Abstinence or controlled drinking – a five-year follow-up on Swedish clients reporting positive change after treatment for substance use disorders

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Abstract

Purpose – *The purpose of this paper is to investigate how clients – five years after completing treatment interventions endorsing abstinence – view abstinence and the role of Alcoholics Anonymous (AA) in their recovery process.*

Design/methodology/approach – *Interviews with 40 clients were conducted shortly after them finishing treatment and five years later. All the interviewees had attended treatment programmes based on the 12-step philosophy, and they all described abstinence as crucial to their recovery process in an initial interview.*

Findings – *At follow-up, the majority remained abstinent. For many, attending AA meetings was still important – some described attending as a routine, whereas others stressed that the meetings were crucial for remaining abstinent. For those who reported controlled drinking (CD), this was described either as a natural step in their recovery process or as associated with worries and self-doubts.*

Research limitations/implications – *The results suggest the importance of offering interventions with various treatment goals and that clients choosing CD as part of their sustained recovery would benefit from support in this process, both from peers and professionals.*

Originality/value – *There are heterogeneous views on the possibilities of CD after recovery from substance use disorder both in research and in treatment systems. This study on client views on abstinence versus CD after treatment advocating total abstinence can contribute with perspectives on this ongoing discussion.*

Keywords *Recovery, Treatment, Alcoholics anonymous, Abstinence, Controlled drinking, Twelve steps*

Paper type *Research paper*

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Introduction

Abstinence from alcohol and other drugs has historically been a core criterion for recovery, defined by the Betty Ford Institute as a "voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" (Betty Ford Institute Consensus Panel, 2007, p. 222). As recovery processes stretch over a long period, it is suggested that stable recovery is obtained after five years at the earliest (Hibbert and Best, 2011).

In parallel with the view on abstinence as a core criterion for recovery, controlled drinking (CD) has been a recurring concept and in focus from time to time in research on alcohol problems for more than half a century (Davies, 1962; Roizen, 1987; Saladin and Santa Ana, 2004). It caused heated debates, and for a long time, it has had a rather limited impact on professional treatment systems (Coldwell and Heather, 2006). Recently, in many European

countries (Klingemann and Rosenberg, 2009; Klingemann, 2016; Davis *et al.*, 2017) and in the USA (Coldwell, 2005; Davis and Rosenberg, 2013), professionals working with clients with severe problems and clients in inpatient care tend to have abstinence as a treatment goal . However, CD is a widely accepted treatment goal in Australia, Britain and Norway (Luquines *et al.*, 2011). The Swedish treatment system has been dominated by total abstinence as the goal, although treatment with CD as a goal exists (e.g., Agerberg, 2014; Berglund *et al.*, 2019).

Some see CD as a step along the way, as harm reduction. It has been argued that CD is more difficult to achieve and maintain, at least initially, than abstinence (Booth, 2006; Coldwell and Heather, 2006; Mann, *et al.*, 2017). Also, treatment outcomes seem to be more successful if patients and caregivers have the same treatment goal (Berglund, *et al.*, 2016). CD is more often associated with clients with a supportive network, psychosocial stability and low problem severity (Dawson, *et al.*, 2005; Rosenberg and Melville, 2005; White and Kurtz, 2005). However, drawing general conclusions concerning the ability of different clients to return to CD is difficult, as views on CD differ between countries and the outcome depends on client group and treatment setting (Luquiens *et al.*, 2011). Moreover, there is research that indicates that CD as a treatment goal is possible also among hazardous drinkers (Koerkel, 2006).

A common objection to CD is that most people fail to return to "normal" drinking, and highlighting those able to drink in a controlled way might attract people into relapse, with severe medical and social consequences. On the other hand, previous research has reported that a major reason for not seeking treatment among alcohol-dependent people is the perceived requirement of abstinence (Keyes *et al.*, 2010; Wallhed Finn *et al.*, 2014, 2018). Moreover, strictly abstinence-oriented organizations such as Alcoholics Anonymous (AA), implying abstinence as the treatment aim, and describing individuals with drinking problems as suffering from a disease might lead to the (unintended) stigmatization of people with substance use disorder (SUD) (van Amsterdam and van den Brink, 2013). In turn, stigma and shame have been reported as a reason for not seeking treatment (Probst *et al.*, 2015). Although research indicates that CD may be a possible option for sustained recovery, at least for certain groups and at least later in the recovery process, it seems as if the dominating approach of treatment systems is still abstinence. The 12-step approach is widely adopted by alcohol treatment facilities (Galanter, 2016) endorsing total abstinence as the treatment goal. A high level of attendance participation at AA meetings is encouraged in the approach. In the present article, clients treated in 12-step programmes were reinterviewed five years after treatment. All the interviewed clients reported a successful treatment outcome, i.e. total abstinence six months after treatment. The aim is to investigate how these clients view abstinence and the role of AA[1] in their recovery process during the past five years. There are heterogeneous views on the possibilities of CD after recovery from substance use disorder both in research and in treatment systems. This study on client views on abstinence versus CD after treatment advocating total abstinence can contribute with perspectives on this ongoing discussion.

Methods

In three Swedish projects, on recovery from SUD, 56 clients treated in 12-step programmes were interviewed approximately six months after treatment (Skogens and von Greiff, 2014, 2016; von Greiff and Skogens, 2014, 2017; Skogens *et al.*, 2017). Clients were recruited via treatment units (outpatient and inpatient) in seven Swedish city areas. Inclusion criteria were drawn up to recruit interviewees able to reflect on their process of change. Therefore, the client should be at the end of or have recently completed post-treatment intervention and be judged by a professional to be in a positive change process regarding their SUD. In the initial interviews, all the clients declared themselves abstinent and stressed that substance use in any form was not an option.

After the interviews, the clients were asked whether they would allow renewed contact after five years, and they all gave their permission. Of these, 40 were reinterviewed (71 per cent), usually over the telephone (34/40). The majority of those not interviewed were impossible to reach via the contact information available (the five-year-old telephone number did not work, and no number was found in internet searches). Three individuals declined to participate, and one was deceased.

Interview themes

Questions on main drug and other problematic drug use were followed by the interviewer giving a brief summary of how the interview person (IP) had described their change process five years earlier. With this as a starting point, the IP was asked to describe the past five years in terms of potential so-called relapse and retention and/or resumption of positive change. The interview guide also dealt with questions on treatment contacts during the follow-up period (frequency, extent and type), the view of their own and others' alcohol consumption and important factors to continue or resume positive change.

Analysis

After transcribing the interviews, the material was analysed thematically (Braun and Clarke, 2006) by coding the interview passages according to what was brought up both manually and by using NVivo (a software package for qualitative data analysis). After relistening to the interviews and scrutinizing transcripts, the material was categorized and summarized by picking relevant parts from each transcript. By iteratively analysing and compiling these in an increasingly condensed form, themes were created at an aggregated level, following a process of going back and forth between transcripts and the emerging themes as described by Braun and Clarke (op. cit.). In the present article, descriptions of abstinence and CD and views on and use of the AA and the 12-step programme were analysed. Quotes are followed by numbers referring to a specific interviewee.

The study was scrutinized and approved by the Ethical Review Board in Stockholm, Sweden (2018/1770-32; 2018/1973-32).

Results

The IPs were between the ages 27 and 75 years (mean = 47) at follow-up. Almost two thirds were women[2]. Alcohol was the dominating abuse form, with a little more than half of the IPs also reporting other drug abuse[3]. Slightly more than half had previous experience of treatment for SUD. At follow-up, 10 out of 40 reported CD, and the rest had stayed abstinent[4]. The gender distribution in the CD and the abstainer group were relatively equal (70 per cent versus 63 per cent). Six abstainers reported single relapses during the follow-up.

Abstainers

Many IPs described the importance of maintaining total abstinence, and some continued attending AA or Narcotics Anonymous (NA) meetings. A few described a deeper involvement with the AA movement:

> [. . .] it's part of my identity that I display addictive traits, I socialize with people with addictive personalities, I talk about addiction with people who are not addicted.//There are people who have relapses after 10-25 years as abstainers, the common denominator is almost always that they have stopped working actively to maintain their abstinence [in the steps, author's note] (IP6).

For IP6, involvement in AA had developed into a lifestyle, with a commitment to the AA philosophy. This IP had not had any relapses during the follow-up period but was

convinced of the importance of being reminded. For some IPs, the meetings served an opportunity to completely be themselves:

> I'm a bit secretive; being a bit of an outsider. You can feel excluded as someone who is abstinent and drug free. And not only because you don't drink and do drugs, but because you aren't honest with people. At AA meetings I can be myself, I can be honest, say just how things are, talk to others just like me. (IP12)

The majority of those sticking to going to AA meetings also regarded their SUD as more of a disease. However, a few also expressed ambivalence towards the AA philosophy. They questioned the strict descriptions given in the AA community on how addiction works and stressed that they did not fit into those descriptions. On the other hand, they found AA meetings supportive. They had a cherry-picking attitude: not buying the whole concept but finding parts of it useful:

> [...] have continued going to AA//there's something very rigid about AA, the steps and all that// it's tough – you don't "have" a relapse, you "take" one, as if you've planned it for a long time. Gestalt therapy has made me take a softer approach, we are humans looking for help.//AA clashes with what has helped me the most: self-compassion and mindfulness, and getting psychiatric help. (IP19)

> Interviewer: You've had a long break? Several times. Then I long to drink my cup of coffee and listen to people. But sometimes you get so sick of it.//Of course it's a sect, but I go there to stay sober, there are AA Talibans but I steer clear of them. (IP34)

Another strategy for the same sort of ambivalence, i.e. when the view of the IP concerning former problems did not agree with the views of the community, was to cut down on meetings:

> I go to meetings sometimes. It's like [...] there's a lot of consensus there. I've started studying and I've changed in many ways.//The 12-step programme – this agrees with me but there's more. There's scientifically-based knowledge that helps me more. (IP18)

Some of the abstainers reported experience of professional contacts, such as therapists or psychologists. These contacts had often complemented the support from AA but in some cases also complicated it as the IPs found that their previous SUD was related to other things that were not in line with the approach to addiction as a disease (e.g. IP19).

None of the IPs that had stopped attending AA meetings expressed ambivalence or criticism towards AA. Most of the IPs that had stopped going to meetings still viewed their problems with alcohol as a disease but had found other ways of getting support. However, if needed, AA was possibly an option:

> [...] it may turn out that maybe I should go to a meeting and if so, I can just walk right in. But for now, I feel stable. (IP16)

A few said that they simply did not have problems with alcohol anymore and thus had no need for meetings:

> I don't have this problem, I don't socialize with these people, they're in the past for me. (IP2)

Controlled drinkers

Ten IPs described using alcohol. Generally, limited amounts and frequency were described. Most IPs described a process during the follow-up period where they went from completely refraining from drinking to daring and being willing to try drinking. When it worked well, with no increased craving, they continued drinking in a controlled manner:

> I am not a teetotaller anymore but drink on a few occasions and it was a process. (IP21)

Several said that starting drinking was preceded by concerns about whether an uncontrolled craving would occur.

> I'd really made a big thing out of it but in the end it wasn't that big a deal// [. . .] I decided I would try//I was prepared that having a glass would be like tugging a wild horse inside me, but it wasn't that dramatic at all. (IP7)

A few IPs were younger, with a background of diffuse and complex problems characterized by, for example, destructive family relationships and experimenting with drugs. Thus, with an increased stability in their lives, they could not see that there was anything that could prevent them from drinking alcohol in an orderly manner:

> At the beginning, I was very careful because you don't know if it'll start something off. But for me, alcohol doesn't have that effect so I can have a glass of wine now and then. (IP29)

These people also reflected on possible risks with alcohol consumption. Quantity and frequency were described as low compared to peers, therefore, it can be assumed that the concern they expressed signalled that they were referring to the risks that AA/the 12-step programme claim are unavoidable for an addict:

> I really enjoy drinking wine. I don't think I have a problem, but I might be someone that could get it [problems] more than anyone else [. . .] (IP30).

A central theme in the descriptions of the process of drinking in a controlled way was the reason for drinking. IPs associated drinking because of a feeling of anxiety with problem drinking, whereas drinking with friends was perceived as something positive and not leading to overconsumption:

> I haven't had two glasses of wine because I've been feeling anxious but because I've been out with friends, because it's fun and then it hasn't had the same effect, but I'm very careful if it should prove to be impossible. (IP9)

> Before, I drank to stun myself; I could just as well die. Now, I have so much to treasure in my life that I want access to everything good, including going out for a drink and celebrating with a glass of champagne sometimes.//It's not as clear as black and white as I was told from the 12 steps. (IP7)

At the follow-up, some of the CDs had totally or partially changed their opinion regarding the AA philosophy. Among those who still had a positive view, some described a process where what was initially helpful was no longer relevant. Therefore, they had left the 12-step movement:

> I have NA to thank for a lot of things, it was very important to create this ability to believe in myself.//In the community we always said "we're addicted" but I started to feel that I couldn't say that I was addicted anymore, I used to be addicted but today I'm not. (IP21)

Some were critical towards the 12-step movement as being "too hard", like a sect with a rigid framework for what was allowed, where your whole life revolved around step work and meetings and with the threat of what would happen if you "didn't do as you should" hanging over them. For them, taking a step back and questioning meetings was about understanding the need for leaving their "old" lives and identities:

> These meetings, they're like a sect. They say that if you don't come to the meetings you'll die. My whole life revolved around attending meetings, it made you anxious, it was a compulsion. You have to go to meetings and help others, otherwise you won't be able to stay away from drinking. It becomes very limiting and disabling. I felt that I had to cope without going to those damn meetings. (IP24)

A recurring theme among the critical voices was a lack of and desire for feedback, often expressed as a need for professional support:

> I prefer institutional care under the guidance of a therapist. I feel safe; I know more or less what I'll get when I go there. Attending meetings is the opposite because it's former addicts who rule. That makes me feel unsafe. (IP35)

> They didn't take into account the effects of how you felt when you became drug free and remained abstinent. Often you have other problems as well.//There was really no support.//That's why I've turned to professional psychotherapists and specialists in psychiatry. (IP24)

One IP described her experience of AA and the 12-step programme as directly harmful. She was asked by her sponsor to talk about a childhood trauma without getting professional help to process what was brought up, which led to her nearly losing her footing in life:

> With the sponsor you were supposed to dig as deep within yourself as you could remember. I experienced a terrible trauma when I was 12. This trauma had to be brought up to the surface, to say why and how and who had done it. But they have no idea how to treat people who have really heavy baggage.//It has taken me years to recover. Now I can put this behind me, but it took time. I needed some other kind of help, maybe a CBT therapist or a psychiatrist to talk to. (IP11)

Discussion

In the present follow-up, the recovery process for clients previously treated for SUD was investigated, focusing on abstinence and CD. All the interviewees had attended treatment programmes following the 12-step philosophy and described abstinence as crucial for their recovery process in the initial interview, five years ago. In previous research, several indicators of whether CD is possible are mentioned (Klingemann and Rosenberg, 2009; Klingemann, 2016; Davis *et al.*, 2017; Luquiens *et al.*, 2011; Berglund *et al.*, 2019). Clients reporting CD in the present study only met one of these criteria – an initial period of abstinence (Booth, 2006; Coldwell and Heather, 2006). However, the results show that the view on abstinence and CD can change during the recovery process.

After five years, the majority remained abstinent and described SUD in line with the views in the 12-step programme. Many still attended AA meetings. For some, attending was just a routine, whereas others stressed that meetings were crucial to them for remaining abstinent and maintaining their recovery process.

Some no longer attended meetings but remained abstinent with a positive view of the 12-step programme. Those clients described meetings as helpful at the beginning of their recovery process. However, they no longer found themselves in need of this help and did not express ambivalence regarding their decision to stop attending meetings. As none of these clients stressed criticism or objections towards AA as a reason for not attending meetings anymore, this might support the suggestion by Laudet *et al.* (2002) that over time, meeting attendance is less important for the recovery process among those that have embraced the programme and live according to the 12-step principles. On the other hand, some clients in the present study had adopted the 12-step principles, intensified their attendance and made it more or less central in their life.

A considerable number of clients reported changed views on the programme, some were still abstinent and some were drinking in a controlled way. The CDs had the strength to leave the community, indicating agency and autonomy. Some of the abstainers still attended meetings because of a fear of what might happen if they stopped, although they questioned parts of the philosophy. For these clients, the recovery process, aiming to reach sustained recovery in the broader sense covering parts of their lives other than the SUD, was in part at odds with the ongoing participation in AA. These results indicate that strict views on abstinence and the nature of alcohol problems in 12-step-based treatment, and AA philosophy may create problems for the recovery process. Previous studies suggests that these strict views might prevent people from seeking treatment (Keyes *et al.*, 2010; Wallhed Finn *et al.*, 2014). The present study indicates that the strict views in AA also might

prevent clients in AA to seek help and support elsewhere, since they percieve that this conflicts with the AA philosophy (Klingemann and Klingemann, 2017). AA is a self-help movement that does not claim to stand on solid scientific ground. Initially, AA was not intended to offer a professional programme model for treatment (Alcoholics Anonymous, 2011). When the premise of AA was transformed into the 12-step treatment programme, it was performed in a professional setting. Many clients in the study described that the 12-step programme was the only treatment that they were offered. The context of treatment in a professional setting, and in many cases, the only treatment offered, gives the 12-step philosophy a sense of legitimacy.

Clients seeking help for their SUD are often in a vulnerable state. When they are offered 12-step treatment, they get exposed to these strict views in a different setting than what was initially intended within AA, namely a self-help group that people join voluntarily. Williams and Mee-Lee (2019) have discussed this shift in the 12-step programme and argue that current 12-step-based treatment settings promote practices that run contrary to the spirit of AA. For example, they point out that the original AA teaching endorses abstinence only for people with severe addiction disorders, which in the 12-step approach has been changed to abstinence for all members. Williams and Mee-Lee (op. cit.) also claim that AA originally taught that it was not the responsibility of group members or counsellors to give medical advice to others while there is a widespread opposition to using medically assisted treatment in the 12-step approach. Further, that the original focus on support has been replaced by a focus on denial and resistance as personality flaws. This pinpoints the conflicting issues experienced by some clients during the recovery process. If the 12-step philosophy and AA were one option among others, the clients could make an informed choice and seek options based on their own situation and needs. This would probably reduce the risk of negative effects while still offering the positive support experienced by the majority of the clients in the study.

Some clients expressed a need for other or complementary support from professionals, whereas others highlighted the importance of leaving the 12-step community to be able to work on other parts of their lives. The descriptions on how the tools from treatment were initially used to deal with SUD and were later used to deal with other problems in the lives of IPs can be put in relation to the differentiation between abstinence and sobriety suggested by Helm (2019). While abstinence refers to behaviour, sobriety goes deeper and concerns the roots of the problem (addiction) and thereby refers to mental and emotional aspects. Differentiating these concepts opens up for recovery without necessarily having strong ties with the recovery community and having a life that is not (only) focused on recovery but on life itself. Also, defining sobriety as a further/deeper step in the recovery process offers a potential for 12-step participants to focus on new goals and getting involved in new groups, not primarily bound by recovery goals. Further, describing recovery as a process also implies paying attention to contributing factors outside the treatment context, such as the importance of work, family and friends.

In the results, we mention that there were a few IPs that were younger, with a background of diffuse and complex problems characterized by a multi-problem situation. Research on young adults, including people in their thirties (Magaraggia and Benasso, 2019), stresses that young adults leaving care tend to have complex problems and struggle with problems such as poor health, poor school performance and crime (Courtney and Dworsky, 2006; Berlin *et al.*, 2011; Vinnerljung and Sallnäs, 2008). Thus, this is interesting to analyse further although the younger IPs in this article, with experience of 12-step treatment, are too few to allow for a separate analysis. However, they will be included in a further analysis on young adults based on the same premises as in present article but with experience from other treatments than the 12-step treatment.

Conclusions

The results suggest that the 12-step philosophy, with abstinence as the only possible choice, might mean that people in the AA community who are ambivalent and/or critical regarding parts of the philosophy must "hide" their perceptions on their own process. Experiences of the 12-step programmes and AA meetings were useful for a majority of the clients. Thus, it was not the sobriety goal in itself that created problems, but the strict belief presenting this goal as "the only way". The results suggest the importance of offering interventions with various treatment goals and that clients choosing CD as part of their sustained recovery would benefit from support in this process, both from peers and from professionals.

Limitations

At the first interview all IPs were abstinent and had a positive view on the 12-step treatment, although a few described a cherry-picking attitude. This might limit the generalizability of the results. As the IP had a successful outcome, six months after treatment, their possibilities for CD might be better than for persons with SUD in general. On the other hand, as the group expressed positive views on this specific treatment, they might question the sobriety goal in a lesser extent than other groups.

The IPs have mixed backgrounds regarding the kind of SUD they originally experienced. All IPs had been in treatment for SUD, a majority more than once. This implies that their SUD had a certain severity. However, the extent of their problems according to ICD-10 (International Statistical Classification of Diseases and Related Health Problems, 10th edition) or DSM 5 (Diagnostic and Statistical Manual of mental disorders, 5th edition) was not measured. Thus, there might be individuals in the sample who do not consider SUD as their main problem.

Almost two thirds of the interviewed IPs were women. Thus, the results may be more relevant for women with similar experiences as the investigated sample.

Notes

1. Some interview person (IP) were former polydrug users and altered between AA and NA meetings.
2. The reason for the female domination of IPs is the focus on women in the second segment of the initial projects.
3. Heroin, benzodiazepine, cannabis, amphetamine, cocaine and opiates.
4. Among those not interviewed (*n* = 16), eight were women and eight men. Their main problem at the first interview were polydrug (4 IP), alcohol (7 IP), drugs (4 IP). The age distribution was from 29 to 68 years (*m* = 44).

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