Thomasina Borkman

Thomasina Borkman, PhD, is Professor Emerita, Sociology, George Mason University, and Editor of the *International Journal of Self Help & Self Care*. Her collective writings on mutual support structures, particularly on Alcoholics Anonymous and the Social Model of alcoholism treatment, have profoundly influenced my own thinking and writing on the distinguishing features of peer-based addiction recovery support. Within her total body of writing, I think there are two classics that should be read by every person working in the arenas of addiction treatment and recovery support services. The first is an early theoretical paper on experiential knowledge. The second is an equally important paper that distinguishes recovery planning from treatment planning. Both are significant contributions. Readers may also be interested in Dr. Borkman's book, *Understanding Self-Help/Mutual Aid* (1999, Rutgers University Press).

William White

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50(3), 445-456. Posted with permission of the author.

Experiential Knowledge:
A New Concept for the Analysis of Self-Help Groups

Thomasina Borkman
George Mason University

Experiential knowledge (truth based on personal experience with a phenomenon) is introduced as a new analytical concept that characterizes self-help groups. The attributes of experiential and professional knowledge are compared. This new concept is useful in considering the theoretical and practical issues regarding the relationship between self-help groups and professionals.

The mushrooming number of self-help groups ranging over an ever-increasing variety of problems has triggered a strong reaction among some human service professionals, especially psychotherapists and social workers.[1]

These professionals are raising important theoretical and practical issues concerning the nature of self-help groups, the similarities and differences between self-help and professional therapies, and the relationship between self-help groups and professionals. They are divided over whether professionals should be involved directly in self-help groups and, if so, what consequences this involvement has for the professions and self-help groups alike.[2] And they question the antiprofessionalism of some self-help groups without explaining analytically the source of the friction.[3]

A self-help group is defined here as a human service-oriented voluntary association made up of persons who share a common problem and who band together to resolve the problem through their mutual efforts.[4] The scope of this article is limited to self-help groups focusing primarily on problems of social, emotional, psychological, and other related human needs.

Excluded are self-help efforts primarily oriented toward physical or material needs such as food cooperatives, funeral and insurance societies, or rural barn-raising efforts.

The purpose of the article is to present a new analytical distinction called "experiential knowledge," which serves as a primary source of truth in self-help groups and which competes with professional knowledge-the foundation of expertise in most other human service organizations. It will be shown that "experiential knowledge" is a critical component that distinguishes self-help groups from their professionally based equivalents and that the concept can be used as an analytical tool to examine the theoretical problems of the nature of self-help groups as well as the similarities and differences between them and professional therapies. This new concept will also help clarify the role of the professional in the self-help group.

The analytical distinction between experiential and professional knowledge is the result of my research on self-help groups which included observation of a number of organizations, interviews with members of such groups as Alcoholics Anonymous (AA), Al-Anon, Parents without Partners, and Reach for Recovery, as well as more extensive research on female consciousness-raising groups, Weight Watchers, and stutterers' self-help groups.[5] My five-year program of research on stutterers' groups began with an intensive study of one group on the east coast, followed by a comparative organizational analysis of eighteen groups in the United States, New Zealand, Holland, and Sweden.[6]

Knowledge: Experiential versus Professional

Experiential knowledge is truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others.[7] *Ruperto experto credite,* goes the Latin proverb ("Believe Rupert, who's been through it"). The two most important elements of experiential knowledge are (l) the type of "information" on which it is based and (2) one's attitude toward that information.

The type of information is wisdom and know-how gained from personal participation in a phenomenon instead of isolated, unorganized bits of facts and feelings upon which a person has not reflected.[8] This wisdom and know-how tend to be concrete, specific, and commonsensical, since they are based on the individual's actual experience, which is unique, limited, and more or less representative of the experience of others who have the same problem.[9]

The second critical element of the definition is the certitude that what one experiences becomes indeed knowledge.[10] Thus the term "experiential knowledge" denotes a high degree of conviction that the insights learned from direct participation in a situation are truth, because the individual has faith in the validity and authority of the knowledge obtained by being a part of a phenomenon. Self-help groups frequently strengthen this faith among their members.

Besides experiential knowledge, there is experiential expertise (the second concept to be introduced), which refers to competence or skill in handling or resolving a problem through the use of one's own experience. While everyone with the same problem may have experiential knowledge, the degree to which an individual has integrated the information and become competent in applying it to a problem varies. The "former deviant," that is, the successful graduate or the experienced old-timer in the self-help group, has more experiential expertise than the newcomer. He becomes both a role model and a source of hope, since "he has already made it."[11]

Thus experiential expertise can serve as a basis for leadership, a higher status in the group, and a source of authority for decision making. An articulate member of Recover, Inc., a

self-help group for nervous persons and ex-mental patients, explains the impact of experiential knowledge on a newcomer this way: "He respects a certain authority in those who have experienced what he has experienced: for this reason he will take advice and even reprimands from a fellow patient which he is not yet disposed to take from his own doctor."[12]

The claims of self-help groups that they can solve the problems of their members by mutual efforts and the presence and testimony of persons who have solved their own problems through participation in the group are manifestations of the importance of experiential knowledge and expertise.[13] Public confessions or testimonials-a ubiquitous feature of self-help groups, in which individuals recount some aspect of their personal experience with the common problem-are probably the major means by which experiential information is expressed and shared in self-help groups.

In contrast to experiential knowledge is professional knowledge or truth developed, applied, and transmitted by an established specialized occupation.[l4] "Professional knowledge" is a better-known concept and a more widely accepted source of truth than experiential knowledge in the United States. Access to professional knowledge is limited to those who have met the requirements of specialized education and formal training in a discipline and who possess appropriate credentials. The potential client has to believe (or take on faith) the claim of the professional that he is competent and skillful in diagnosing and handling the problem at hand because of the "possession of a skill so esoteric or complex that nonmembers of the profession cannot perform the work safely or satisfactorily and cannot even evaluate the work properly."[15]

Professionals are respected, deferred to, and treated as authorities by clients who are convinced that the professionals possess truth. The belief in the professionals' competence and expertise as authoritative is widespread among clients. And, of course, professionals themselves are committed to truth based on professional knowledge. Many professionals expect their truth to be accepted without question. Some of these professionals who visit self-help groups often get upset when they do not receive the deference to which they are accustomed. In this case, they find themselves in an uncomfortable situation, in which the self-help group has given a higher priority to experiential than to professional knowledge.

The Relationship between Professional Knowledge and Experiential Knowledge

As sources of truth, professional and experiential knowledge are not mutually exclusive. First, even professionals use some experiential knowledge in their practice. Newly credentialed professionals are not regarded as seasoned until they have had personal experience in the real world of work. This experiential knowledge, however, is defined within and subsidiary to their professional knowledge.[16]

Second, both self-help groups and professionals can and do allow for a second source of truth as a legitimate input to a problem. Some professional models, such as client-centered therapy, show great respect for the experiential knowledge and expertise of clients.[17] And some self-help groups, such as stutterers in the United States, use both professional and experiential expertise.[18]

Third, an individual may have and use both sources of truth simultaneously. The physician in a wheelchair specializing in the rehabilitation of the physically handicapped has available both sources of knowledge. A member of a self-help group may also be professionally

trained in the problem the group is trying to solve; for example, some stutterers in self-help groups in the United States are also speech therapists.

Experiential and professional knowledge can coexist just like religious and scientific truth, for they are neither inherently conflicting nor antithetical, especially if applied to different phenomena. Conflict occurs when there are competing sources of authority about the same phenomena-a realistic possibility for some self-help groups and human service professionals.

Attributes of Experiential Knowledge

There are similarities between professional and experiential knowledge. Both are properties of an individual which, once gained by learning, are imperishable.[19] Such individual knowledge cannot be bestowed by delegation, transfer, or confirmation. Since this knowledge is the property of the individual, it is self-determining, in that the possessor has to use his own judgment in making decisions in his area of competence. The nonhierarchical peer or collegial basis of relationships among professionals or among those in a self-help group stem from the fact that knowledge is an individual property. All who have the information are essentially equal. The self-help group, composed of persons with the same problem, is thus comprised of individuals who are peers by virtue of their experiential information about the shared problem. Furthermore, both professional and experiential expertise can be pooled and organized on a shared basis.

There are also major differences between professional and experiential knowledge. In contrast to professional information, experiential knowledge is (1) pragmatic rather than theoretical or scientific, (2) oriented to here-and-now action rather than to the long-term development and systematic accumulation of knowledge, and (3) holistic and total rather than segmented.

Experiential knowledge is *pragmatic*, in that it emphasizes obtaining concrete observable results that "work," as subjectively perceived by the individual who is going through an experience. Professional knowledge is also oriented to results, but in addition it emphasizes the accumulation of knowledge and defines results within some scientific or theoretical framework accepted by the professional community.

Experiential knowledge is also oriented to *here-and-now action*, and self-help observers frequently refer to this action orientation: "Groups are action oriented, their philosophy being that members learn by doing and are changed by doing .... To put it in other words, experiential fulfillment, rather than didactic instruction, is frequently an explicit aim of certain self-help groups, and it is sometimes achieved.[20] Although professionals, especially practitioners, are also action oriented, their time perspective is longer. They are frequently as concerned about such additional considerations as peer esteem and working within established theoretical models as they are about results helpful to their clients.

Finally, experiential knowledge is *holistic*, in that it encompasses the total phenomenon experienced, that is, that which individuals distinguish and perceive from their commonsense viewpoint. For example, the physician who performs a mastectomy is oriented primarily to the surgery and the biologically pathological state of the patient. But the patient, who is holistic in approach, is anxious about the illness, surgery, and prognosis; the change in body image and its implications for her sexual relationships; the presentation of a "normal" appearance to others; and the financial and familial effects of her illness, to name a few topics of concern.[21]

Professions by definition deal with a limited aspect of a phenomenon and from a selected point of view. A complex division of labor has evolved, in which fields or disciplines have

carved territories based on their own distinctive points of view. Part of this specialization includes the deliberate structuring of a nonexploitive relationship with their clients that excludes "inappropriate" emotional involvement.[22]

The holistic approach of experiential knowledge adds an important element not found in professional knowledge-the cathetic dimension, especially individuals' feelings about and evaluation of themselves and various aspects of their situation. The feeling of being understood as well as the open, natural communication between those with similar experiences, which are regarded as critical features of self-help groups, stem from this added element: "Because peers reveal themselves and have had similar life experiences, they are role models for each other, they identify with each other, and do not question each other's ability to understand, emphasize, etc. ... Peers do not represent 'significant others'; they are significant others; and each one's acceptance of the other is not symbolic but real."[23]

Self-Help Models: Organized Experiential Knowledge

How can experiential knowledge that is concrete, specific, and both commonsensical and atheoretical be helpful to people who share a common problem but whose individual circumstances are unique? My hypothesis is that the usefulness of experiential knowledge derives from the fact that the self-help-group structure provides for the sharing of a relatively large amount of knowledge. By pooling the experiences of a number of people, the common elements of the problem and attempts to cope with it emerge, while simultaneously highlighting the uniqueness of each individual's situation. Consequently, the individual learns how his problem is both similar to and different from that of others, which forces him to utilize the knowledge selectively to fit his situation. Similarly, the group is protected against inapplicable knowledge that is too idiosyncratic or peculiar because a number of people rather than just one or two persons are pooling their knowledge.

In contrast to new self-help groups, developed ones have codified the format or model of their experiential knowledge and their expertise, as applied to the problem for which the group was formed. These models are analogous to the theoretical frameworks of treatment used by professionals.

A self-help model is used here to describe the definition of the common problem, group guidelines to solve the problem, rules on organizational processes such as decision making, leadership, and the structure of relationships among members of the group. The Alcoholics Anonymous model, the oldest and best known, has served as a prototype for initiating a large number of other anonymous groups.[24] It consists of (1) twelve steps which provide the definition of the problem, guidelines to solve the problem, and some components of the relationships in the group; and (2) twelve traditions which provide the guidelines for organizational processes of decision making, leadership, and other aspects of the relationships among members of the group.

Newcomers to an established self-help group have to accept the model of the group; they are not free to enter and redefine the group or its model in their own terms. There is extensive room for individual self-determination, however, since the models are limited in their definition of the components of the problem and there is room for variability in applying the general guidelines to one's own personal situation.[25] For example, in AA the problem is defined simply as drinking alcohol, and the twelve steps to stop drinking are not specific. Although newcomers have to accept these guidelines to participate successfully, they are free to determine other components of their drinking problem and to make specific applications of the general

guidelines. For example, one long-term AA member I interviewed felt that occupational stability and security were important to him to overcome his alcohol problem. The fact that he and his wife were social recluses was not seen by him as a problem related to his drinking. In contrast, some of his AA acquaintances thought that their lack of social life was part of their drinking problem.

Self-help models developed on the basis of experiential expertise differ extensively from those developed by professionals. Because self-help groups are pragmatic and voluntary (any member is free to come and leave as he wishes), the model is being tested constantly for "workable" results by each member and by each generation in the group. If the individual considers the model unworkable or unsatisfactory, he will drop out of the group. And, if the model is unsatisfactory to enough members, the group will disintegrate. Sagarin, for example, maintains that Illegitimates Anonymous never developed into a viable self-help group because the proffered "model" was unacceptable to potential members.[26]

Self-help models vary according to the extent and kinds of professional knowledge regarded as legitimate input. At one extreme, for example, Alcoholics Anonymous and most copiers of AA are based solely on experiential knowledge. Alcoholics within the group are the sole source of knowledge, decision making, and leadership. Toward the other extreme, stutterers' self-help groups in the United States allow extensive input from professional speech therapists in their model-they encourage members to obtain therapy from a professional while participating in the self-help group, and professionals are often "advisers" or honorary members who suggest activities and directions to the groups and who may even assume a leadership position in the group.[27]

Midway between the U.S. stutterers and AA is the model of Plus Club, a Swedish stutterers' self-help group.[28] These Swedish stutterers will frequently use information and techniques from professionals, but on their own terms. The difference is the way in which they use professional information and the criteria of usefulness. For example, they will cordially invite to their meetings anyone-speech therapist, physician, hypnotist-who claims to have an effective technique for stuttering. They will learn the technique and test it out on themselves. However, each stutterer decides personally whether and to what extent the technique was effective and useful to him. Furthermore, the Swedish stutterers have no special category of membership (honorary member or adviser) for professionals; there is only one membership category—common member.

Conclusions and Implications

Self-help groups oriented to the human services can be distinguished from volunteer and governmental human service organizations by their reliance on experiential knowledge and expertise. Because of the emphasis they give to experiential knowledge, self-help groups can be redefined as voluntary human service organizations of persons sharing a common problem who band together to resolve the problem through their mutual efforts, with experiential knowledge being a primary basis of authority in decision making.

Given this definition, the alleged antiprofessionalism in self-help groups can now be reconceptualized as the substitution of experiential authority for professional authority. Viewed from this perspective, if some self-help groups can be seen as antiprofessional, then some professionals can be seen as antiexperiential.

Experiential knowledge can compete with professional knowledge. But competition is

nothing new to human service professions, for human service professionals are not a homogeneous group. Rather, they represent a variety of fields and use a bewildering number of models both within and across fields. Professionals committed to these various models compete constantly to prove the superiority of their own models, again both within and across fields. This struggle for ascendance among professional segments is acceptable, since the parties to the struggle are operating on the same premise that professional knowledge is truth. In contrast, experiential knowledge is based on a different premise, that the source of truth is experience, and as such it can and will be viewed by some professionals as a radical challenge to their authority.

The plurality and diversity among professionals includes the extent to which experiential knowledge is legitimate input to their model. In fact, professional models can be classified on the basis of the extent and kinds of experiential knowledge accepted as serious input. It is hypothesized that professional reactions to experiential knowledge in self-help groups will be associated with the degree to which the professional's model allows input of experiential knowledge.

This introduction to the concept of experiential knowledge has been necessarily limited. Many additional questions need to be raised. First, an important step will be to conduct empirical research on the nature and distribution of experiential knowledge and the problem of developing instruments to measure experiential knowledge.

Second, the variation among self-help groups in the origin, development, and use of experiential knowledge needs to be explored. What are the conditions and processes by which individuals with a problem develop conviction about the validity of their experience? What is the relationship between the development of experiential knowledge (in either an individual or a self-help group) and exposure to the kind of professional knowledge that the client deemed inadequate to solve his problem? My impression is that many self-helpers gradually discover experiential knowledge as truth only after repeatedly trying a variety of professional therapies, none of which was viewed as satisfactory.

Third, how do self-help groups vary in their reliance on experiential, professional, and other bases of authority?

Fourth, questions raised about the role of the professional vis-a-vis the self-help group need to be reexamined within the framework presented here. An important factor will be the professional's attitude toward experiential knowledge, his degree of open-closed mindedness, and his tolerance of a competing source of truth. The diversity among professionals and their ideologies insures varying responses to experiential knowledge in self-help groups. Such questions as whether, in what ways, and with what effects professionals can and should relate to self-help groups will have various answers, depending both on the type of professional and his ideology and on the type of self-help group and its ideology about professional knowledge. Research is needed to determine under what conditions and for what kinds of problems experiential knowledge emerges in competition with professional knowledge as truth.

Finally, the concept of experiential knowledge is applicable to more phenomena than self-help groups. The usefulness of experiential knowledge as an explanatory factor in the civil rights, consumer participation, and other "client power" movements needs to be explored.[29] The current skepticism and distrust of government, bureaucratic, and professional problem-solving efforts may be more than just an expression of anomie, alienation, and the like. It is clear that some demands for "client power" are indications of the ascendance of experiential knowledge.

Notes

1. Self-help groups are developing at a faster pace than observers can catalog them, noted Alfred H. Katz, "Self-Help Organizations and Volunteer Participation in Social Welfare," *Social Work* 15 (January 1970): 52-53. In addition to such well-known older groups as Alcoholics Anonymous, Synanon, Overeaters Anonymous, Gamblers Anonymous, and Recovery, Inc., self-help groups for parents who abuse their children, stutterers, sex offenders, divorced Catholics, adoptees, priests and nuns leaving religious life, and alienated people, among others, have developed. Many researchers describe only one or two groups; an exception is Edward Sagarin, *Odd Man In: Societies of Deviants in America* (Chicago: Quadrangle Books, 1969). References to recent articles on self-help groups are given by James M. Jertson, "Self-Help Groups," *Social Work 20* (March 1975): 144.

2. See, e.g., Jertson, pp. 144-55; Alfred H. Katz, "Application of Self-Help Concepts in Current Social Welfare," *Social Work* 10 (July 1965): 68-74; Matthew P. Dumont, "Drug Problems and Their Treatment," in *American Handbook of Psychiatry,* ed. Gerald Caplan, 2d ed. (New York: Basic Books, 1974), 2:287-93; Gerald Caplan, *Support Systems and Community Mental Health* (New York: Behavioral Publications, Inc., 1974); Nathan T. Hurvitz, "Peer Self-Help Psychotherapy Groups and Their Implications for Psychotherapy," *Psychotherapy: Theory, Research, and Practice* 7 (Spring 1970): 41-49; O. H. Mowrer, "Peer Groups and Medication: The Best 'Therapy' for Laymen and Professionals Alike," *Psychotherapy: Theory, Research, and Practice* 8 (Spring 1971): 44-54; and Herbert Barish, "Self-Help Groups," in *Encyclopedia of Social Work,* ed. Robert Morris et al. (New York: National Association of Social Workers, 1971),2:1163-69.

3. Sagarin; Barish, p. 1168; Jertson, p. 145; and Lewis Yablonsky, *The Tunnel Back: Synanon* (New York: Macmillan Co., 1965), pp. 367-403.

4. Paraprofessionals or indigenous workers employed in official or voluntary agencies are not included here under the rubric of self-help. Voluntary associations are organized groups based on voluntary, usually part-time, unpaid participation deve1oped for the purpose of furthering some common interests of the members. For definitions, see Charles Perrow, "Members as Resources in Voluntary Organizations," in *Organizations and Clients,* ed. William R. Rosengren and Mark Lefton (Columbus, Ohio: Charles E. Merrill Publishing Co., 1970), pp. 94-95; and David Sills, "Voluntary Associations: Sociological Aspects," in *International Encyclopedia of the Social Sciences* (New York: Free Press and Macmillan Co., 1968), 16:362-63.

5. See Thomasina Borkman, "Changing Sex Roles: Consciousness-raising Groups as a Vehicle of Adult Resocialization," in *Sociological Research Symposium V,* ed. J. Sherwood Williams, Allan Schwartzbaum, and Rodney Ganey (Richmond: Virginia Commonwealth University, 1975); and "A Typology of Self-Help Groups from an Organizational Perspective," Xeroxed, 1975.

6. See Thomasina Borkman, "Participation Patterns in a Self-Help Organization of Stutterers," in *The Strength in Us: Self-Help Groups in the Modern World,* ed. Alfred H. Katz and Eugene Bender (New York: New Viewpoints, 1976); "A Cross-national Comparison of Stutterers' Self-Help Organizations," *New Zealand Speech Therapists' Journal* 29 (May 1974): 6-16; "Stutterers' Self-Help Organizations: Emergence of Group Life among the Stigmatized," in Williams, Schwartzbaum, and Ganey; and, with Aurora Zappolo, *A Sociological Survey of the Council of Adult Stutterers,* mimeographed, 1972.

7. A distinction is made here between "information" (acquaintance with or recognition of facts) and "knowledge" (understanding or having a complete mental grasp of the nature and significance of something).

8. Although in one sense everyone "learns" something from personally experiencing a phenomenon, some people may be unaware of and or untouched by "going through" a situation, while others may not have integrated the information learned but, instead, have stored bits of disjointed items in their memories.

9. What constitutes common sense will depend on the individual's perceptions, his background, and his sociocultural milieu. Individuals will also vary in their ability to articulate their experiential knowledge to others or to apply it to similar situations.

10. Knowledge is defined as "the certainty that phenomena are real and that they possess specific

characteristics," as used by Peter L. Berger and Thomas Luckmann, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (Garden City, N.Y.: Doubleday Anchor Books, 1967), p. 1. Berger and Luckmann define knowledge sociologically (not philosophically), and the basis of knowledge could be, e.g., belief in magic, science, religion, or experience.

11. See Barish, p. 1166; and Hans Toch, *The Social PsychololfY of Social Movements* (Indianapolis: Bobbs-Merrill Co., 1965), p. 82.

12.Toch, p. 79.

13.Ibid., p. 83; and Hurvitz, p. 44.

14.Following the analysis of Eliot Freidson, *Profession of Medicine* (New York: Dodd, Mead & Co., 1970). Freidson's incisive analysis of professional knowledge is based on the preeminent profession of medicine, and, since others emulate the model of the medical profession, it is used here, although it does not apply in all particulars to other professions.

15.Ibid., p. 45.

16.See Freidson's analysis of the important role of experience among clinical physicians (chap. 8).

17. See J. T. Hart and T. M. Tomlinson, eds., *New Directions in Client-centered Therapy* (Boston: Houghton Mifflin Co., 1970). One extreme example is the self-directed group described in this volume by Lawrence N. Solomon and Betty Berson in "The Self-directed Group: A New Direction in Personal Growth Learning" (pp. 314-47). The professional recruits the group members and provides guidelines to them, but he does not participate in group interaction, which is conducted solely by the client members.

18.Borkman, "Stutterers' Self-Help Organizations."

19.See Amitai Etzioni, *Modern Organizations* (Englewood Cliffs, N.J.: Prentice-Hall International, Inc., 1964), pp. 75-93, for a discussion of professional knowledge.

20. Katz, "Self-Help Organizations and Volunteer Participation," p. 55. See also Sagarin; and Anthony J. Vattano, "Power to the People: Self-Help Groups," *Social Work* 17 (July 1972): 7-15.

21. Terese Lasser and William K. Clarke, *Reach to Recovery* (New York: Simon & Schuster, 1972).

22. See Talcott Parsons, *The Social System* (Glencoe, Ill.: Free Press, 1951), chap. 10, for a formal analysis of the professional-client relationship and the professionals' "detached concern" for the client.

23. Hurvitz, pp. 43-44. See also Katz, "Self-Help Organizations and Volunteer Participation," pp. 53-55.

24. Sagarin describes the development of many self-help groups and their imitation of the AA model. The Widespread use of the AA model is seen in the fact that it is listed as one of eight contemporary models of alcoholism, one of the few treatment models, by Miriam Sieglar and Humphry Osmond, *Models of Madness, Models of Medicine* (New York: Macmillan Co., 1974).

25. See Roben F. Bales, "The Therapeutic Role of Alcoholics Anonymous as Seen by a Sociologist," *Quarterly Journal for Studies of Alcohol* 5 (September 1944): 267-78; and I. P. Gellman, *The Sober Alcoholic: An Organizational Analysis of Alcoholics Anonymous* (New Haven, Conn.: College & University Press, 1964).

26.Sagarin, pp. 69-71.

27.Borkman, "Cross-national Comparison of Stutterers," p. 14.

28.Ibid., p. 13.

29.See, e.g., Vattano; and Mowrer, p. 45.