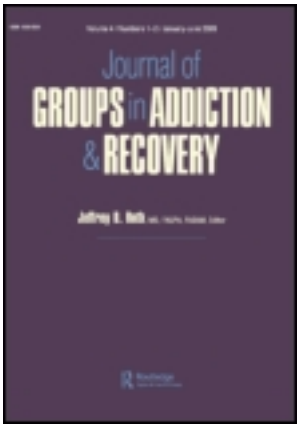

Journal of Groups in Addiction & Recovery
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wgar20

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Published online: 28 Feb 2014.

To cite this article: Melissa Brideau & Rick Csiernik (2014) How Open is the Meeting? Attending AA in a Wheelchair, Journal of Groups in Addiction & Recovery, 9:1, 4-13, DOI: 10.1080/1556035X.2014.868723

To link to this article: http://dx.doi.org/10.1080/1556035X.2014.868723

Journal of Groups in Addiction & Recovery, 9:4–13, 2014

ISSN: 1556-035X print / 1556-0368 online
DOI: 10.1080/1556035X.2014.868723

Routledge
Taylor & Francis Group

How Open is the Meeting? Attending AA in a Wheelchair

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Nearly 2 million Canadians have a recognized disability, and of these, 200,000 have identified mobility issues. The rate of substance dependency among Canadians with ability issues is greater than the national average, but because of attitudinal, programming, and environmental barriers, this population accesses professional services at a lesser rate. The use of self-help resources by this group is unknown. A case study highlights the barriers faced by one individual in her attempt to attend her first Alcoholics Anonymous meeting as a component of her social work education. The potential and importance for group work are discussed in the context of reaching out to this underserviced population to better engage them in their recovery process.

KEYWORDS accessibility, disability, mobility, self-help groups, case study, addiction, Canada

INTRODUCTION

Nearly 2 million Canadians self-identify as having some form of ability issue (Statistics Canada, 2006). However, despite the notable progress that has been made in both the disability and addiction fields, significant gaps in the treatment continuum remain in instances where the two intersect. Individuals with ability issues continue to face a multitude of attitudinal (Koch & Nelipovich, & Sneed, 2002; Robertson, Davis, Sneed, Koch, & Boston, 2009), programming (Guthmann & Graham, 2004; Koch et al., 2002), and environmental barriers (Voss, Cesar, Tymus, & Fiedler, 2002; Substance Abuse and Mental Health Services Administration, 1998; West, Graham & Cifu, 2009a,

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2009b; West, Luck, & Capps, 2007) when attempting to access appropriate substance abuse treatment. To reduce such barriers, professionals and peer helpers in both the disability and addiction fields need to place a priority on examining practices at the individual, agency, and policy levels of service to identify both existing and potential barriers that may inhibit the ability of those with ability issues to access care that is both supportive and holistic in nature. The mutual aid movement was responsible for the most significant paradigm shift in the addiction field (Csiernik, 2010) and has been identified as one of the significant social movements of the 20th century (Room, 1993). A question arising, then, is if the treatment system continues to lag in meeting the recovery needs of individuals with these intersecting issues, is the mutual aid movement in a position to lead here?

MOBILITY ISSUES AMONG CANADIANS

In Canada, there are more than 200,000 persons self-reported as living with mobility impairments (Statistics Canada, 2006)—a term used when discussing individuals who have difficulty using their extremities or those individuals who demonstrate a lack of strength to walk, grasp, or lift objects. As a result, the use of devices such as a wheelchair, crutches, cane, or walker may be required to assist with mobility. Due to increased awareness and recent legislative changes, attempts have been made to reduce many of the barriers commonly experienced by this population on a daily basis. The limited studies in this field indicate low rates of treatment participation among individuals with ability issues. A study conducted by West, Graham, and Cifu (2009c) revealed that within the province of Ontario, addiction treatment providers had served only 235 individuals with various disabilities during a 1-year period. Further, the study also highlighted the fact that out of the 235 individuals with ability issues who participated in treatment, only 6 (2.6%) reported a mobility impairment. The low rate of formal treatment participation among this population has been identified as primarily being due to the fact that many treatment centers are inaccessible to those with mobility impairments despite claims of accessibility. For example, Pritzlaff Voss et al. (2002) assessed the perceived versus actual physical accessibility of substance abuse treatment centers. In a telephone interview, 30 of 32 facilities surveyed reported that they were wheelchair accessible; however, an on-site follow-up visit to 15 of the facilities revealed significant differences between what was perceived by the managers to be accessible and those facilities that actually followed legislative guidelines designed to reduce barriers for those with mobility impairments. During the visits, several components of each treatment facility, including the exterior and interior of the building as well as policies and procedures, were examined to determine the actual accessibility of these programs for those with mobility impairments. Inspection

by qualified experts familiar with accessibility standards revealed that only 9 of the 15 sites surveyed had an entrance door that met the width guidelines to accommodate individuals in wheelchairs, and only 2 had washroom facilities that met the appropriate guidelines. In terms of overall accessibility, while 93% of staff indicated in a phone survey that their facility was physically accessible for those with mobility impairments, completion of on-site surveys showed that only 13% of the facilities actually met all accessibility requirements.

Although it has been documented that those with mobility impairments experience lower rates of treatment participation than others in the general population, less is known about these individuals and their involvement in self-help groups as due to the anonymity of such programs, it is not only impossible to identify the number of people with mobility impairments who attend meetings in person, but it is also impossible to know how many have been unable to access this vital source of support as a result of barriers that inhibit effective treatment participation. There is also no information found in the literature examining how accessible locations for self-help group meetings were for those with mobility concerns, or if accessibility was a consideration when determining the location for a group to meet.

THE CONTEXT: ATTENDING AN AA MEETING AS AN EDUCATIONAL REQUIREMENT

Education in the field of addiction attracts two dichotomous groups: those with a recovery history and those without. Historic issues in the underprofessionalization of the field have led to the development of competencies to bring a baseline level of knowledge and practice to those who wish to work in this field (Graves, Csiernik, Foy, & Cesar, 2009). Those entering the addiction field without a recovery history have typically never attended a self-help meeting, and thus, in professional schools, primarily social work, attending an open meeting has become not just a critically important activity in creating competency, but an assigned and graded activity. Fuller (2002) wrote of his experience in attending a meeting as part of his bachelor's of social work program. He highlighted his trepidation about getting to the meeting, about his concern that those in attendance would think he was them—an alcoholic, of which he writes, "of course I was not"—and then about the transformation he experienced watching participants interact, share, and trust.

In Social Work 4430: Introduction to Addiction, taught at King's University College at Western University in London, Ontario, Canada, students have been required to attend at least one open mutual aid meeting of their choice for the 15 years the course has been a component of the curriculum. Students have until the midpoint of the course to attend a meeting at which time one 3-hr class is entirely devoted to discussing their experiences during the open

meeting. The vast majority of students elect to attend an Alcoholics Anonymous (AA) meeting, though over the years, some have attended Narcotics Anonymous, Adult Children of Alcoholics, and on one occasion a Sex Addicts Anonymous meeting. As with Fuller's (2002) published discussion, their experiences typically run the gamut of uncertainty and even fear prior to attending the meeting and developing an understanding of what it means to label oneself an alcoholic. In addition, by attending such meetings, students are given the opportunity to witness the unconditional support that arises within a group framed in a highly structured format. However, all experiences are not positive; over the years, a minority of students has not felt welcomed for a variety of reasons. Some have had their presence at an open meeting questioned; two female students during the course of the 15 years have been approached after a meeting by male members wishing to provide them with greater details of what AA is about; and two other students had a police escort into a meeting when they were observed driving around lost in a neighborhood watch community by an on-duty police officer. However, in 2011, the first person to have a mobility issue necessitating the use of a wheelchair enrolled in Social Work 4430, and her experience was unique from the more than 300 students who had completed this assignment before her.

ATTENDING AA IN A WHEELCHAIR: A FIRST-PERSON NARRATIVE

As I opened my eyes on the bright and sunny Tuesday morning, suddenly it hit me. Today was the day I was going to attend my very first AA meeting. Along with this realization, I began to feel slightly anxious and fearful of what to expect from this new experience. Thoughts such as "I wonder how many people will be there," "will they know I'm the new one?" and "what am I going to say if I'm asked to speak?" were replaying over and over in my head. On top of worrying about events that were going to occur during the meeting, I also had an additional set of concerns that were related to my ability to physically get to the meeting: I have been driving a motorized wheelchair now for 21 years, so I am more than well aware of the fact that just because a building is said to have wheelchair access, it does not necessarily mean that this is the case. However, to rid myself of this extra stress, I chose to go to the meeting that was being held at the main campus of the university I attend as that was a building with which I was very familiar and I believed that I would have no problem navigating my way around.

Upon arriving at the center, I went to use the elevator as the meeting was going to be taking place on the third floor, but once I was inside the elevator of the university building, it froze and would not move. I was able to maneuver myself out and access another elevator to reach the third floor only to discover that the room where the meeting was supposed to be located was actually an equipment storage area. At this point, if I had gone alone, like

so many people do to their first AA meeting, I probably would have already left, but because I had gone with somebody else, while still awkward, it made it easier to ask for directions from a person in an office on the same floor. My support and I were directed to where the anonymous meeting was actually to be held, although not as anonymous as I had thought and hoped after all. To access the meeting, we still had to travel down a very narrow corridor that seemed even smaller given the size of my wheelchair. Once we found the room, an overall feeling of relief washed over me as I made it to the right location and realized that all I had to now was just concentrate on the meeting. However, when we tried to enter the meeting room from the corridor, we discovered that the door was locked and we had to wait in the corridor until the chair of the meeting arrived and let us inside. The waiting period was very uncomfortable because not only did I feel out of place, but given the size of my wheelchair, I was certainly not inconspicuous or in any way anonymous as people had to squeeze past me to get farther down the corridor to other rooms. When I finally was given access to the room, I was forced to sit right in front of the door as there was a table that spanned the entire length of the room and made it impossible for me to maneuver anywhere else.

However, once everyone was seated inside the room, the attitudes of the older members were very welcoming and friendly. Each individual took the time to say hello and introduce themselves. Before I fully realized what was occurring, the meeting was under way. To begin, three pieces of paper were passed around and people took turns reciting aloud what was on the sheets. The first was the 12 Steps, the second was the Serenity Prayer, and finally, there were the traditions, which I was asked to read. This was a very strange moment for me as I was under the impression that my participation in the meeting was completely voluntary and that I would not be asked to speak, but only invited. In addition, when reading the traditions, I encountered another barrier as I realized that the print was too small and close together for me to read. However, the person who had accompanied me noticed my difficulties and assisted me by helping me to keep track of my place on the page. It was at this particular moment in time that I felt very embarrassed and uncomfortable, which does not occur very often as I am quite used to dealing with a number of challenges on a daily basis. Nonetheless, it was an experience that left me feeling very uneasy—like an outsider, like the other.

Next, the chair of the meeting explained the purpose of the chips and everyone was invited to take one if they wished. After what seemed liked the most formal part of the meeting, the chair then welcomed the discussion of three topics, which included rigorous honesty, enablers, and stress. As each member began to discuss these topics in relation to their drinking, the mood in the room completely changed. It was a true transformation as these men went from very business-like, matter-of-fact attitudes to attitudes of a

much softer nature, which helped to foster an environment that provided an opportunity for each member to experience nonjudgmental support and understanding—something that they do not receive outside of the group on a regular basis. In addition, although I was aware that I was the only member of the group with an ability issue that did not entail the use of alcohol, what struck me at this moment was the fact that other than my colleague, I was the only woman in the room as well.

Once everyone in the group was given the opportunity to speak, we all gathered in a circle joining hands and said the Lord's Prayer. I felt very awkward holding the hand of someone I had just met, and I was not even able to reach properly to finish off the circle as the table created a barrier for me. This was very unfortunate because one of the goals of a mutual aid group is to develop an atmosphere of inclusiveness where one does not have to worry about barriers such as this. This barrier, which was significant to me, remained invisible to other members of the group who had used this space for years to meet together for mutual aid, personal growth, and social support. I had encountered so many challenges in this 1 hr that upon reflecting on my experience at this meeting, I became very saddened and then angered. This was not because of what I had personally gone through, but rather because I kept thinking of all the others who have decided to take the courageous step of going to their first meeting who are met with so many unexpected barriers that they decided the process was not worth all of this extra stress. I imagined how much more vulnerable other newcomers with an ability issue, visible or hidden, would feel, especially if they, like me, felt like an outsider and because of this, ended up not coming back or, worse, never making it to the other elevator, to the correct room, past the staring eyes, and past the too large table to experience the wonder that a mutual aid self-help meeting can be. It was very disheartening for me to think of how many individuals there may be in my city, my province, my country, and globally who may never get the opportunity to reach out for assistance that could be potentially valuable, simply as a result of barriers such as the ones described. It is only when others in the community, such as students, families, professionals, and colleagues, begin to communicate and collaborate that each of us can unite together and work toward a substance abuse treatment strategy that is effective in providing assistance that is both holistic and supportive in nature regardless of an individual's abilities or disabilities.

DISCUSSION

Although the evolution of AA was not by happenstance, the theoretical foundations pertaining to group work of which we are now aware certainly were not consciously drawn upon in creating this social movement. The

underpinnings upon which group work in addiction functions, both peer and professional, entail providing a space that includes opportunities to experience, share, and strengthen one's social support, knowledge through information sharing and education, identity formation, affiliation within a community, and finally, personal growth and transformation (Csiernik, 2011). In terms of social support, it has become increasingly apparent that this occurs almost immediately after an individual has arrived at their first group or self-help meeting. People are typically very welcoming and are genuinely pleased when a new member attends, which is conveyed through their willingness to introduce themselves and make the new member feel as comfortable as possible. In addition, for many people, groups such as AA offer a type of social support that may not be available in other aspects of their lives, particularly if they have had a lifetime of oppression due to a disability. Johnson and Jerringer (1993) reported that participation in aftercare groups, either professionally or peer-led, contributed to maintaining abstinence rates for those who had previously completed a residential treatment program. The authors claimed that the use of self-help groups was even more significant in sustaining abstinence than was family support. However, for this to occur, a person must be present, which upon reflection on the case described in the previous section, may be an extremely difficult task for those with mobility impairments given the many barriers that continue to inhibit the effective treatment participation of those with ability issues.

Addiction treatment and mutual aid groups can provide substantive education and information sharing if consideration of the needs of the other occurs. For many people struggling with issues of ability and the process of addiction, it is easy to feel alone and isolated with respect to one's own experience. However, psychoeducational and self-help groups can both provide a forum where individuals are invited to share experiences in dealing with addiction and where their individual experience is valued. As a result of this mutual sharing of experience, individuals may have an opportunity to normalize others' thoughts, feelings, and behaviors surrounding addiction, their disability, and themselves. This process can be extremely beneficial as this information sharing and education allow an individual to realize that they are not alone in dealing with their particular intersecting challenges, which is one reason why groups have a worldwide appeal (Ronel, 1997). Education and information sharing within groups are central aspects in aiding individuals to address their addiction. However, here too, extra time and consideration need to be taken to ensure that the specific needs of those with ability issues are recognized and incorporated into the group session. This can not only aid in enhancing other group members' understanding of these two issues and how they intersect, but it also may be the only opportunity where an individual who is contending with a mobility impairment feels comfortable enough to share their experiences and concerns without fear of judgment.

Addiction treatment and mutual aid groups also assist individuals with the task of identity formation, which is a substantive issue for many struggling with issues of ability. This is because the substance abuse issue and the disability often come to constitute the entirety of one's identity. Unfortunately, one of the major errors when working with individuals who have a mobility impairment and a coexisting substance use issue occurs when only one facet of the individual's identity (the intersection of addiction and ability) is observed, while other important aspects of the person's life are ignored. Using labels such as "cripple" has the potential to create an atmosphere where assumptions, stereotypes, and ideas of what someone should or should not be are given free reign and the uniqueness and diversity that exists within the human experience is stifled. These are issues that must be addressed within the group process in creating a new identity not centered on limits, but rather upon possibilities and abilities. Thus, it is important to ensure that the group environment is not only physically accessible for all participants, but also emotionally accessible to allow for open, honest communication among all members of the group. While identity formation is a critical component of professional addiction treatment and mutual aid groups, it is also equally important to assist individuals in their goals of personal growth and transformation as well as to create an increased sense of community and affiliation. When members participate in a group setting, they are given the opportunity to invest their time and energy into contributing to and participating in communal supportive activities rather than drug-using behaviors. Everyone should have a valued voice, and each member brings a unique perspective that enhances the life of the group. This sharing of perspectives sets the stage for each member's sense of community and affiliation to emerge. It is through this sense of community and affiliation that personal growth and transformation can occur. Addiction groups should be designed for the specific purpose of gaining strength and hope by learning from the experiences of others, and their construction must be considered for inclusion of the other (Csiernik, 2011). Thus, time must be allocated to allow for all of those with various ability issues to have the opportunity to actively participate.

In addition, the fact that self-help groups are self-supporting sends a message about the value of independence to its members by saying no one supports us, but we can support each other. This is very empowering for many individuals who have lived their entire lives with issues of ability as this allows for the development of an alternative narrative on how their presence and participation can influence others in the group, which in turn fosters personal growth and one's sense of community (Csiernik, 2011). Therefore, although it is crucial that a member experience personal growth as well as a sense of affiliation and community, they must also utilize the skills and abilities that have been learned within the confines of the group

to further contribute to their own development, health, and well-being so that they can eventually learn to live independently.

There are inherent issues in using a case study as a sole source of knowledge. Being only one anecdotal example, there is limited generalizability. Thus, to enhance the generalizability of this case study, it needs to be tested again in not only the same setting, but also in a number of different environments. This is also required to further open the doors to both self-help and professional treatment in the addiction field. By participating in group meetings and critically reflecting upon the basic theories and principles that are the foundation of such groups, individuals with intersecting issues of ability and addiction can become better equipped to not only deal with their addiction issues, but to respond to seeing themselves as the other. Thus, it becomes imperative for all those involved in the addiction community, be it in a professional or mutual aid capacity, to become aware of the other and to work to ensure their group environment is not only accessible, but also inviting so that the other is not turned away before they can even begin their recovery journey.

AA led a paradigm shift that welcomed alcohol-dependent individuals to a new experience, a new way to see themselves. The question every member of a self-help group needs to ask him or herself is whether their meeting is open to those who are not like them but who have a need to be in the room. If 12-steps groups can take the lead here, perhaps we professionals might again follow.

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