



**The Age of Miracles is Still with Us:
Analysis and Discussion of Selected Results
of the Membership Surveys of Alcoholics Anonymous
by Charles Sigler, D.Phil.**

Over the past fifty years there has been an increased cultural acceptance of recreational drug use, leading to a question of whether a “pure” alcoholic will someday become as rare as a “pure” drug addict once was. Has an organization like Alcoholics Anonymous, whose primary purpose is to carry the message to the still suffering alcoholic, outlived it’s usefulness or is there still a need for a Fellowship with such a single-minded purpose?

The following data was taken from the membership surveys conducted by A.A. on a periodic basis from 1978 to 2007, typically every three years. Pamphlets containing the results of the surveys were obtained from the GSO Archives of Alcoholics Anonymous. What follows does not examine all of the data reported in these pamphlets. For example, information on occupations was not compiled, but was available in many of the surveys. A few of the less frequently given responses were left out of the tables as well. When it was available, corresponding data on Narcotics Anonymous was noted and discussed. **The interpretation and discussion of the data was done by the author and should not be understood as representing the opinions of Alcoholics Anonymous in any way.**

Since 1986, the most often reported introduction to A.A. has been from some type of counseling or addiction treatment center (41.4%). Coming to A.A. via another A.A. member has been the second most reported route (35.5% average). The first three surveys (1978, 1981 and 1984) indicated that another A.A. member was the most frequent way someone came to A.A., but already the trend away from A.A. members was beginning. Between 1981 and 1984 there was a 5% decrease in reported introductions to A.A. from other A.A. members and a corresponding 5% rise with introductions from counseling and rehabs. Self referrals have been the third most frequent source of introduction (32.8%). An interesting trend is the steady, 11% average introduction to A.A. from court ordered attendance. The importance of family members for A.A. referrals is increasing. From 1978 to 1989, 20% of the surveyed A.A. said a family member had helped to introduce them to A.A. From 1992 to 2007, family members were noted as referrals 25.8% of the time. See Tables 1a and 1b for the data.

Introduction to A.A.
(many gave two answers)

Table 1a: Introduction to A.A. 1978-1989

in percentages	1978	1981	1984	1986	1989
Another AA member	41	42	37	36	34
Self referral	38	27	27	27	27
Counseling/Rehabs	24	26	31	36	40
Family member	21	21	20	19	19
doctor/health care				7	7
Non-A.A. friend/neighbor					4
A.A. literature					3

Table 1b: Introduction to A.A 1992-2007
(many gave two answers)

in percentages	1992	1996	1998	2001	2004	2007
Another AA member	34	48	36	32	31	33
Self referral	29	51	34	33	30	31
Counseling/Rehabs	36	56	43	40	39	41
Family member	21	39	25	23	23	24
doctor/health care	7	8	8	7	8	8
Non-A.A. friend/neighbor	4	8	4	4	4	3
A.A. literature	3	5	2	2	1	2
court order	8	13	11	12	11	11
correction facility	3	3	3	2	2	3
clergy		3	2	1	1	1
internet						1

Demographic Characteristics of A.A. Members

Information on the age, sex and racial, ethnic backgrounds of members has been gathered. Categories giving greater specificity with regard to age were used consistently after 1989 and will show some interesting trends.

A.A. members are getting older and younger. In 1978, 35% of the membership was over the age of fifty. In 2007, 41.4% of the membership was over 50; 17.6% were over the age of 60. In 1978, 11% of the members were 30 and under. In 2007, 13.6% were under 30. More specific age data gathered after 1989 shows that approximately 2% of A.A. members were 20 and younger. The percentages of members in the two most senior categories (61 through 70 and over 70) have steadily increased. In 2007, the middle-aged range from 31 through 50 fell below 50 percent (at 45%) for the first time since the surveys began. N.A. seems to have similar percentages of its members 30 and younger (16% for N.A.; 13.6% for A.A.). But a much higher percentage of its members

between the ages of 31 and 50 (60% for N.A.; 45% for A.A.). A.A. has a greater percentage of its membership over the age of 50 (41.4% for A.A.; 25% for N.A.). See Tables 2a and 2b for the data.

Table 2a: Age of Membership 1978-1986

in percentages	1978	1981	1984	1986
20 and younger				3
21 through 30				18
30 and younger	11	15	20	---
31 through 50	52	51	52	52
50 and over	35	32	28	27

Table 2b: Age of Membership 1978-1986

in percentages	1989	1992	1996	1998	2001	2004	2007	N.A.
20 and younger	3	2	1	2	2	1.5	2.3	2
21 through 30	19	17	12	9	9	7.9	11.3	14
31 through 40	30	32	30	28	24	18.2	16.5	23
41 through 50	25	25	29	30	31	33	28.5	37
51 through 60	14	14	16	18	20	23.1	23.8	22
61 through 70	7	8	9	9	10	11.5	12.3	---
over 70	2	2	3	4	4	4.8	5.3	---
over 60								3

The ratio of men to women in A.A. has held steadily at nearly 2 men for every 1 women member. Demographic information from the 2006 census indicated that males comprised 49.2% of the population; and females 50.8% of the population. There is a higher percentage of women in N.A. (44% are women; 56% are men) See Table 3 for the data.

Table 3: Sex of Membership 1984-2007

	1984	1986	1989	1992	1996	1998	2001	2004	2007	N.A.
women %	30	34	34	35	33	34	33	35	33	44
men %	70	66	66	65	67	66	67	65	67	56

Data on the racial/ethnic composition of A.A. was only available since 1996 and indicated that A.A. members were overwhelmingly white: an average of 87%. White membership percentages are above the national average of 80.2%. Black membership percentages are well below the national averages of the general population (12.8%). The same is true for Hispanic and Asian members when compared to the national averages for Hispanics (14.4%) and Asians (4.3%). The percentage of Native American members is above the general population average of 1.0%.¹ An encouraging trend is the slight increase in ethnic diversity within A.A. noted in the 2007 data for Blacks, Hispanics and Asians. Data available on the racial/ethnic composition of N.A. show similar trends, with a tendency to be more diverse than A.A. See Table 4 for the data.

¹ Data for the comparison was taken from the U.S. Census Bureau, National Population Estimates for May 10, 2006. Retrieved online from infoplease.com.

Table 4: Racial/Ethnic Composition of Members 1996-2007

in percentages	1996	1998	2001	2004	2007	U.S.	N.A.
White	86	88	88	89.1	85.1	80.2	73
Black	5	5	5	3.2	5.7	12.8	7
Hispanic	4	4	4	4.4	4.8	14.4	7
Native American	4	2	2	1.8	1.6	1	---
Asian and other	1	1	1	1.5	2.8	4.3	---
Other							7

Working the Program

In March 2002, Junior wrote the following for the *Grapevine*: “I was told by a sober member of AA that if I wanted to stay sober I would need to do three things: get a sobriety date and don't change it; get a sponsor; and get a home group. I did these three things on blind faith because I didn't understand how they were going to keep me sober. . . . Now I understand. The sobriety date gives me a sense of purpose, the sponsor gives me a sense of direction, and the home group gives me a sense of belonging.” The importance of not drinking, going to meetings, getting a sponsor and a home group, cut to the heart of beginning to work the program for many AAs. Sadly, those who return after a relapse invariably will say: “I stopped calling my sponsor, I quit going to my home group, I stopped going to meetings and eventually I began to drink.”

Overall sobriety at a typical A.A. meeting has been gradually increasing. There are still a fair amount of people with less than a year. In 2007, this was 31%—down from the 35-40 percent reported in 1978-1984. However, in 1978, only 20 to 30 percent reported having over 5 years of sobriety; in 2007, 45% had over 5 years of sobriety. This was a drop from 2004, where 50% of those surveyed said they had 5 years or more of sobriety. Since the surveys began identifying those with over 10 years of sobriety in 2004, the reported percentages have exceeded those reporting over 5 years

of sobriety from 1978 through 1989. AAs with long term sobriety are increasing; and just as importantly, still going to meetings. See Tables 5a and 5b for the data.

Table 5a: Sobriety at a Typical Meeting 1978-1989

in percentages	1978	1981	1984	1986	1989
sober under 1 year	35-40	35-40	35-40	33	34
1 to 5 years	35-40	35-40	35-40	38	37
over 5 years	20-30	20-30	20-30	29	29

Table 5b: Sobriety at a Typical Meeting 1992-2007

in percentages	1992	1996	1998	2001	2004	2007
sober under 1 year	31	27	27	30	26	31
1 to 5 years	34	28	26	22	24	24
over 5 years	35	45	47	48	---	---
5 to 10 years					14	12
over 10 years					36	33

Personal sobriety has also been on the rise among A.A. members since 1984. The first two surveys quantified sober time in months, but then switched to years in 1989. Even so, with this indicator, we can see a steady increase of reported sober time from 1978 through 2007. Average reported abstinence in N.A. was higher than in A.A. at 9.1 years. It works if you work it. Members reporting that they have a home group have remained in the mid-80s range (85.4% average). A.A. members reporting they have a sponsor have been in the high 70s since 1992 (78% average). A disturbing trend, the average number of weekly meetings attended by A.A. members had fallen from 4 in 1984 to 2 in 2004, but had a resurgence to 2.4 weekly in 2007. We'll have to see where weekly meeting attendance goes in future surveys. See Table 6 for the data.

Table 6: Time Sober and Participation 1984-2007

	1984	1986	1989	1992	1996	1998	2001	2004	2007	N.A.
sobriety (months)	45	52	---	---	---	---	---	---	---	---
sobriety to date (years)	---	---	4+	5+	6+	7+	7+	8+	8+	9.1
mtgs. per week	4	4	3	2.5	2+	2	2	2	2.4	
have a home group (%)			88	83	86	85	85	86	85	
have a sponsor (%)			85	78	76	75	77	78	79	

Friendly with Our Friends

Information is available on counseling prior to A.A. involvement, counseling after A.A., and the influence of counseling on A.A. involvement and sobriety. An average of 62% of A.A. members since 1984 reported some previous involvement with counseling before coming to A.A.; 76.3% reported that their prior counseling helped them get to A.A. Many A.A. members (61.7%) continued in counseling after coming to A.A. and large majority (85%) said that counseling helped them in their sobriety. Always a good idea in ongoing sobriety, 73.7% of members said their doctors knew they were in A.A.

In three earlier surveys, there was also information available on members reporting drug addiction in addition to their alcoholism. Each time the data was reported, it had a different formulation in "The AA Membership Survey" pamphlet. In 1984, 31% of A.A. members said they were addicted to another drug. In 1986, 38% of A.A. members said they were also addicted to drugs. In 1989, "In addition to their alcoholism, 42% of members indicated they were addicted to drugs." At the 40th General Service Conference, it was recommended that the answer to the survey question pertaining to drugs should be presented as follows: "In addition to their alcoholism, X% of members indicated they were addicted to drugs," and then followed by the disclaimer "AA's primary purpose is recovery from alcoholism." At the 42nd General Service Conference it was recommended that Question #14--"In addition to your alcoholism, were you addicted to drugs?"--be removed from the 1992 A.A. Membership Survey Questionnaire. It was, and has not appeared since then in any of the reported results of the membership surveys. See Table 7 for the data.

Table 7: Friendly with our Friends 1984-2007

	1984	1986	1989	1992	1996	1998	2001	2004	2007
PC-prior counseling (%)	60	60	68	63	60	60	61	64	63
PC helped get to AA (%)			80	80	77	75	74	74	74
CA-counsel after AA (%)			60	56	62	62	64	65	63
CA helped sobriety (%)			85	87	85	83	85	84	86
Doctors know in AA (%)			70	74	73	75	73	77	74
also addicted to drugs (%)	31	38	42						

Discussion of the Membership Survey Data

With regard to working a program of recovery—as that is reflected in honesty with your doctor about being in A.A., having a sponsor and a home group, and the amount of personal sober time—A.A. as a whole seems to be healthy. Sober time reported by members has more than doubled since 1984; sponsorship and having a home group remains a priority for most of the Fellowship—as does letting your doctor know you are in the program.

Data on the average number of weekly meetings is a bit trickier. It's hovered between 2 and 3 weekly since 1992 (down from 4 in 1984), which may be an adequate number for those members with longer term sobriety—the 45% (reported in 2007) with 5 years or more of sober time. It still may be fine for the majority of those with between 1 and 5 years of sobriety (24% of members in 2007). But it may be inadequate for many of those with less than 1 year (31% in 2007); and it could be one of the factors in their inability to maintain abstinence once they've established it. If a newcomer actually did their “90 in 90,” they would still be able to meet the average meeting weekly attendance reported here by only going to 1 weekly meeting for the remainder of the year.

Statistical midpoints (mean or average, median, and mode) are often influenced by skewed data. Averages will be effected by extremes, so that data on weekly meeting attendance is influenced by the number of members who attend more or less often. This means that if those with less than 1 year of sobriety are in fact attending more than 2.4 meetings weekly (which is a good thing), then some section of the remaining A.A. members is attending less than 2.4 meetings weekly (which may be a bad thing). The less frequently that members with sobriety are at meetings, the less opportunity they have to share their experience, strength and hope with the new person at that meeting. Remember the Responsibility Statement: “I am Responsible. When anyone, anywhere, reaches out for help, I want the hand of A.A. always to be there. And for that: I am responsible.” Are newcomers getting to enough meetings? Are oldtimers around enough to share their experience, strength and hope with the newcomer? The May 20th Thought for the Day in “Twenty-four hours a Day” reads:

If we get up in a meeting and tell something about ourselves in order to help the other person, we feel a whole lot better. It’s the old law of the more you give the more you get. . . . Helping others is one of the best ways to stay sober yourself. And the satisfaction you get out of helping a fellow human being is one of the finest experiences you can have. Am I helping others?

In the future, looking at the weekly meeting attendance data within the above reported categories of sober time may give some insight into these questions.

Comparing and discussing data on the racial composition of A.A. members is a potentially sensitive subject, but can be helpful if considered in the context of the First Tradition and the Responsibility Statement.² The population comparisons clearly indicate that A.A. is less racially diverse than the U.S. population. To a certain extent, this is understandable in that it began within a largely white racial context of the original membership. Both of the cofounders were white as well. But the explicit inclusiveness of the Fellowship, embodied in the First Tradition, suggests that A.A. could be more diverse than it is after seventy years of existence.

² Data used in the following discussion for race, gender and age was taken from a brief report on [Alcohol Dependence and Abuse](#) from the National Survey on Drug Use and Health or the [2007 National Survey on Drug Use and Health](#).

In light of the Responsibility Statement, carrying the message to the still-suffering alcoholic who is Black, Hispanic, Asian or Native American could be better as well. Data from the National Survey on Drug Use and Health indicated that 7.6 percent of the U.S. population (18.2 million) met the criteria for alcohol dependence or abuse in 2006. When racial data from the 2007 NSDUH survey is compared with racial data from the 2007 A.A. member survey, Table 8 is the result. A disproportionate amount of A.A. membership (85.1%) is made up of Whites who meet the criteria for alcohol abuse and dependence (7.9% of the White population). Keeping in mind the importance of both Traditions Six and Ten, how can this issue be addressed? One suggestion may be to intentionally start and maintain more meetings within residential areas that have a large population of Blacks, Hispanics, Native Americans and Asians.

Table 8: Percentages of Persons Who Met the Criteria for Alcohol Dependence or Abuse by Race and A.A. Racial Diversity

	White	Black	Hispanic	Native Amer.	Asian
NSDUH Survey	7.90%	6.50%	8.20%	14%	4.30%
A.A. Members	85.10%	5.70%	4.80%	1.60%	2.80%

Although there are more males in A.A. than there are females (67% to 33% respectively in 2007), statistics indicate there are more females than males in the U.S. population (51% to 49% respectively). However, this proportionally higher percentage of male A.A.'s approximates the gender ratio data from the NSDUH survey for alcohol abuse and dependence according to gender. Males over the age of 12 are about twice as likely as females to meet the criteria for alcohol abuse and dependence. Of males aged 12 or older in the U.S., 12.5% met the criteria for substance abuse or dependence. For females aged 12 and over, 5.7% met the criteria for substance abuse or dependence. There are still more males than females in N.A., but the ratio is closer to that of the overall U.S. population. See Table 9 for a comparison of the data.

Table 9: Gender in A.A. N.A. and Alcohol Abuse/Dependence

	A.A. Membership	N.A. Membership	U.S. Population
Males	67%	56%	49%
Females	33%	44%	51%

Comparing data on the age of A.A. members to the age of those meeting the criteria for alcohol dependence and abuse cannot be done in a straight forward fashion, because A.A. and NSDUH used different age categories. As Table 10 shows, A.A. reported its data by decades (under 20, 20s, 30s, etc.), while NSDUH used a different setup (12 to 17, 18 to 25, 26 to 34, 35 to 49, 50 and over). Nevertheless, a rough age comparison can be done of the youngest to oldest age categories. The simplest interpretation of the age data seems to be that A.A. membership is disproportionately over represented among adults above the age of 40 with alcohol abuse and dependence issues; and under represented among individuals meeting the criteria for abuse and dependence who are under the age of 30. The age differences between A.A. and N.A. members most likely reflect the dual influences of A.A. having a greater amount of time since it was founded as a Fellowship than N.A.; and the more recent cultural acceptance of recreational drug use.

Table 10: Age and Alcohol Abuse/Dependence

NSDUH: AA:	12 to 17 >20	18 to 25 21-30	26 to 34 31-40	35 to 49 41-50	50 or over 51 or over
A.A.	2.30%	11.35%	16.50%	28.50%	41.40%
NSDUH	5.90%	17.40%	11.10%	7.50%	3%

It seems that A.A. members and counseling/treatment programs for alcoholism have had an uneasy coexistence from the beginning. The non-professionalization of the

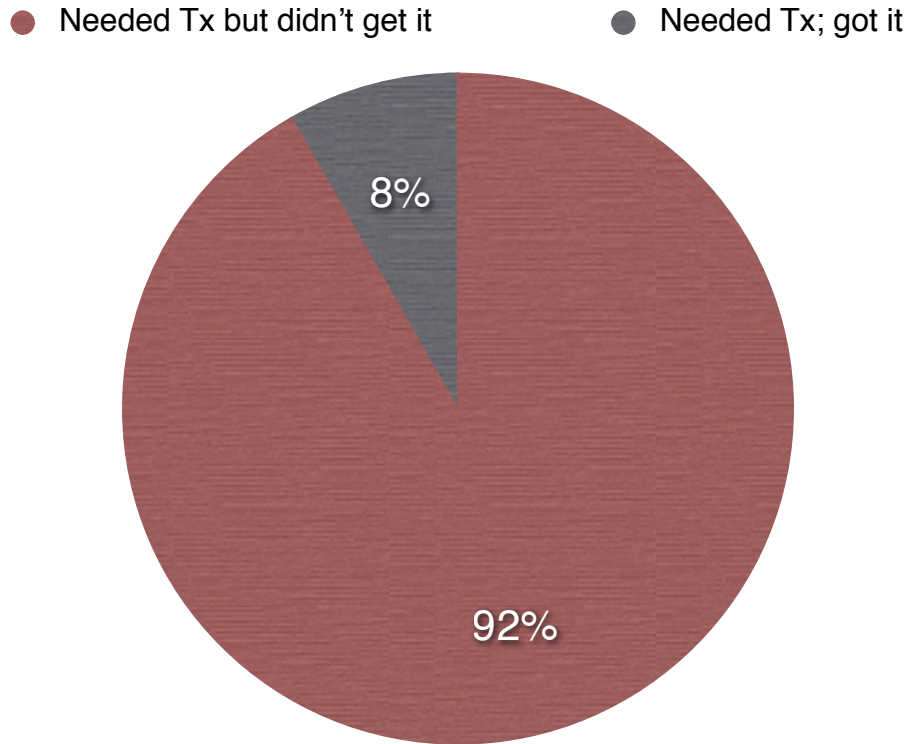
Fellowship, embodied in Tradition Eight, has conflicted at times with the professional treatment field that was literally built on the successful foundation of the Twelve Steps. Rightly so, some A.A. members are disturbed when treatment professionals look at A.A. as just another “treatment approach” to alcoholism and then discuss its advantages and disadvantages for reaching the still suffering alcoholic. Perhaps most disturbing are treatment professionals and alcoholism researchers who are critical of the effectiveness of A.A., and then imply that alcoholics are best served to avoid A.A. But what are those who are interested in helping the still suffering alcoholic with the Twelve Steps, A.A. members and treatment professionals alike, to do? There cannot be some sort of integration of the approaches. Remember Bill W.’s words in his essay on Tradition Eight:

Alcoholics Anonymous will never have a professional class. We have gained some understanding of the ancient words, “Freely ye have received, freely give.” We have discovered that at the point of professionalism, money and spirituality do not mix. . . . Every time we have tried to professionalize our Twelfth Step, the result has been exactly the same: our single purpose had been defeated.

But why can’t there be a peaceful sort of coexistence between A.A. and professional treatment? There is still a vast, untouched population of individuals with alcohol problems who aren’t getting help. The 2007 NSDUH estimated that there were 19.3 million people over the age of 12 who needed treatment for an alcohol use problem in the U.S. This translates to 7.8 percent of the population aged 12 or older. For the purposes of the NSDUH study, someone needing treatment was defined as an individual who met the DSM-IV (APA, 1994) diagnostic criteria for dependence on or abuse of alcohol in the past 12 months; or if he or she actually did receive specialty treatment³ for alcohol use in the past 12 months. Out of these 19.3 million individuals with potential alcohol problems, 17.7 million persons who needed treatment did not receive it (92%); while 1.6 million (8.1 percent of the people who needed treatment for an alcohol use problem) received alcohol use treatment at a specialty facility (8%). This was equal to 0.6 percent of the total population. See Chart 1 below.

³ Meaning hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers.

Chart 1: Perceived Tx Need for Alcohol Use

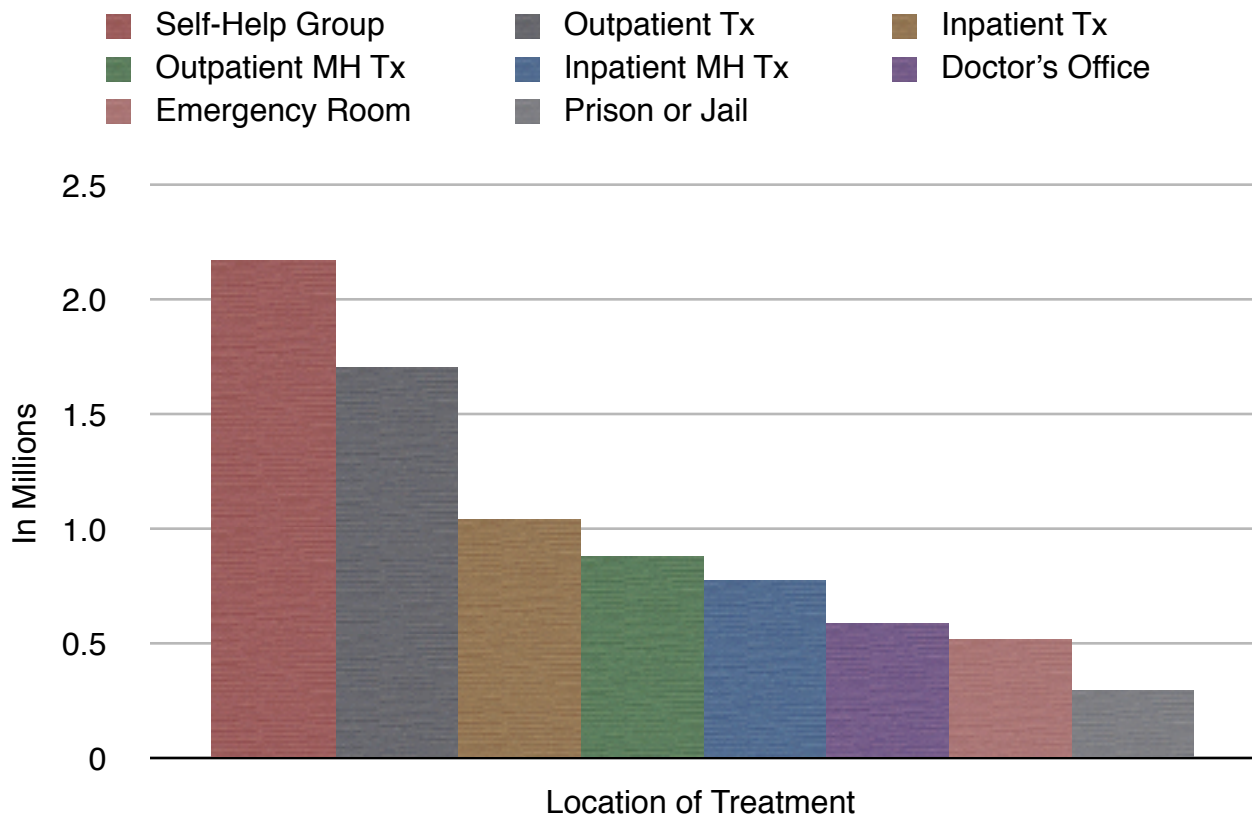


When self-help is considered a type of “treatment” for a substance use problem (drugs or alcohol), it is the most frequently received type of treatment. Among the 3.9 million persons 12 or older who received treatment for alcohol or drug use, 2.2 million persons received treatment at a self-help group, and 1.7 million received treatment at an outpatient rehabilitation facility. There were 1.0 million persons who received treatment at an inpatient rehabilitation facility, 889,000 persons who received treatment at a mental health center as an outpatient, 779,000 at a hospital as an inpatient, 593,000 at a private doctor's office, 523,000 at an emergency room, and 302,000 at a prison or jail. None of these estimates have changed significantly between 2002 and 2007. See Chart 2 below for the data.

Although self-help groups are the most widely used “treatment” for a drug or alcohol use problem, most of the surveyed A.A. members were introduced to A.A. from the outside. Since 1986, 41.4% of all A.A. members said they were introduced to A.A.

through some type of treatment or counseling. A.A. membership surveys indicated that an average of 62% of its members since 1984 have had some counseling before coming to A.A. and 76.3% of those said their prior counseling helped them get to A.A. Similarly, 61.7% continued in counseling after they came to A.A. and 85% of those reported that counseling helped them in their sobriety. A.A. members as well as treatment professionals and researchers need to acknowledge the benefits for the still suffering alcoholic when treatment and self-help work together.

Chart 2: Substance Use Treatment for Persons Aged 12 or Older.



At least three research studies in the recent past have shown the benefits to addicts and alcoholics who combined professional treatment and self-help involvement. A 3-year study of alcohol dependent outpatients found that self-help participation (mostly in A.A.) “was associated with both greater abstinence and fewer drinks per drinking day.” The researchers concluded that even modest levels of participation may be

helpful.⁴ A comparison of five 12-Step-oriented treatment programs and five Cognitive Behavioral-oriented treatment programs within the VA found a substantially higher level of abstinence in participants in the 12-step programs than for those in the Cognitive Behavioral treatment programs (49.5% versus 37.0% respectively). The researchers concluded that actively promoting self-help involvement is a useful method for extending the benefits of treatment while lowering its cost.”⁵ A third study showed that being actively involved in a self-help group “significantly improves one’s chances of remaining clean and sober.” Which kind of self-help wasn’t important, but some type of group involvement “directly increases the amount of time one stays clean and sober.” Related to this, a person’s religiosity and belief in a Higher Power was not found to directly influence that individual’s chances of remaining sober.⁶

As noted above, after collecting and posting data in three surveys on A.A. members who reported having a problem with drugs in addition to their alcoholism, the question was removed from the 1992 survey and has not been reinstated in the Membership Survey. It’s not hard to guess why; the disclaimer in the 1989 results, that the primary purpose of A.A. is recovery from alcoholism, is the obvious reason. While the action may be an attempt to be consistent with the Traditions of A.A, is this lack of information about A.A. members masking a growing trend that needs to be addressed? Is the “pure” alcoholic going the way of the dinosaur? Is the primary purpose of carrying the message to the still suffering *alcoholic* an increasingly meaningless Tradition?

The percentage of members reporting that they were also addicted to drugs was rising in the three available surveys: 31% in 1984, 38% in 1986 and 42% in 1989. Data on A.A. members self report of having a problem with drugs has not been available for twenty years; so there is no way to know what percentage of the membership would

⁵ Humphreys, K. and R. Moos. (2007). “Encouraging posttreatment self-help group involvement to reduce demand for continuing care services: Two-year clinical and utilization outcomes.” *Alcoholism: Clinical and Experimental Research*. Jan. vol. 31, no. 1. pp 64-68.

⁶ Atkins, R, and J. Hawdon. (2007). “Religiosity and participation in mutual-aid support groups for addiction.” *Journal of Substance Abuse Treatment*. vol. 33. pp 321-331.

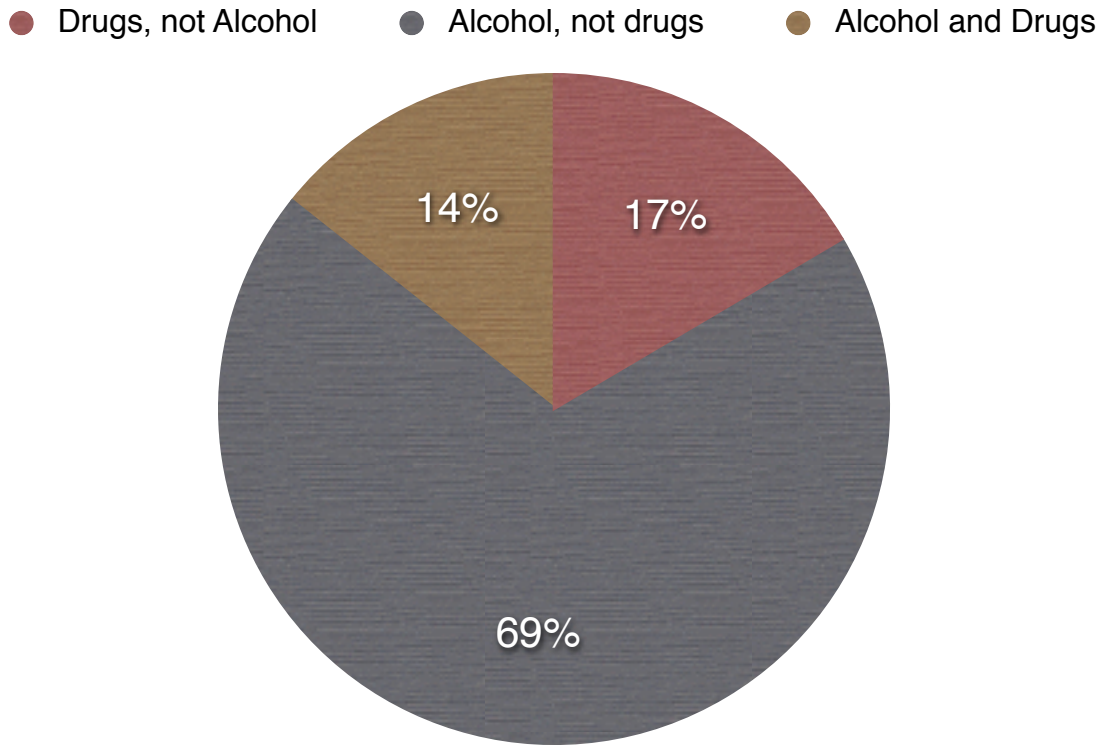
report a concurrent drug addiction today. We can speculate that the percentages would continue to be high; perhaps even higher than the 42% reported in 1989. But there is no way of knowing where the membership of A.A. stands without asking the question. However we can look at data that estimates the number of persons in need of treatment for alcohol and drug problems and whether those problems are with alcohol or drug use only; or a combination of drugs and alcohol.

Turning again to the NSDUH, in 2007 an estimated 22.3 million persons 12 and older could be classified with substance dependence or abuse problems in the year previous to the survey. Of these, 3.7 million (16.6%) were dependent on or abused drugs but not alcohol. Another 15.5 million (69.5%) were dependent upon or abused alcohol but not drugs; and 3.2 million (14.4%) were classified with dependence on or abuse of both alcohol and drugs. An overwhelming majority of those who met the criteria for substance dependence or abuse in the year prior to the 2007 NSDUH were only using/abusing alcohol (69.5%); and another 14.4% had co-occurring problems with both drugs and alcohol. So 18.7 million (83.9%) of the 22.3 million people estimated to have a substance dependence or abuse problem in 2007 have the potential to qualify for membership in A.A., if they have the desire to stop drinking. See Chart 3 below for a comparison of the data.

This data suggests that the “pure” alcoholic is nowhere near extinction; and that the need for a Fellowship whose primary purpose is to reach out to the still suffering alcoholic seems to have a long future ahead of it. Alcohol is still far and away the primary drug of abuse and dependence in the U.S. But the last fifty years has seen the rise of widespread “recreational” drug use along with a corresponding growth in the reported problems of drug abuse and dependence. An estimated 31% of the 22.3 million people in potential need of treatment for drug and alcohol problems in 2007 met the diagnostic criteria for drug abuse or dependence diagnosis.

The rapid development of the Twelve Step Fellowship of Narcotics Anonymous, N.A., has also occurred in this time period. Like A.A., N.A. does not keep strict membership records, but there is information available on the number of registered groups and estimates of weekly meetings on their website. In 1978, there were fewer than 200 registered N.A. groups in three countries. By 1993, this had risen to over 13,000 registered groups holding over 19,000 meetings in 60 countries. By 2007, there were 25,065 registered N.A. groups holding an estimated 43,900 weekly meetings in 127 countries.

**Chart 3: Substance Dependence and Abuse Problems
with Drugs and Alcohol**



A.A. experienced a similar growth spurt in its beginnings. In 1940, there were 50 groups with an estimated membership of 1400. By 1945 there were 556 groups with almost 13,000 members. By 1950, there were 3,527 groups and 96,475 estimated members. In 1978, there were 33,241 groups and an active membership of 627,456. By 1993, there were 90,155 groups with 2,062,380 members. In 2007, there were 113,168 groups and an estimated 2,044,655 members. See Table 11 for the data on A.A. and N.A. growth.

Table 11: A.A. and N.A. Growth

Year	A.A.		N.A.	
	Members	Groups	Groups	Countries
1940	1400	50	---	---
1945	12986	556	---	---
1950	96475	3527	---	---
1978	627456	33241	200	3
1993	2062380	90155	13000	60
2007	2044855	113168	25065	127

At this time, in many areas of the country the prevalence of A.A. and N.A. is such that an individual seeking to be active in both Fellowships for alcoholism and drug addiction can easily do so. The available data on the number of A.A. members reporting that they also have a problem with drug addiction suggests this has been occurring as well. But it seems to create a problem for A.A. groups as a potential violation of its primary purpose, namely to carry the message to the still suffering *alcoholic*. The Fifth Tradition can at times grate against the inclusiveness of the Third Tradition, where Bill W. flatly stated in his Tradition Three essay that: “For A.A. is really saying to every serious drinker, ‘You are an A.A. member if *you* say so. . . . nobody can keep you out.’” So accommodations like these are widespread: only speaking about problems with alcohol at A.A. meetings and not speaking about personal struggles with drugs; identifying as an alcoholic at A.A. meetings—even if you have rarely been drunk.

In the May 2004 issue of the *Grapevine*, David T. shared his experience in helping a newcomer get settled in N.A. instead of A.A. He received a call from a newcomer through a “Bridge the Gap” program conducted by his local A.A. district, which helps newcomers get in contact with A.A. members willing to do Twelve Step work. David discovered that while the man had a drug problem and not an alcohol problem, he

came to A.A. because he was told in his treatment center that there was more recovery in A.A.

David explained that he did not presume the man was nonalcoholic or that A.A. was not the path of recovery for him. But he told him “I will help you to get started in recovery and we will begin by studying “The Doctor's Opinion” in the Big Book. But I will only help if you attend NA meetings in addition to AA meetings. This is because there will come a time and place where you will have to take suggestions to stay sober that go against your nature—things you don't want to do—and if you are not absolutely convinced that the person giving you the suggestions has overcome the same problem you have, you will not follow the suggestions that may save your life.” The man quickly settled into an N.A. home group that he felt comfortable with, picked an N.A. sponsor and was grateful for David’s help.

David himself said he had a drug history as long as his alcoholism, but was not an addict. While he was sympathetic to the stories of addicts, gamblers and others, the place “where I actually begin to feel the pain experienced by the speaker and relate his experience to my own” was with alcohol. Because of the importance of identification to the recovery of alcoholics, “I do not wish to risk weakening my effectiveness by speaking of my drug use in an AA meeting.”

Given the diversity of people and problems in AA, the unity necessary to function as a group would be impossible and our effectiveness with newcomers diminished if we did not keep our focus on our common problem. I have to relate myself to the group as a whole for my own recovery, and the recovery of those I would help. I would hate to see the day in AA when an alcoholic's chance to recover was dependent upon whether an AA had the "right" person with the "right" set of problems for him that day on the answering service. I would hate to see the day when any real alcoholic found herself unable to relate to a speaker or discussion due to too much talk of problems other than alcoholism that she does not possess. I want every alcoholic to have the chance I had to enter an AA meeting and come to realize, as I did, that "those people are like me and maybe if I do what they did it will work for me too."

He noted that A.A. is not all-inclusive; nor was it intended to be. The purpose of A.A. was not to expand its program to fit all situations or persons, but to grow in effectiveness at the one simple thing that it do well.

I am learning that if we keep in mind that “to be helpful is our only aim,” we can maintain our singleness of purpose with kindness, compassion, and tolerance. By doing so, we may see to it that Alcoholics Anonymous continues to be the single most effective treatment for alcoholism in history and that all those who suffer from alcoholism may find the hand of AA when they reach out for help.⁷

Conclusion

Despite the increased cultural acceptance of recreational drug use of all kinds in the past fifty years, alcohol has remained the most commonly used and abused mind altering substance. When such a small percentage of those who need treatment for their abuse and dependency problems actually obtain it, there are potentially millions of still suffering alcoholics out there. Self help groups like A.A. are the most frequently used from of “treatment” for substance abuse and dependence problems. The “pure” alcoholic is nowhere near extinction, with an estimated 15.5 million individuals meeting the criteria for alcohol dependence and abuse. The need for a Fellowship whose primary purpose is to reach out to the still suffering alcoholic has a long future ahead of it.

A.A. also seems to be an older, largely white, male Fellowship. Some rather simple outreach efforts by the Fellowship, like helping to maintain groups in ethnic population centers, could diversify the demographic makeup of A.A. in the future while simultaneously carrying the message to the still suffering alcoholic of different ethnic backgrounds.

The uneasy coexistence of A.A. and professional treatment programs needs to find a way to work more effectively together for the good of the alcoholic. For over twenty years, most A.A. members have reported that the primary source of their introduction

⁷ “How Can We Help?: Welcoming someone into AA may not be the answer.” *Grapevine* May 2004, vol. 60, no. 12. Retrieved online from the *Grapevine*’s digital archives.

to A.A. was from treatment programs. In addition, there have been clear indications that A.A. members felt that counseling not only helped them find A.A., but also that counseling helped them in their recovery. Research has demonstrated that the combination of treatment and self help has had the greatest positive impact on ongoing sobriety.

In terms of the basics of the program—sponsor, home group and meetings—A.A. members seem to be active, involved and healthy. The percentages of individuals at a typical meeting with over five years of abstinence has steadily increased and is now approaching 50%. The average overall abstinence among A.A. members has also been increasing and is now over eight years. The age of miracles is still with us; one day at a time.

The interpretation and discussion of the data in this paper was done by the author and should not be understood as representing the opinions of Alcoholics Anonymous in any way.