

# Singleness of Purpose

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“Singleness of purpose” is essential to the effective treatment of alcoholism. The reason for such exaggerated focus is to overcome denial. The denial associated with alcoholism is cunning, baffling, and powerful and affects the patient, helper, and the community. Unless alcoholism is kept relentlessly in the foreground, other issues will usurp everybody’s attention. Mental health workers, however, have great difficulty with A.A.’s Fifth Tradition: “Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.” Since mental health workers often admire the success and geographic availability of Alcoholics Anonymous, they understandably wish to broaden its membership to include other substance abusers. They also note that pure alcohol abuse is becoming less frequent, and poly drug abuse more common. In addition, mental health workers sometimes view singleness of purpose as outmoded and exclusionary.

They worry that the Tradition is a holdover from the early days of A.A. and that the young, the poor and the minority with a criminal record will be barred. Besides, when there is no professional drug treatment center or Narcotics Anonymous (NA) group easily available, mental health workers find it hard to understand why A.A., with its tradition of Twelfth Step work, won’t step in and fill the breach. As both a mental health worker and a researcher, it seems to me that there are two arguments that trump these concerns. First, the Third Tradition of A.A., “The only requirement for A.A. membership is a desire to stop drinking,” renders A.A. non exclusionary. Each year A.A. welcomes many thousands of minorities, many thousands of poor, many thousands of alcoholics with coexistent drug problems and tens of thousands of convicts into its membership. Nobody with a desire to stop drinking is excluded. The second argument, that “Singleness of Purpose” is necessary to overcome denial, is even more compelling.

Given a choice, nobody wants to talk about alcoholism. In contrast, drug addiction commands newspaper headlines, research funding and the attention of clinical audiences. After two years of work at the Lexington, Kentucky Federal Narcotics Treatment Center, I, a mere assistant professor, was invited around the world to lecture on heroin addiction. In the late 1990s, as a full professor and after 25 years of research on alcoholism and its enormous morbidity, I was finally asked to give a medical grand rounds on alcohol in my home city. My assigned topic, “Why alcohol is good for your health.” In short, the greatest single obstacle to the proper treatment of alcoholism is denial. I first began my psychiatric career at a deeply dedicated community health center. The community had voted alcohol abuse as their biggest problem. After its first ten years of operation the center was still confining itself to addressing the community’s most pressing second, third, and fourth problems.

No resources at all were devoted to alcohol treatment. I moved to another community mental health center that had listened to its citizens and had opened an alcohol treatment center. In being asked to fill the position of co-director of the clinic I was the last staff psychiatrist hired by the mental health center. Significantly, I had had no experience with alcoholism, but no one else wanted the job. Put differently, the experimentally documented success of A.A. in the treatment of alcoholism is in part because A.A. groups are the only place in the world where the focus is on alcoholism and nothing but alcoholism. There is simply no other way to overcome the denial.