship with God, including recovery (AA World Services, 2001a, p. 25, 55, 46, 71). Many statements illustrate members have internalized the concept that A.A. and God are the answer not only to recovery, but also satisfactory living: "God gives hopeless, desperate people a second chance to live a life beyond their dreams" (J. K., 2003, p. 6). Members also have learned to

believe everyone's true purpose is to do God's work – "…my purpose here on earth was to be of maximum service to God" (AA World Services, 2001a, p. 395) – so all members must act and behave in ways aligning with Christianity in order to create God's Kingdom as described in this excerpt: "…we have been given the Keys of the Kingdom" (AA World Services, 2001a, p. 276). Indirectly, this discourse suggests that a world governed by God is the true and right way of existence with A.A. being the one way for those disconnected from God to get there: "…I know I serve a merciful God. Thank you, A.A., for saving me a seat" (D. S., 2000, p. 51). Member survival and existence moved from alcohol's control to God's: "My life is in God's hands now" (B. R., 2004, p. 12).

These passages highlight an overarching discourse emphasizing a Christian existence is necessary for individuals looking to curb their alcohol consumption. These connecting discourses between alcohol, recovery, and spirituality are indicative of a larger ideology where religion is equated not only with recovery, but also with happiness and a better, "right" way of living because "people of faith have a logical idea of what life is all about" (AA World Services, 2001a, p. 49). "The spiritual life is not a theory" (AA World Services, 2001a, p. 83), according to A.A. and "[they] are convinced that a spiritual mode of living is a most powerful health restorative" (AA World Services, 2001a, p. 133).

Model Behaviour & Citizenry

Another theme prevalent in A.A. literature is the expectation of "right-mindedness", or model behaviour. This discourse is closely connected to religion and spirituality discourses as it advocates for "correct" and "proper" behaviours demonstrated in Judeo-Christian traditions. Visible in the texts is the requirement for individuals to be humble, selfless, controlled, respectable, obedient, and productive (AA World Services, 2001a, p. 268). Productivity and

usefulness are especially important, for, according to A.A., "if we did not work, we would surely drink" (AA World Services, 2001a, p. 15). Persons dependent on alcohol are portrayed as lacking these appropriate, ideal behaviours: "our crippling handicap had been our lack of humility" (AA World Services, 2005b, p. 71). Similarly, illustrations of a man hiding behind a wall drinking in secret, a man collapsed on bed clutching his head and reaching for bottle of alcohol, and a woman passed out on table holding glass of alcohol while neglecting a pot boiling over perpetuate bad behaviour discourses by depicting individuals who use alcohol as liars who are out of control, in denial, deceitful, and useless (AA World Services, 1989, pp. 5-25).

These negatively-viewed traits are described to be inherent qualities, or symptoms, of alcoholism: "Denial is the most cunning, baffling, and powerful part of my disease, the disease of alcoholism" (AA World Services, 2001a, p. 328). Heavy alcohol use has removed all good behaviour associated with a faithful and spiritual existence such as usefulness, humbleness, selflessness, and control. An image of a clock and empty time stamp area in *Is A.A. for Me?* (1989) signifies that person has not come to work or is late and reinforces A.A.'s value for productivity as active alcohol use causes the opposite as negatively portrayed. Without these good behaviours there is little chance of healthy existence as indicated in the following excerpts: "Without a willing and persistent effort to do this, there can be little sobriety or contentment for us" (AA World Services, 2005b, p. 43) and "the A.A. member has to conform to the principles of recovery. His life actually depends upon obedience to spiritual principles" (AA World Services, 2005b, p. 130). Without this specific spiritual presence, individuals are left to become "bad". A.A., therefore, focuses on re-connecting members (since discourse and ideology posit that we all began with an affiliation to God) with spirituality in order to re-establish culturally appropriate, acceptable, and desirable behaviours. Once a person becomes a member of A.A. and

is working towards recovery, they develop "worthy" and approved behaviours: "… In good time provided, however, the alcoholic continues to demonstrate that he can be sober, considerate, and helpful, regardless of what anyone says or does" (AA World Services, 2001a, p. 99). Members also "learn to spot and correct these flaws" (AA World Services, 2005b, p. 95) and eventually find themselves "in possession of a degree of honesty, tolerance, unselfishness, peace of mind, and love of which he had thought himself quite incapable" (AA World Services, 2005b, p. 107). Developing these "model behaviours" is a crucial component of member recovery as according to A.A. "… without some degree of humility, no alcoholic can stay sober at all" (AA World Services, 2005b, p. 70).

This discursive theme goes beyond dictating what members should believe by prescribing how they should behave. In A.A.'s opinion, the only way to be free of alcohol and live a good life is by developing these principles of good behaviour and productivity: "The A.A. program showed me the way to come down to earth, start from the bottom, and work up" (AA World Services, 2001a, p. 255). It is the only way to exist. This discourse depicts good people as individuals who demonstrate behaviours that align with Judeo-Christian values (Holt, 2006b), as the tradition has a heavy presence in North America (Herbener, 2013). This discourse laden with Judeo-Christian values reflects western cultural values that existed when A.A. began. Bill Wilson and Bob Smith founded the A.A. fellowship at the time when Christianity was considered an ultimate and exclusive religion. In 1924, 91 percent of American society believed Christianity was the "one true religion", while only a quarter of the population maintain this belief today (Chaves, 2011). Members see the behaviours described positively in texts such as humbleness, humility, and productiveness/usefulness positively as qualities they must exhibit in order to recover:

- "Today I'm living my life, my journey, as a productive member of Alcoholics Anonymous" (R. L., 2003, p. 19)
- "I have a family to be proud of, actively sharing in the responsibilities of good citizenship" (AA World Services, 2001a, p. 349)

It is apparent in this discourse that once a person is in A.A. and sober, they are respectable and worthy for they have become "as fine a specimen of manhood as one could wish to meet" (AA World Services, 2001a), a contributing member of society for if "we couldn't make a living, we had a feeling of uselessness" (AA World Services, 2001a, p. 52), and one of God's helpers since our "true ambition is the deep desire to live usefully and walk humbly under the grace of God" (AA World Services, 2005b, p. 125). Thus, once these traits have developed, members become ideal citizens for helping build "God's Kingdom". Similar to the spirituality discourse, encouraging these behaviours promotes an ideology focused on people behaving in certain ways and constructing an identity that helps forward a moral framework centered around Judeo-Christianity. If members are ever to recover, they will need to demonstrate these types of traits since "there is plenty wrong with us alcoholics about which plenty will have to be done if we are to expect sobriety" (AA World Services, 2005b, p. 47) and "learning daily to spot, admit, and correct these flaws is the essence of character-building and good living" (AA World Services, 2005b, p. 95). This discourse has a cyclical effect as the only way to maintain these qualities is by being abstinent, which ties into the prominent themes on disease and abstinence.

Alcoholism as a Disease & Treatment as Abstinence

The disease – or medical – model plays an integral role in identification processes of individuals with severe alcohol use and is another prominent theme observed in A.A. texts. For example, A.A.'s "alcoholic" is frequently referred to in medical terms such as sick and abnormal

(AA World Services, 2005b, p. 108) with alcohol use disorders being described as uncontrollable and a condition to which the diseased person is completely victim to. For example, A.A. describes many of its members as people who:

- "have no mental defense against the first drink" (AA World Services, 2001a, p. 43),
- are "seized with a rebellion so sickening" (AA World Services, 2005b, p. 105), and
- have been "reduced to a state of absolute helplessness" (AA World Services, 2005b, p. 25).

An essential part of becoming a member of A.A. appears to require prospective individuals acknowledge these so-called flaws: "we have to admit that we had many of these defects" (AA World Services, 2005b, p. 69). A.A. has been effective in getting members to see their heavy alcohol use as a genetic, biological trait that is recessive until a person begins consuming alcohol: "I now believe I was an alcoholic from the first drink" (AA World Services, 1976b, p. 19). Alcohol is also described as a controlling force that leaves the individual with little choice as to its "effects" and not vice versa. Images in *Is A.A. for Me?* (1989) demonstrate this disease discourse, maintaining that individuals are powerless over alcohol because they drink even when it is causing problems in their life (pp. 5-25). Members have shown to align with these discourses as well:

- "Alcoholism had whipped me into total submission" (B. W., 2004, p. 5)
- "Mere cessation from drinking is not enough for an alcoholic" (AA World Services, 2001a, p. 299)

There is a strong emphasis on abstinence as the only way to address problem drinking and achieve a satisfactory recovery. According to A.A., "sobriety has to be its sole objective" (AA World Services, 2005b, p. 147), members "must live without [alcohol] if [they] are to avoid

disaster" (AA World Services, 1984, p. 7), and "the alcoholic must learn to stay away from alcohol completely in order to lead a normal life" (AA World Services, 1976a, p. 8).

Abstinence theories help reinforce the permanent nature of alcoholism as a disease portrayed by the medical model. Passages such as, "alcoholism is a progressive illness, that it cannot be cured in the ordinary sense of the term, but that it can be arrested through total abstinence from alcohol in any form" (AA World Services, 1956, p. 9) and "The alcoholic is a sick person suffering from a disease for which there is no known cure – that is, no cure in the sense that he or she will ever be able to drink moderately" (AA World Services, 1976a, p. 8) emphasize the symbiotic relationship between medical model and abstinence discourses in A.A. The portrayal of alcohol as a controlling and powerful substance solidifies the disease concept and justifies abstinence discourses. Members show that they see their alcohol use as uncontrollable: "It turned out to be much more powerful than I was…" (AA World Services, 2001, p. 194), which required permanent abstinence in order to avoid – "I learned early in my A.A. life that I could not afford to fondle such thoughts [of drinking]" (AA World Services, 2001a, p. 256). These discourses also deny any non-abstinent methods of recovery: "The result was nil until we let go absolutely" (AA World Services, 2001b) and "there must be no reservation of any kind, nor any lurking notion that someday we will be immune to alcohol" (AA World Services, 2001a, p. 31).

The disease model also plays an important role in emphasizing the damaged "bad" condition of alcoholism. A.A. often refers to alcohol use – or "alcoholism" – as a violation or threat to spirituality, specifically Judeo-Christianity. For example, "No matter how far we have progressed, desires will always be found which oppose the grace of God" (AA World Services, 2005b, p. 66). Alcohol addiction is described to as a disease that can only be solved through

spiritual connection as "A.A. holds that alcoholism, in addition to being a physical and emotional illness, is also a spiritual disorder to some degree" (AA World Services, 1796a, p. 12). Alcoholism, thus, is keeping people from their *natural* relationship with God. And, according to A.A., the only force strong enough to counteract alcohol's invincible effects is God. Abstinence helps keep members in a state ready to do God's work, ensuring they remain His followers and continue spreading His "word". Without God, abstinence is not enough, which members believe about themselves:

- "…And I won't have a drink, if I remember one simple thing: to keep my hand in the hand of God" (AA World Services, 2001a, p. 199).
- "The disease inside of me is like gravity, just waiting to pull me down" (AA World Services, 2001a, p. 457)
- "The disease is always with me, and my old attitudes and behaviors still creep up on me" (R. L., 2004, p. 55)

A.A. says "the alcoholic must learn to stay away from alcohol completely in order to lead a normal life" (AA World Services, 1976a, p. 8) and many members appear to have internalized the concept that because A.A. focuses on sobriety, and sobriety is equated with a better life, A.A. is a necessary part of member happiness.

Individual & Social Identities in A.A.

The final observed discourse emphasizes the importance of A.A. as a group. This discourse has been a crucial element in A.A.'s preservation and longevity as it declares, "our common welfare should come first…" because "we stay whole, or A.A. dies" (AA World Services, 2005b, p. 129). It encourages members to behave in certain ways that benefit and maintain the fellowship. In order to do that, A.A. taps into the discourses highlighted here to

forge similarities among members and, ultimately, form one common identity. These tactics not only preserve A.A., they ensure a continually growing membership base. One tactic includes the expectation for members to spread A.A.'s work and "repay" for their recovery:

- "We have recovered, and have been given the power to help others" (AA World Services, 2001a, p. 132)
- "The relative success of the A.A. program seems to be due to the fact that an alcoholic who no longer drinks has an exceptional faculty for 'reaching' and helping an uncontrollable drinker" (AA World Services, 1956, p. 8)

It is such an important component that A.A. made it its twelfth step "Having had a spiritual awakening as the result of these steps, we tried to carry this message to other addicts, and to practice these principles in all our affairs" (AA World Services, 2001a, p. 106). It is during this step that the majority of discourses seen in A.A. literature are reproduced by and between members and, eventually, to the public as "people needed to be told what alcoholism was, so we'd educate the public, even rewrite school and medical textbooks" (AA World Services, 2005b, p. 155). This discourse retains member identification within the fellowship by threatening to jeopardize the recoveries of those who do not take part: "Neither he nor anybody else can survive unless he carries the A.A. message" (AA World Services, 2005b, p. 130).

The identity of an "alcoholic" serves a functional purpose for the A.A. group as well. Unlike other discourses describing alcohol use disorders as a health problem that appears differently for each individual, A.A. describes alcohol use and dependency as a characteristic that every individual has in order to establish bonding and solidarity among members. Disease model characteristics – or "defects"– such as powerlessness and selfishness are defining features used to unite members: "They comfort the melancholy one by first showing that his case is not

strange or different, that his character defects are probably no more numerous or worse than those of anyone else in A.A." (AA World Services, 2005b, p. 46). A.A. has been effective in this process as similarities among members appear to play a large role in individual assimilation to the fellowship:

- "I realized that this was the first time I had met a person who had the same problems I did and who, I sincerely believe, understood me as an individual" (AA World Services, 2001a, p. 243)
- "I thought at times that he was telling my story!" (AA World Services, 2001b, p. 261)
- "She went on and her words made sense. I felt as if she were talking right at me" (R. L., 2003, p. 18)
- "I found myself surrounded by people I could really relate with" (AA World Services, 2001a, p. 286)

Among those who accepted the discourse, "the sense of belonging was tremendously exciting" (AA World Services, 2005b, p. 57). This alikeness among members appears to be a large factor in shaping members' new identities constructed during recovery:

- "I peered into the meeting hall area. I was home!" (S. B., 2000, p. 37)
- "'I am an alcoholic.' It came out in a whisper, but it sounded right" (AA World Services, 2001a, p. 343)
- "…it wasn't too hard for me to say my name and, 'Hi, I'm an alcoholic'" (AA World Services, 2005b, p. 401)

Connections over this apparent misunderstood, stigmatized condition has caused the fellowship to posit that they are the only ones who will understand the experiences of individuals who misuse alcohol: "Just as firmly bound by obligation are the members of Alcoholics

Anonymous, who have demonstrated that they can help problem drinkers as others seldom can" (AA World Services, 2005b, p. 150). An image in *Is A.A. for Me?* (1989) of an "alcoholic" sitting by himself in a restaurant while others at a nearby table socialize reinforces A.A. discourses purporting that "normal" people won't understand you because they will never be able to relate (p. 13). Only A.A. understands you since everyone is an alcoholic. This discourse further adds to A.A.'s recovery ideology as it claims recovery is only effective within this peer-support scenario because: "most individuals cannot recover unless there is a group" (AA World Services, 2005b, p. 130) since "it was a statistical fact that alcoholics almost never recovered on their own resources" (AA World Services, 2005b, p. 22). Illustrations such as of a group pulling out a person drowning in water, or potentially alcohol (AA World Services, 1971, p. 3), and of a man being crushed by a gigantic bottle of alcohol who can only be freed by a group of people (AA World Services, 1991, p. 3) similarly suggests that only the A.A. fellowship can save an alcoholic.

Because definitions and descriptions of alcohol dependency disseminated within A.A. persuade members that they are all the same, bonding and assimilation is more effective among members of the fellowship because they learn to believe they share similarities, specifically an identity characterized as a disease that can only be 'avoided' through an active spiritual practice and abstinence as reiterated in the following passage: "Most important of all, we try to face up to the fact that, no matter how long we have been dry, we will always be alcoholics" (AA World Services, 1984, p. 14).

A.A. as the Right Way

Member testimonies reflected each of the themes identified in key A.A. literature. For example, alignment with Christianity: "I firmly believe that God needs people like us to carry the

A.A. message to those alcoholics society has locked away, out of sight and out of mind." (B. C., 2003, p. 7), model behaviour: "I am grateful to be a good husband, a good citizen, sober and dedicated to A.A." (B. W., 2004, p. 7), and disease and abstinence models – "I realized that I was a drunk" (AA World Services, 2001a, p. 183) "…and believe me, an alcoholic cannot fight alcohol" (AA World Services, 2001a, p. 298) – reflect prominent discursive themes in A.A. texts. However, combined they help produce, reproduce, and maintain a dominant ideology of alcohol use and dependency, which the "alcoholic" identity envelopes.

That ideology prescribes that a good life comes to good citizens who live free of alcohol and maintain a consistent religious practice and relationship with God. Put another way, to successfully 'recover' from alcohol addiction – or alcoholism – members must abstain from alcohol in order to be religious, productive and useful, and help other alcoholics find sobriety as part of "God's work" so they are worthy of God and being part of His Kingdom. Crucial to this discourse is the implication of A.A. and its principles as the only way to successfully recover. Throughout A.A. literature, the fellowship's methods are conveyed as objectively true and that no other way of recovery will work as effectively for those with alcohol issues:

- "We all need the light of God's reality, the nourishment of His strength, and the atmosphere of His grace. To an amazing extent the facts of A.A. Life confirm this ageless truth" (AA World Services, 2005b, p. 98),
- "We are not theorizing. These are facts out of our experience" (AA World Services, 2001a, p. 70), and
- "We have seen the truth demonstrated again and again: 'Once an alcoholic, always an alcoholic'" (AA World Services, 2001a, p. 31).

Member narratives showing adoption of A.A. discourses reinforce the fellowship as an objective truth among ways to treat alcohol use disorders as visible in these excerpts, "having no place left to go but A.A." (AA World Services, 1976a, p. 11) and "now that we're in A.A. and sober, and winning" (AA World Services, 2005b, p. 92).

Members embody these ideological discourses more readily when they acknowledged similarities mentioned in the texts and by other members: "The book described my life and problems in language not used by those who had tried to help me" (B. W., 2004, p. 5). In the video, *Hope: Alcoholics Anonymous* (2009), one member demonstrated the influence of this process claiming, "these people have a certain something and what it does is creates the desire to emulate." These identifications with discourses eventually progress into morphing members' entire identities so that they no longer have a separate identity that includes *some* alcoholic traits; their identity is the "alcoholic." This shared identity solidifies membership and loyalty to A.A, ensuring its longevity. If members do not identify with the overarching discourse, they are prevented from being happy or living a 'normal', desirable life:

- "…sobriety will usually have brought with it a semblance of normalcy and progressive success" (D. S., 2000, p. 51).
- "If I did not maintain my sobriety, I would lose my family anyway…. I would not have a job… I would have no friends left" (AA World Services, 2001a, p. 264)
- "The members of Alcoholics Anonymous offered me a gift, a gift of life" (AA World Services, 2001a, p. 474).

These ideologies of recovery from alcohol dependency and what it should look like continue to dominate as they are perpetuated throughout the fellowship via discursive practices and identity

processes such as internalizations of texts, bonding over imposed similarities, and adoption of the shared practices in A.A. to the point that they are accepted as the true, only way to recovery:

- "No matter what I thought of people in A.A., they obviously had answers about staying sober that I didn't have" (AA World Services, 1976b, p. 26)
- "I truly wanted what these people had freedom from alcohol, the keys to a new life" (R. L., 2003, p. 19)

Eventually the ideology moves beyond the fellowship and into the daily practices of families, friends, professionals, and the general public:

- "I think you should stop drinking, see a doctor, and go to A.A." (AA World Services, 2001a, p. 343)
- "'Doc, I think I'm an alcoholic.' 'Yes,' he said, surprisingly, 'you are.'" (AA World Services, 2001a, p. 385)
- "The doctor strongly suggested that I participate in the local A.A. program" (AA World Services, 2001a, p. 538)
- "Finally, in desperation, my family appealed to a doctor for advice, and he suggested A.A." (AA World Services, 2005b, p. 549)
- "The priest suggested I try A.A." (AA World Services, 1976b, p. 30)

These member excerpts show that A.A.'s discourse and the values that underpin it can quickly influence targeted audiences and then move beyond to society via social reproduction in interpersonal communication.

Discussion

This analysis of A.A. literature identified dominant discursive themes that may exercise influence on member behaviours and identities. Findings show dominant discourses in A.A. involve religiousness, model behaviour, disease and abstinence models/theories, and group identity expectations. Approached from a critical perspective, these discourses can be seen as contributing to a larger ideological process of understanding and addressing alcohol. Member narratives show identities reflect this ideology, a finding that is significant because other scholars have pointed out the relationship of identity discourses and recovery (Gibson, Acquah, & Robinson, 2004).

Religious Foundations

At the base of A.A.'s dominating ideology lie religiousness and model behaviour discourses. While A.A. claims that members are encouraged to find their own faith and create their own understanding of God, analysis of A.A. principles and member accounts say otherwise. A.A.'s heavy inclusion of Judeo-Christian values, particularly those associated with Protestantism, such as complete abstention/forbidden consumption of alcohol (Dietler, 2006, p. 241) and monotheistic references (Herbener, 2013) reflect this religious tradition's dominance in western societies (Holt, 2006b) and the fellowship, which have affected members' construction of themselves. Monotheism – the doctrine or belief that there is only one God – is present in almost every reference to God and religion in A.A. texts. Judeo-Christian traditions are full expressions of Monotheism and refer to a specific set of religious experiences and philosophical perceptions emphasizing "God as one, perfect, immutable, creator of the world from nothing, distinct from the world, all-powerfully involved in the world" (Herbener, 2013, p. 621). Similar descriptions are found in A.A. discourse. An exclusiveness and shared truth exists within these

monotheistic, or Abrahamic, religions that officially denies the existence of other gods besides the one true god and bans, or even represses, religions deemed 'false' (Herbener, 2013, p. 625), which is clear in A.A. discourse's aversion to atheists and agnostics and repression of narratives from people with these belief systems. A.A. depictions of alcohol as an evil and dangerous substance that "defiles the drinker" (Dietler, 2006, p. 242) reflect Judeo-Christian traditions and early understandings of alcohol consumption developed born from the Temperance Movement, Prohibition, and high moral cultural values (Holt, 2006a). Judeo-Christian denominations are the most popular religious organizations in Canada and the United States, particularly Protestantism and Catholicism (Warf, 2006, p. 533), and have many sects that portray alcohol as sinful, immoral, and a jeopardizer of social, moral, and cultural customs (Dietler, 2006, p. 242; Holt, 2006b, p. 155). For example, in Holt's (2006b) research, protestant militants, claiming to take a literal interpretation of the Bible, declared war on alcohol (p. 31). These descriptions and viewpoints of alcohol are also apparent in A.A and effectively demonstrate the fellowship's parallel values. Other religions do not hold this combination of worshipping a singular god and frowning upon drunkenness. For example, Buddhism, Hinduism, and Sikhism are polytheistic religions that believe in multiple gods and while some abstain from alcohol, many refer it as an important part of healing and health (Herbener, 2013).

While researchers such as Young (2011), Cain (1991), and Blocker Jr. (2006) claim A.A. primarily maintains the disease model, this discourse analysis shows that the disease model is a smaller component of a larger discourse exercised by A.A. and its members, one that constructs a specific social phenomenon incorporating values from Judeo-Christian traditions, disease and abstinence theories, and collectivism. After people join A.A., members learn to believe they are now a part of God's plan and are responsible for furthering His message. Part of doing God's

work requires members to exude certain qualities and behaviours, which will help them be a better person – a person worthy of living in "God's Kingdom" such as staying abstinent from alcohol and building a relationship with God. Similar behaviours were noted among Protestants in sixteenth-century Europe who declared war on alcohol in order to transform Earth into God's Kingdom (Holt, 2006b, p. 31). Alcohol according to this religious group tarnished efforts to show citizens as diligent and deserving" (Powers, 2006, p. 150). The medical model, which is based on disease and abstinence theories, was originally intended to transform social understanding of alcohol use from poor morale to a health issue (Blocker Jr., 2006, p. 234), but A.A. reframed it to reinforce Judeo-Christian understandings of excessive alcohol use. A.A. uses a Christian lens to describe alcoholism as a disease; a condition that can only be overcome through regular religious practice. Peele (2010), similarly, noted that the disease model was not a new scientific perspective as the Temperance Movement had advanced the same view previously (p. 375). Disease and abstinence understandings in A.A. discourse require members to admit their shortcomings and inability to consume alcohol 'normally,' meaning they must abstain entirely if they are to improve their health and be in a position to help others as part of A.A.'s and God's plan.

One Way of Recovery

The individual discursive themes construct an overall discourse in which there is only one way to live in recovery and avoid problematic alcohol use. Here is where ideologies within A.A. text began to reveal themselves. To Christian extremists, alcohol is a threat to their theological culture with consumers more interested in consuming alcohol than worshipping God (Holt, 2006b, p. 32). My analysis found the disease model describes alcohol use as inescapable and the only way to avoid its "powers" – or effects – is through abstinence. This finding is

similar to Sifer and Peltz (2013) findings indicating that members believe alcoholism is a disease best treated by complete abstinence (p. 717). It does not end there, though. Once alcohol is removed from an individual's life experience, individuals are then described as finally being able to focus on their true purpose: to participate and maintain God's kingdom. Thus, the abstinence discourse and the engagement of the disease model are predicated on an underlying ideology which asserts that a religious practice – specifically Judeo-Christianity– is the right way to live and exist as God must come first for successful recovery (AA World Services, 2001, p. 521). The dominance of this ideology is reinforced by the discursive insistence that only A.A.'s approach is 'right.'

Taleff and Babcock (1998) point out that this powerful discourse pervades the addiction field with many people claiming, "that A.A. is the only true answer to recovery" (p. 34). This singular prescribed way of living dictates member's self-identification by requiring them to behave in ways that promote and sustain A.A. ideologies, which may stigmatize individuals who struggle to align with such beliefs, achieve recovery via different means, and/or do not adopt the 'alcoholic' identity. This stigmatization is a systemic consequence of A.A.'s membership processes requiring individual adoption of the social "alcoholic" identity of A.A. As Cain (1991) confirms, the A.A. member comes to see not only his or her drinking as alcoholic, but also his or her self as an alcoholic. Thus, the disease is part of one's self (Cain, 1991, p. 214). This process was also observed in Rodner's (2005) study, which found identity to be "an internal organization of self-perception that incorporates views of the self perceived to be held by others" (p. 343). As part of this identity process in A.A., individuals must first understand the identity, then internalize and become emotionally attached to it. The majority of members in my study demonstrated that they had adopted this "alcoholic" identity, confirming both Rodner's (2005)

and Bailey's (2005) findings that people's sense of who they are comes from a shared understanding. Within the "alcoholic" identity, members understand they are required to maintain a specific religious practice, behave properly, and avoid alcohol entirely if they desired to prevent the disease of alcohol. This aligns with other findings noting A.A. discourse describes alcohol use disorders as a combination of abnormal thought processes, undesirable behaviors, and deficient spirituality (Young, 2010, p. 714) and sees alcohol consumption not as a temporary health problem, but as an identity which is routinely constructed, practiced, and performed (Bailey, 2005, p. 539; Dietler, 2006, p. 235).

Societal Adoption

Taleff and Babcock (1998) said, "people become slaves to a dominant discourse and consider it the truth" (p. 39) and this was apparent among A.A. members, immediate friends and families, and medical professionals as narrated in member testimonies. This A.A. identity discourse has spread beyond the fellowship into the general public. The popularity of A.A.'s alcoholic identity discourse among society members reinforces findings from Bailey (2005) who noted the weight of certain addiction discourses is maintained through "expert positions" (p. 536). In other words, society's acceptance of A.A. and its subsequent ideologies are a result of societal perceptions seeing its long-term existence as a reflection of effectiveness and, thus, expertise on alcohol use. Eventually, like in Taleff and Babcock's (1998) study, the A.A. discourse became so entrenched in interpersonal communication and, at some point, in professional settings that anyone displaying symptoms of excessive alcohol use were told they were alcoholics *and* needed A.A. Eventually, this A.A. identity discourse gained systemic influence over drug and alcohol use, which likely contributed to its continued popularity today. As Gibson et al. (2004) note, alcohol and drug use discourses like those promoted in A.A. serve specific social functions and

provide clear answers to drug-related problems with simple and clear solutions. Because substances like alcohol are described by discourses like A.A.'s as being very powerful and requiring minimal input from the person then the only approach to reducing access is eradication, to treatment is abstinence, and to prevention is to insist that drug use should never be initiated (Gibson et al., 2004, p. 600). These macro processes are visible in Canada and the United States' initiatives towards drug and alcohol consumption. The United States' retired "war on drugs" strategy is an example of these systemic processes, which, while widely believed to have been ineffective, still influences current policies today.

Disadvantages of the "Alcoholic" Identity

Discourses are shown to affect individual identities in a variety of ways. Of specific focus is the ways in which they can perpetuate and maintain ideologies in society since they are often presented as certainty (Taleff & Babcock, 1998, p. 33). Bailey (2005) noticed alcohol and drug use was not an objective phenomenon that society was progressively learning more about, but a social phenomenon created by societies and cultures via discourses (p. 536). Both Holt (2006b) and Dietler (2006) found that the consumption of alcohol and, as a result, definitions of problem drinking and alcoholism were constructed by a set of cultural rules and beliefs. Like Bosticco and Thompson's (2008) analysis of illness narratives, which showed patient and healthcare communication maintained dominating healthcare ideologies (p. 47), A.A.'s alcoholic identity discourse has been so prominent that individuals beyond the fellowship and without membership have adopted it. While many members declared in their testimonials that they would not have addressed their alcohol issues without A.A. and its principles, the "alcoholic" identity has had some implications for others (Thompson, 2012b). For one, the identity discourse instills traits on individuals that may be more inhibiting than helpful. In A.A. literature, the disease of alcohol is

described as forever affecting the individual. Within this condition, descriptions such as sick, disabled, helpless, damaged, victimized, and without free will are used to describe members. Rodner (2005) and Thompson (2012b) recorded similar descriptions of individuals using alcohol and other substances, which were shown to negatively affect individual recovery. In other research studies (Avants, Beitel, & Margolin, 2005; Bailey, 2005; Gibson et al., 2004; Taleff & Babcock, 1998), the "alcoholic" identity was observed to potentially negatively impact self-esteem, confidence, and autonomy of individuals in alcohol recovery. Avants et al. (2005) found individuals with alcohol and drug use disorders and dependencies were likely to regard themselves as 'bad' people, "a self-image unfortunately supported by widespread social stigmatization" (p. 168).

Lack of Individual Focus

These drawbacks of A.A.'s identity discourse reflect its lack of focus on individual experience. As Thomas (2006) asserts, "healthcare consumers fall into a variety of different categories, each with specific needs" (p. 47). Bailey (2005) noted in her study that many popular discourses see 'addiction' as "inherent in the person rather than the activity" (p. 540). This study had similar findings with individuals in A.A. defining themselves based on the group's – or fellowship's – social identity. The social identity is based on collective features of A.A. members as determined by A.A. When individuals become A.A. members, there is pressure to adopt this predetermined identity or else face social stigma and isolation (Kitchin, 2002), since challenging in-place power structures tends to generate enormous resistance even from well-meaning people (Dutta & Zoller, 2008, p. 308)**.** A.A.'s identity discourse prioritizes its own survival via assimilation rather than supporting persons based on their specific, individual needs. A.A. does not account for the many, powerfully different ways of drinking and of experiencing alcohol as

Peele (2010) describes (p. 375). As a result, when a person is an "alcoholic", A.A. knows what is best for him or her and how to treat them; nothing else besides alcohol matters.

With little concern for individual complexities among those with alcohol use disorders, the "alcoholic" identity has, without challenge or critical inquiry, dominated treatment, education, healthcare, and other fields since it is treating an apparently objective, unchanging health phenomenon. Furthermore, as a result of A.A.'s substantial ability to reach and conform other individuals with alcohol use issues, alternative alcohol treatment methods are repressed, allowing A.A. to become the most recommended, referred to, and relied upon method. The maintenance of this dominant paradigm represses the emergence of other treatments that could help those struggling with alcohol use disorders and/or A.A principles. Taleff and Babcock (1998) found the dominance of the A.A. method to marginalize new approaches, and Bosticco and Thompson (2008) recorded that narratives can silence other narratives and, subsequently, reinforce dominant ideologies (p. 46).

Because A.A. identity discourse tells people who they are and how they need to act in order to reduce heavy or problem alcohol use, instead of focusing on individualized care, individuals who do not succeed in A.A. are often subject to blame and shame for not working hard enough (part of the "good behaviour" discourse) instead of A.A. not being appropriate or suitable for that particular individual. As one member claims, "because it works for me, it will work for all of us" (AA World Services, 2005b, p. 552). This treatment towards "unsuccessful" individuals or members reflects universal understanding and acceptance of A.A.'s definition of alcohol and A.A. principles stating the fellowship "…is concerned solely with the personal recovery and continued sobriety of individual alcoholics who turn to [it] for help" (AA World Services, 1956, p. 6).

A.A.'s identity discourse also conflicts with individualist values in western societies. According to Rodner (2005) western societies and cultures value 'individual identity discourse', which favors and highlights state of minds demonstrating control of one's situation and behaviour. Self-control is, thus, described as a "superior part of identity" (Rodner, 2005, p. 342). Bailey (2005) notes addiction discourses "may be seen as presenting risks to the autonomous, self-governed individual" (p. 536). Findings in this study similarly show identity discourses in A.A. threaten individualism by expecting its members to adopt the group identity of the "alcoholic", at the expense of their personal autonomy and agency, and requiring them to behave in certain ways and perform specific tasks such as spreading God's word, recruiting people with alcohol use issues to do the same, and demonstrating certain behaviours like abstinence and a spiritual practice in order to achieve successful recovery. The fellowship maintains ultimate control by, as A.A. claims, God's decree and encourages collectivist, interpersonal processes. A.A.'s "alcoholic" identity discourse, thus, can have many potential negative outcomes for those who internalize it.

Unchallenged Power

Li (2011) asks, "Are the more devout adherents "better" people, more deserving of health than others?" (p. 666). Left unquestioned and without being critically analyzed, A.A. discourses depicting the "right" kind of recovery have morphed into "common sense" (Bailey, 2005, p. 536; Fairclough, 2010; Taleff & Babcock, 1998, p. 33). But this critical discourse analysis has provided for awareness and critique of ideologies, allowing for possibilities of empowerment and change (Fairclough, 2010, p. 68). A.A. discourses and ideologies tell members who they are and how to be as shown in this member testimony: "I told him that I just didn't want to be an alcoholic. He said it didn't matter what I wanted" (AA World Services, 2001a, p. 372). A.A.

discourse also removes personal agency that can be helpful during the process of change from one lifestyle – and potential identity – to another. Furthermore, these discourses expecting individuals to behave in certain ways reinforce dominant ideologies and societal conventions and, in the process, potentially damage the identities and self-confidence of individuals who pursue alternative ways in confronting their alcohol dependency. There is little to no acceptance for those who view alcohol addiction as a result of anything else other than a spiritual deficit/disconnection and physiological, irreversible illness. Theories that promote moderation, harm reduction such as clean equipment and managed alcohol programs, medicinal-assistance, or secular treatments are ostracized not only by members of A.A., but also friends and family, professionals, and healthcare and legal institutions because the A.A. ideology has reached and affected understandings of alcohol use and dependency at micro, meso, and macro levels. Concepts such as "you can cut back" are forbidden with individuals being ridiculed and despised for such ideas (Peele, 2010, p. 376) as a result of the Judeo-Christian traditions and Temperance movement values embedded in A.A.

The options, then, appear to be for individuals to adopt the A.A. way out of peer and societal pressure and endure the personal and health implications of this "fake it until you make it" strategy or defy this expected process of recovery and, while they may experience better outcomes, face immense stigmatization for not utilizing the traditional paradigm of alcohol treatment. This emphasis on individual failure versus program fit and appropriateness has shown to deteriorate and jeopardize individual autonomy, self-awareness, and confidence (Thompson, 2012a; Thompson, 2012b), because they do not align with traditional, outdated concepts never questioned or critically analyzed by its users. Approaches based on exclusivity and universality, like A.A.'s, as Boyd (2014) notes, ignore the multiple harms and costs to society that stem from

outdated perceptions of substance use and dependency and demonization of people who use them (p. 228). Findings in this study also confirm widespread ideologies of alcohol use stemming from A.A. that depict appropriate ways to consume alcohol for “alcoholics” and “non-alcoholics” are based on cultural values and expectations, not program effectiveness. These discourses satisfy Judeo-Christian and associated societal values in the United States and Canada at the expense of individual positive wellbeing.

Conclusion

The role of identity in addiction recovery is a topic receiving much scholarly attention. Studies show dominant ideologies of addiction such as abstinence and disease models may affect individual identities and self-perceptions and contribute to the ways in which society perceives and treats people with substance use disorders. Some studies show how these dominant narratives and the well-known program, A.A., help support and foster healthy identities for people in recovery. Other research displays opposite findings with data showing many in A.A. do not agree with A.A. philosophies and confirm participation in the program has had negative personal outcomes (Frank, 2011; Kitchin, 2002; Sifers & Peltz, 2013). Within this context, this study aimed to expand existing research and address identity construction and its relationship to philosophies and terminology in A.A. that maintain dominant alcohol treatment and recovery narratives. CDA was chosen as a suitable methodology to examine and heighten awareness by examining the potential existence of hidden ideologies in A.A. From awareness and critique arise possibilities of empowerment and change for those in addiction recovery (Fairclough, 2010, p. 68).

Findings in this study showed a powerful discourse exists in A.A. and influences member identities and experiences in recovery. A.A. maintains a specific identity discourse that incorporates Judeo-Christian traditions, model behaviour expectations, medical models of alcohol dependency such as disease and abstinence, and social identity requirements. Each of these themes were present throughout the analyzed texts, media, and member accounts. These themes reflected existing societal values regarding health behaviours, substance use, and individual existence in society. As a result, a combined discourse appears to have formed in A.A. that reinforces and maintains these values by requiring members to identify with the “alcoholic”

identity and agree that they are spiritual deficit – specifically lacking a relationship with Judeo-Christian interpretations of God – as a result of their disease, alcoholism. As a result, this ideological discourse dictates to individuals and the general public that the only route for "successful" recovery is through good behaviours and hard work, a monotheistic religious practice, and complete abstinence. Any other method is deemed false and will result in social stigmatization and isolation from A.A. and society as a whole. In order to support more people in living enhanced lives after alcohol use disorders, I hope this study will help the public become aware of the ideological assumptions embedded in A.A. discourse and consider the value of alternative approaches. become aware that A.A. is popular not as a result of being the "answer" to "alcoholism", but as a reflection of existing power structures and ideologies in society.

Bailey (2005) asks in her study "can someone who has been labeled, or labeled themselves, an 'addict' ever move beyond that discourse? And how can these ever change?" (p. 537). A.A. has its place in the treatment and recovery world and has been very successful as a peer-support group as apparent in member testimonies and some research. Yet, as discussed here, A.A. does not necessarily work for all individuals. The expectation that one treatment approach may offer the one and only solution is problematic. A.A.'s approach resonates with dominant discourses in that it reflects ideals that are largely influenced by longstanding Judeo-Christian traditions and prevalent medical theories. This may lead society to ignore the revelation of effective treatments that conflict with these ideals. It seems that the hegemonic position of A.A. discourse needs to be challenged to broaden the scope of treatment options. Not everyone needing support for alcohol use should be expected to adhere to A.A.'s principles and ideological expectations or feel unable to recover because they do not maintain the spiritual practice, behaviours, and identity prescribed in A.A. A.A. discourse constructs the lack of viability of any

other perspective to recovery as a given, oversimplifying the nuances of individual alcohol use. As Thompson (2012a) notes, “the goal of addiction treatment is not only recovery from addiction, but full restoration to the fullness of life” (p. 429). Rather than being understood as a value-free ‘truth’ of alcohol use and recovery, A.A. discourse needs to be understood as a reflection of existing societal ideals related to Judeo-Christian traditions and popular health behaviour discourses (Bailey, 2005; Taleff & Babcock, 1998). Rodner (2005) agrees that we should be focusing on “possible latent and negative consequences of current policies” in order to address alcohol use more effectively (p. 344). And while, as Dutta and Zoller (2008) highlight, it may not be realistic to expect the dominance of A.A. discourse to decrease in the near future, casting a critical eye upon taken-for-granted power structures, such as this recovery ideology, is a necessary first step towards promoting awareness and inspiring change.

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