GOING TO THE SOURCE: A SURVEY OF A.A. MEMBERS ABOUT A.A.

by

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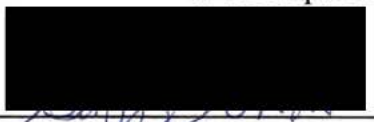

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ABSTRACT

This study undertook to measure the knowledge, attitude and beliefs of members of Alcoholics Anonymous about the program of AA, an approach rarely encountered in the literature. One hundred and thirteen members responded to a questionnaire, and there was found to be a high degree of program knowledge, as tested by questions taken from AA literature. Belief in the efficacy of AA by AA members was also high, as measured by compliance with the various suggestions which the program makes to its members, with one question achieving a 100% score. Attitudes about AA were generally positive. This study is consistent with the current trend in alcoholism research, that of gathering data on matching the client to the treatment.

This survey identified what could be an impediment to recovery which has not been previously identified, according to a search of the literature. In the overall results, the related Steps Six and Seven of the program, when taken together, were reported to be more "difficult" than Step Four. Step Four receives a great deal of attention and assistance, both in and outside the AA program, and in the literature, because of its demands for self-knowledge. Steps Six and Seven, by contrast, are largely taken for granted. This study suggests that the reason for the reported difficulty may relate to a perceived threat to the identity of the client. Recommendations are made for further research on this and other subjects of this study.

The questionnaire also identified AA members who have previously received other types of treatment for alcoholism, and who are currently receiving such therapy. There was found to be sufficient evidence to conclude that AA alone is treatment enough for some members, while others (23%) require additional therapy.

The results of this survey study are similar to those of the 1996 AA Triennial Survey, where similar demographic questions occur.

Examiners:

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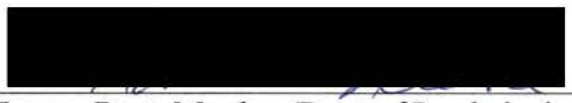

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A special group of people, the one hundred and thirteen respondents, have earned my gratitude. In the finest tradition of Step 12, each of them overcame their fear of imperiled anonymity to contribute to this research. They carried the message.

DEDICATION

To Dian, for her inspiration.

To Julie, Vicki, Toni, Michael, Robyn and Kent for their unwitting motivation.

To Sidni: she can't talk the talk, but she can sure walk the walk.

But mostly, to my love, Dian.

CHAPTER 1

INTRODUCTION

The *zeitgeist* in alcoholism treatment research today concerns itself with matching the client to the treatment. As will be demonstrated in the literature review, the majority of researchers have conceded defeat on any "one size fits all" treatment, and have turned their attention to the process of identifying "which kinds of individuals, with what kinds of alcohol problems, are likely to respond to what kinds of treatments by achieving which kinds of goals when delivered by which kinds of practitioners" (Institute of Medicine, 1990). This undertaking more than implies the need for a bottom-up approach, since the clients themselves must be consulted in one way or another in this process.

The search for answers from the users of a treatment is the purpose of this thesis. Specifically, this research focuses on members of Alcoholics Anonymous (AA). Even more specifically, it seeks to record the self-reported behaviors of AA members and compare these actions with the behaviors recommended by the program of AA. Furthermore, this research investigates the attitudes of AA members about other types of treatment, about AA itself, and seeks to identify areas of relative ease and difficulty experienced by the members when they address each of the 12 steps of the program. Comparisons will be drawn with other research on similar questions, however, a search of the literature reveals that some of the questions have never been posed to AA members before.

Background and Overview

It is estimated that one in eight North Americans will develop alcohol abuse or dependence in their lifetimes (Kassel & Wagner, 1993). Emener and Dickman (1992) calculate that the lives of 50-60 million citizens in the U.S. alone are impacted by alcoholism. Alcohol chalked up $U.S.116 billion in social costs, and contributed to 100,000 deaths in 1993 (1993, Kassel & Wagner).

It was in response to this human, social, and economic devastation that the "largest, statistically most powerful, psychotherapy trial ever conducted" was launched (Project MATCH Research Group, 1996). Project MATCH has as one of its main goals to evaluate the procedure of matching alcoholism clients to three different treatments with reference to a variety of client attributes (ibid.). This project is just one example of the *zeitgeist* mentioned earlier, and it will be referred to throughout this thesis.

Alcoholism Treatments

There are many different treatments for alcoholism. Therapies which dominate the research include cognitive-behavioral, motivation enhancement therapy, pharmacological treatment, psychoanalysis, twelve-step facilitation therapy, some aspects of behavioral therapy, as well as AA. In fact it was probably of some significance that Project MATCH selected the first three treatments for trial as cognitive-behavioral, motivation enhancement, and twelve-step facilitation therapy. It should be noted that the latter of these is distinctly not AA, but rather a one-on-one approach which otherwise employs what is meant to be similar strategies to those of AA. Project MATCH intends to evaluate other types of treament. This thesis will assess these three treatments, AA, and other treatment strategies, as well as combinations of treatments, and they will be expanded upon in the literature review.

AA treatment

A great deal of research surrounds the Alcoholics Anonymous method of therapy. As will be shown in the literature review, some of these inquiries arrive at conclusions favorable to AA methods, and some is critical of it. To compound the matter, as Miller & Kurtz point out, "writers of professional articles and monographs have mistakenly attributed key elements of other models to AA" (1994). This diversity of findings, and the implications of partiality which accompany them, is summed up by veteran alcoholism researchers McCrady and Miller (1993) when they write, "it is difficult to find ... a professional with no opinion about AA". Emrick, Tonigan, Montgomery and Little (1993)

go somewhat farther when they say, "Rarely does one meet a person who does not have an opinion about (AA)".

Compliance with AA treatment

One area of research which appears to have been largely overlooked is member compliance with the "suggested" AA program. The studies which have been conducted on compliance have been limited to those which include another type of treatment and/or couples therapy, such as the recent work of McCrady, Epstein & Hirsch (1996). Or in another example, compliance was measured as abstinence from alcohol, milieu, and behavior in group therapy (Verinis, 1996). Yet another inquiry involved two treatment interventions, one of which was based on the AA program. The point is that no research can be found which seeks to measure compliance with the AA program itself based on the self-reported behaviors of the members themselves. That is one of the approaches the current study employs.

One of the suggestions of the program of AA is that members should look for a "home group". Alcoholics Anonymous describes the home group as "the strongest bond between the AA member and the Fellowship" (The AA Group, 1965). A limited amount of research has been done on AA home groups, some of it seeking correlation between belonging to a home group and length of sobriety (for example, Chappel, 1993), or as ways to enhance positive referrals to AA by therapists (see Johnson & Chappel, 1994). This thesis deals with having a home group as one behavior which tends to corroborate compliance with the recommendations of the AA program.

Another measure of adherence to program recommendations is meeting attendance. Several researchers quote the AA cliché for newcomers: "go to 90 meetings in 90 days". This is, of course, a drastic introduction to what is offered as the solution to a drastic problem. Whereas AA does not specify meeting frequency, other than the lore for newcomers just quoted, it does say that "attendance at meetings and other informal

contacts with fellow AA's are important factors in the maintenance of our sobriety" (This is AA, 1984).

Another essential component of the AA program is the adoption of the disease model. This model holds that alcoholism is a progressive malady which can be arrested but never cured (Miller, 1993). Almost from its inception in 1935, AA has maintained that alcoholics respond to alcohol with a reaction similar to an allergy. According to Milam & Ketcham (1983), "physiology, not psychology, determines ..." alcoholism. A review of the literature will demonstrate how broadly the medical model is held to be true. One of the points of this thesis is to determine to what extent a sampling of AA members subscribe to this model, which is yet another way to measure compliance with the AA program.

Research on AA Members

Some research has been conducted on members of AA themselves, although this line of inquiry occurs much less frequently than does the investigation into the AA institution or the AA process. The literature review will bear out the fact that the majority of inquiry seeks to explain the success or failure of AA treatment in terms of the policies of AA, which are referred to as Traditions, or the processes, which usually focus on the 12-steps of the program.

One of the reasons for the paucity of data on AA members is that acquiring such information is generally a source of frustration to researchers. Anecdotal information forms the majority of this research, with little controlled inquiry (Kassel & Wagner, 1993; Littrell, 1991). According to Galaif & Sussman, "research determining AA's effectiveness is scanty and difficult to achieve, mostly because of the enforced anonymity of its members, even though AA supports scientific inquiry" (1995).

Of the research on AA members, some of the data is acquired directly from AA itself, in spite of the fact that AA has been faulted for its survey methods (Room, 1983). As an example, Room cites AAs estimate of membership in North America at 0.48%, and compares it to a nationwide survey (n = 2,058) which reveals three times that number. Yet

in many cases, the entire source of information for some alcoholism researchers is the information provided by AA (ibid).

Member Knowledge of the AA Program

The AA program is comprised of 12 steps and 12 traditions, from which flow a number of policies, prescriptions, proscriptions, and procedures. Many of the most important of these steps and traditions are repeated at some time or other during the course of each meeting. At no time is a member asked to memorize any part of AA literature as a part of the recovery program. Any retention of this type of information would probably be through some rote mechanism. A search of the literature has failed to turn up any prior testing of AA members about their knowledge of the 12 steps and 12 traditions which lead to the norms. This thesis addresses that research void by posing a number of knowledge-based questions about AA to AA members.

Attitudes About AA held by AA Members

As mentioned before, the thrust of research today is centered on matching the alcoholic client to the treatment. It would seem to be worthwhile, therefore, to seek the opinions of AA members on what attitudes they hold about AA. For example, what would the members record as what they like, and dislike, about AA and its program? With what degree of facility or difficulty do they negotiate the 12 steps? The answers to these questions might contribute to any screening process which might emerge from the current direction of research.

Belief in the Efficacy of AA and Other Treatments

Few if any AA researchers have polled AA members themselves on the extent to which they believe in the AA program. The answers to this question would also seem to be helpful in the search for matching client to treatment. As the literature review will show, a high degree of belief in a treatment correlates strongly to positive outcomes (Tonigan, Miller & Brown, 1997).

It would also seem worthwhile to determine how AA members might rank other alcoholism treatments, especially in relation to AA itself. The answers from AA members who have undergone other treatments, both in the past and presently, would be particularly valuable in the search for matching treatment to client. A search of keywords in the PsychLit database, as well as a direct search of research articles and books, has failed to turn up any inquiries which go in this direction.

In summary, almost every alcoholism research project relies to a large extent on a self-reporting method in one way or another. The majority of these projects are of the survey type. This thesis continues this methodology, and in addition seeks to contribute to the information available current trend in modern research, particularly that of matching the client to the treatment. It achieves this end by questioning AA client beliefs and attitudes, and by measuring satisfaction. It does so by pursuing the relatively under-utilized method of surveying AA members themselves.

The following are the research questions of this thesis:

Research Questions

1. Is there relationship between knowledge about the program of Alcoholics Anonymous and belief in its efficacy?
2. To what extent does the self-reported behavior of members of Alcoholics Anonymous adhere to the suggestions of the AA program?
3. What are the self-reported behaviors of members of AA with respect to other alcoholism treatments prior to coming to the program?
4. What are the self-reported behaviors of members of AA with respect to other alcoholism treatments today?
5. What do AA members like and dislike about the program?
6. Which of the 12 steps do AA members record as "easy", and which "hard"?
7. Where there is similar data, how does the present research compare to the most recent AA Triennial Survey?

CHAPTER 2

Review of the Literature

History of Alcoholism

In 1849 Huss coined the term "alcoholism" (Miller & Kurtz, 1992). Prior to that time, drinking was considered a willful act of a weak and depraved character as presented by temperance organizations (Lender & Martin, 1987). As recently as a decade ago, the U.S. Supreme Court determined that alcoholism can be regarded as "willful misconduct" (Connors & Rychtarik, 1988).

Until recently, alcoholism had been largely viewed and treated as a learned, maladaptive coping behavior (Bissell, 1996). However the modern current model regards it as a complex disease in its own right (ibid.). In summarizing modern approaches to alcoholism treatment, Bissell writes:

> Treatment of the illness increasingly recognizes alcoholism itself as the primary problem needing attention, rather than regarding it as always secondary to another, underlying problem. Specialized residential treatment facilities and separate units within general or psychiatric hospitals are rapidly increasing in number. As the public becomes more aware of the nature of alcoholism, the social stigma attached to it decreases, alcoholics and their families tend to conceal it less, and diagnosis is not delayed as long. Earlier and better treatment has led to encouragingly high recovery rates (1996).

A contrasting opinion is reasoned by Chiauzzi & Liljegren (1993). They argue that there are 11 taboo subjects in alcoholism research, including: lack of empirical support for some models, the existence of spontaneous remission, the overuse of the addiction concept, the value of patients' self-reports, etc. They conclude that research needs to move from experience and faith into empiricism, and that a greater degree of flexibility may encourage the creation of new interventions that enhance outcomes (p. 312).

In a typical article of its type and time (1987), Raul Caetano argued that there were competing definitions of alcoholism on either side of the Atlantic. At that time, (only 10 years ago) Caetano listed the differences between DSM-IIIR (Diagnostic and Statistical

Manual of Mental Disorders) and its World Health Organization counterpart, the ICD-10 (International Classification of Diseases) on the subject of the Alcohol Dependence Syndrome. In anticipation of the DSM-IV, and any subsequent ICD versions, Caetano provided arguments intended to bring the two versions together (p. 604).

Models of Alcoholism

Miller and Kurtz (1994), while acknowledging other valid perspectives, have proposed four models of alcoholism which have been adopted into current U. S. beliefs about alcoholism. They list these as "moral-volitional, personality, dispositional disease and AA models" (p. 159).

The moral-volitional version is evidenced by "Just say no" campaigns, assumes choice and provides punishment for violations. The personality model is derived from the psychoanalytic school, it first appeared at the turn of the century and posits a departure from normal development. The dispositional disease model, dating to the '30s and '40s, proposed that one either is or is not alcoholic, that the disease has its roots in biological factors, that the inability to control drinking after the first drink is an inexorable reaction, and that the condition cannot be cured, but only palliated (ibid., p. 160). Although the AA model is described by Miller & Kurtz as basically spiritual, and it is held to be a way of living rather than a treatment (ibid. p. 161).

In an earlier publication (1993), Miller, one of the most prolific writers on the subject of AA and alcoholism today, elaborated on the moral volitional model. He describes an interdisciplinary model which differs from the disease model in that it does not embrace the "single, incurable, all-or-none disorder caused by biological abnormalities" (p. 129). Miller argues for an approach which avoids describing subtypes, and instead adopts a variety of dimension of severity, marked by consumption, life and health problems, and dependence, arranged on a continuum (p. 133).

Vaillant and Hiller Sturmhofel, in their 1996 research, refer to alcoholism as either alcohol abuse or alcohol dependence. One of their most significant findings is that they

provide evidence to contradict the theory that people drink to palliate depression, even though depression and alcoholism occur together frequently (p. 154). Citing results of a 55 year longitudinal study, they point out that: alcoholism among manic-depressive patients is not higher than other psychiatric patients; depressed alcoholics can be shown to have environmentally induced, rather than genetically induced depression, according to biochemical tests; only four of 14 alcoholic patients had evidence of depression prior to becoming alcoholic; in multigenerational studies, the predisposition to alcoholism and depression can be shown to be genetically separate; and, whereas antidepressants did not alter the course of alcoholism, abstinence from alcohol did alleviate depression (ibid.). Vaillant and Hiller-Sturmhofel also point out that researchers reach similar conclusions with other maladies such as generalized anxiety disorder (p. 154).

Alcoholism has been described by Morse and Flavin (1992) as a chronic primary disease, often progressive and fatal, marked by continuous or periodic impaired control over alcohol consumption; preoccupation with alcohol; the use of alcohol in spite of adverse consequence; and distortions in thinking which includes denial of the condition. In 1957, the American Medical Association designated alcoholism as a disease, and in 1987 named other drug addictions as a disease (Johnson & Chappel, 1994).

However, AA itself avoids the word "disease", and in its literature employs the terms "malady" and "illness" (Riordan and Walsh, 1994). Ernest Kurtz, a historian known for his definitive work on AA history, explains that AA avoids the term disease intentionally "to avoid conflict", and under any circumstances, considers the etiology of alcoholism to be superfluous (1979).

History of AA

Alcoholics Anonymous was founded in 1935 in Akron, Ohio, when two alcoholics, Bill W. and Bob S. supported each other to achieve sobriety (Alcoholics Anonymous, 1976). Over the next three years they and a small group of others worked out a system of long term recovery from alcoholism and published its "Big Book". What the small band

accomplished is noteworthy in the annals of field research. Today AA has a worldwide membership approaching 2 million who attend an estimated 100,000 groups (AAWS, 1996). The most scholarly and definitive history of AA is that provided by Ernest Kurtz in his 1979 book *Not God* (1979), according to Riordan and Walsh (1994).

AA is as much for women as for men, and AA also presents itself as cross-cultural. Women and minorities attend AA meetings more readily than was originally thought, which may be because meetings are becoming more responsive to the specialized needs of members, according to Gilbert (1991). AA "is a fellowship of men and women" (This is AA, 1984), and women form one third of the membership, and 40% of those age 30 and under, indicating more women are attending AA at a younger age (Alcoholics Anonymous 1996 Membership Survey).

From a research standpoint, the differences between male and female alcoholics has been summarized by Canada's Addiction Research Foundation (1996). These differences are (p. 30):

- women tend to drink less alcohol (per occasion, per week) than men.
- women are less likely than men to drink alcohol daily.
- women are less likely than men to use illegal drugs.

However, Tonigan, Toscova & Miller (1994) found that women differed from men when measured on AA involvement and abstinence. This finding was interpreted as indicating men and women may respond differently to AA, possibly because women require different settings than men. Some studies (for example, Jarvis, 1992) suggest that women may prefer more one-on-one treatment.

AA and racial / cultural issues is a subject in itself, and, like spirituality, is outside the scope of this thesis. However, AA describes itself as an international fellowship that is "non-professional, self-supporting, nondenominational, multiracial, apolitical and available almost everywhere" (AAWS, 1997). In 1997 there was AA-related activity in 146 countries, including Eastern Europe (About AA, 1997). "Nine percent of the American

population have at some time attended a meeting of Alcoholics Anonymous - that is a number greater than practically any institution, save the public school and the Catholic Church" (Robin Room, as cited by Ernest Kurtz, 1993, p. 21).

AA Treatment

Vaillant and Hiller-Sturmhofel (1996) have described four non-treatment-related factors and dynamics that coincide with the development of abstinence, cautioning that self-reports drive the study, and that the results may therefore be biased. The first of these factors is a substitute dependency, which can take many forms including overeating, chain smoking, taking tranquilizers, working compulsively, excessive dependence on one's parents or getting heavily involved in AA. Secondly, through a process similar to behavior modification, the attitude toward drinking is strengthened by regarding alcohol as the enemy, and this is reinforced because of medical, legal, or social sanctions. Third, abstinence is enhanced through hope and/or raised self-esteem, such as may be derived from group forgiveness in AA participation, relieving shame from past wrongs to others. Finally, new romantic interest or mentor relationship is often associated with abstinence (p. 159). Vaillant and Hiller-Sturmhofel make the point that self-help organizations, such as AA, can provide all four of these non-treatment-related factors that are associated with abstinence (p. 159).

AA as such is not a treatment, but rather a social movement (Makela, 1993). However, AA does provide its members with rationales such as the one which is suggestive of a medical model, wherein alcoholism is held to be a progressive illness that is "a manifestation of an allergy; that the phenomenon of craving is limited to (alcoholics) and never occurs in the average temperate drinkers" (Alcoholics Anonymous, 1976). For this and other reasons, AA and most other treatment programs generally consider abstinence as the only desirable treatment outcome (Vaillant & Hiller-Sturmhofel, 1996).

Identifying potential change mechanisms is a common theme in research on AA. One such study by Kassel & Wagner (1993) examines four such possible change agents.

The first of these factors is group therapy, wherein it is believed that general as well as context-specific curative processes are at work in groups which have as their purpose behavioral change (p. 225). The second factor lies in self-help group processes, where various aspects of social support (such as encouragement, acceptance, etc.) have been demonstrated to be the most important influences (p. 226). The third of these factors, ideology, although there is less empirical evidence of its influence, is held to contribute to change (p. 228). Finally, Kassel and Wagner cite Kanter (1968); Becker, (1960); Galanter, (1980), and others as providing convincing evidence that commitment generation contributes to the process of change (p. 299).

It should be noted that Kassel and Wagner err on one important point not directly related to the change process. On Page 223 they list "meetings of three (general) types: the Step Meeting ...; the Discussion Meeting ..., and the Speaker Meeting ...". Although they are clearly referring to meeting format when they list these types, they overlook the importance, and even the differences, between Open versus Closed meetings. The first, as the name suggests, is open to anyone. The Closed Meeting, on the other hand, is only open to "those with a desire to stop drinking" (This is AA, 1984). The dynamics of Open and Closed meetings differ in many ways, not the least of which is intensity, and as a consequence measures of change would probably vary between the two.

AA group dynamics and differences in AA groups is the subject of a study by Tonigan, Ashcroft, and Miller (1995). Three groups were studied for a period, and were found to differ from each other in measures of perceived group cohesiveness, independence, aggressiveness and expressiveness. There was also variation in the frequency with which the steps of the program were discussed (p. 618). Citing a common problem in AA research, Tonigan et al. acknowledge that AA (closed) meetings may differ from other meetings. Another shortcoming of the study is that migration occurs from one meeting to another by AA members (p. 619). Tonigan et al. caution that AA groups should not be considered homogeneous, and also point out that "omnibus" profiles of

affiliation and outcome are inappropriate because of these variations (p. 620). They suggest that studying the relationship between AA fellowship and program characteristics may make it easier to understand who may do well in specific groups, and may also address the question of why (p. 620).

Sociologist Rouse describes AA as not only a system for gaining sobriety, but also a socially organized means for transforming identities (1996). Thus AA is a prime example of a place and a process where spoiled, stigmatized identities are deconstructed and reconstructed; where degraded identities seek a persona more socially acceptable and of elevated status. In sociological jargon, such organizations are known as ITOs (Identity Transforming Organizations). Rouse (citing Garfinkel, 1956) describes the emphasis as on "motivational as well as behavioral aspects given the motives an audience imputes to an actor" (p. 21). According to Rouse, the recovering alcoholic adopts a new ethos and new values such as sobriety versus drunkenness, service versus self-centeredness, etc. (p. 33).

The AA system employs a sponsor, or mentor, in their methodology. Kassel and Wagner (1993) describe the Sponsor as an "important element of the AA approach ... an 'expert' senior member to whom initiates can turn for advice during the course of recovery" (p. 223). They also cite the Sponsor as one who facilitates the process of socialization (of the newcomer) to the group (p. 224). Le, Ingvarson and Page (1995) describe sponsorship as a source of continuous, personal help from those members who have made some progress in the program. Fagan (1986) demonstrates that, especially in the early stages of the process, sponsorship can contribute significantly toward recovery. Thompson and Thompson, on the other hand, express some misgivings about the non-professional, casual way in which sponsors are selected according to traditional AA customs (1993). Citing Ogborne and Glaser (1985), they point out that the profile of successful sponsors in AA are over 40, with a tendency to guilt, external locus of control, low conceptual level, a religious orientation, and suffering from existential anxiety. This,

say Thompson and Thompson, is "hardly the characteristics of someone equipped to form a therapeutic bond" (p. 50).

Alcoholism as a spiritual malady is a fairly common subject in the literature. For example, McCrady (1990) says that most professionals consider it a spiritual disease. AA itself places great emphasis on the loss of spirituality and faith as major determinants of alcoholism (Alcoholics Anonymous, 1976). Nowinski (1976) says, in relation to the AA program, "It is God, not will, that is seen as the locus of control" (p. 30). Ellis and Schoenfeld (1990) suggest that long-term abstinence from alcohol may only occur if control over the disease has been turned over to divine intervention. Richard Gorsuch (1993) reasons that the spirituality of the AA program is the source of hope for recovering alcoholics, and that without hope the individual quickly gives up on the attempt to stop drinking. Gorsuch adds that current psychological terms for hope include self-efficacy and acceptance of responsibility, that another word for hope is "empowerment", and that spirituality is even more than locus of control (p. 313).

Margolis (1993) likened the recovery process, and especially that part of it which deals with spirituality, as literally a "leap of faith" required by the recovering alcoholic. His research article reviews the history of the medical model of alcoholism, and employs the metaphor of the leap of spiritual faith as similar to his own son's leap of faith in removing the training wheels from his bicycle (p.187). Margolis urges psychologists to consider taking a leap of faith by integrating 12 step thinking into their practices and to evaluate the research objectively (p. 191).

Countering the spiritual position, Davidson (1987) regarded alcoholism as a state of dependence that is distinct from a spiritual disease model. Edwards and Gross (1976), argue that alcoholism is regarded as a clustering of cognitive, behavioral, and physiological components, and that accordingly, alcoholism can be viewed as a continuum ranging from mild to severe, with mild considered "normal".

Support for AA

Most research which tends to support AA is derived from anecdotal data, is based on the number of individuals who participate in its program, or on the testimony of individual members (Galaif & Sussman, 1995). However, some researchers have employed correlational data (Miller & Hestor, 1986; Vaillant, 1983; etc.). Nonetheless, the literature which tends to support AA is very much greater than are critical evaluations. Although researchers decry the difficulty in identifying subjects in an anonymous program, and despite the paucity of empirically derived information upon which to base an assessment, the AA program is endorsed by most (McCrady & Miller, 1993: Emrick, 1987: Kassel & Wagner, 1993; Sheeren, 1988; Ogborne & Glaser, 1988; etc.).

The American Psychiatric Association Task Force wrote in 1989, "AA has been and remains to this day a major influence in the field of alcoholism and its treatment, and there are no signs that its significance is waning" (p. 1161).

Criticisms of AA

The primary criticism of the AA program is from an empirical research standpoint. For example, Galaif and Sussman (1995) point out that correlational studies do not provide evidence to support a causal link between AA participation and sobriety (p. 164). Litrell (1991) points out that only five to 13% of members will maintain an enduring relationship with AA. Furthermore, in studies where alcoholics are randomly assigned to different treatment, there is no evidence that AA works better. Vaillant & Hiller-Sturmhofel (1996) found that "about 2% of all alcoholics return to stable abstinence each year, with or without receiving treatment" (p. 157).

Le, Ingvarson and Page (1995) criticize the AA steps as revolving around themes of powerlessness, dependency, and humility. They adapt the steps to conform to counseling standards, and to change the orientation from those of removing character defects and personal shortcomings, as the AA program suggests, to developing strengths and abilities, as good counseling practice would prefer (p. 607). In urging these changes,

Le et al. also cite Ellis and Schoenfeld (1990), which questions AA's spirituality; Bufe (1991), who objects to AA's "self-absorption and irrationality"; and Trimpey (1989) who was concerned about those who had objections to AA spirituality (p. 607).

Thompson and Thompson also go one-by-one through the 12 steps of the program, isolating issues and implications, once again from the perspective of counselors. They find at least some misgivings with each of the steps. The researchers summarized their reservations about the program as those related to sponsorship, working the steps, and the "Spiritual Imperative", and their recommendations to counselors was to be vigilant with any clients who are also members of AA (p. 58).

Whether in fact AA is a religious organization was addressed by Riordan and Walsh (1994). They argue that religion dictates how a person should believe, while 12-step groups tells a person of the need to believe in a "power greater than yourself". In 1988, Flores argued that AA is not a religious program any more than when William James and Carl Jung employed spiritual themes in their treatments.

Another criticism of AA is that it is a substitute dependence (see, for example, Bean-Bayog, 1985; Vaillant, 1985, etc.). Flores (1988) counterargues that this criticism reflects the attitude of professionals that anything less than complete autonomy is a problem, and that in fact, limited dependence on others allows for intimacy and encourages personal growth. Flores goes on to say that AA's critics do not understand the subtleties of the AA program and "often erroneously attribute qualities and characteristics to the organization that are one-dimensional, misleading, and even border on the slanderous" (p. 203).

Trimpey argues that people can perceive AA as their only alternative (1989). He went on to say that many people do not succeed for four basic reasons: inability or reluctance to work in a group situation; preference for rational solutions over those based on spirituality; resistance to religious aspects, which they may perceive as integral to the AA program; and those with dual diagnosis issues (1989). He also points out that harm

can occur to persons who are ordered to attend AA meetings, such as through the court system.

An alternative to AA for women, Women For Sobriety (WFS), was introduced in 1975 by Dr. Jean Kirkpatrick, a sociologist (Kaskutas, 1994). Kirkpatrick argued that AA is "fundamentally wrong for women". The emphasis of WFS is on improving self-esteem and reducing guilt feelings, and the rationale is that the solution lies within their own minds and not from a higher power (p. 260). Women for Sobriety has a membership of about 1,000 in the U. S. and Canada (p. 259). In a 1996 article, Kaskutas says that of all members who make up Women for Sobriety, three quarters have undergone individual therapy, suggesting that the membership is open to a psychological approach to alcoholism treatment, such as this organization offers (p. 260). According to Kaskutas, one third of all members also belong to AA (p. 259). A membership survey revealed that those who attend AA do so as insurance against relapse (28%), because of availability (25%), for sharing (31%), and for support (27%). Member reasons for attending WFS were: for support and nurturance (54%), for sharing about women's issues (42%), because of positive emphasis (38%), focus on self-esteem (39%), and for a safe environment (26%) (p. 185).

Other Treatments

Behavioral therapy and AA are compared and contrasted in a 1994 article by McCrady, one of the leading investigators into Alcoholics Anonymous. McCrady examines the theoretical foundations, view of change process, and treatment practices of both methods. She points out that a first necessary environment for successful change, using any treatment, is a desire to stop drinking - which is exactly the expression of the main purpose of AA (p. 1160). Where AA and behavior therapy notably differ can be found in the attitude toward the prognostication: AA believes alcoholics have a progressive disease which cannot be cured, only arrested; by contrast, behaviorists believe alcoholism is a habit disorder that can be resolved. All other differences pale in

comparison to this one. McCrady concludes that theoretical integration of the two models is inappropriate (p. 1164).

Dramatic cognitive metachange is the central idea of understanding the alcoholism recovery process according to James White (1992). White argues that this enormous change amounts to a reversal of how the recovering person views alcohol itself, the world, self, and others. This in turn provides an opportunity for increased ability to entertain paradoxical thought, which he describes as the cognitive tendency to permit contradictory ideas to co-exist without resolution in conventional meaning (p. 23). White describes the importance of the ability to entertain paradoxical ideas as a necessary condition to a new spiritual attitude, which he holds as important, if not essential, for recovery (White, p. 31).

Brown, Peterson, and Cunningham (1988) tailored a cognitive-behavioral approach to spirituality in the treatment of alcohol and drug addiction. This research had as one of its major motives the bridging of the gulf between researchers, counselors, psychotherapists and AA, with particular emphasis on the spiritual aspects of the AA program. Ann Bristow-Braitman (1995) stresses a similar approach, focusing on cognitive-behavioral psychologists, by discussing spiritual constructs as used by AA. She argues that professionals best serve recovering clients through a willingness to integrate the spirituality of self-help programs with their knowledge of psychology and behavior (p. 414). Bristow-Braitman points out one shortcoming of this approach to educating professionals is that the nature of spirituality may be lost through attempting to relabel in a scientifically acceptable vocabulary (p. 414). Behavioral techniques, such as contracting and cognitive restructuring can be similar to affirmations and the ritual of 12-step programs, Bristow-Braitman says (p. 418).

Oei and Baldwin (1994) describe a two-process model of alcohol use and abuse which employs expectancy theory. They theorize that the need to drink is like a "compulsion toward closure", and provide a five step strategy to disrupt the automatic process of the alcohol abuser.

Co-treatments

This portion of the chapter will review treatments which have been successfully used in conjunction with AA. For example, one treatment which is inconsistent with AA treatment, and therefore not likely to be a co-treatment, is behavioral therapy. As Laundergan (1993) points out, studying AA from a behavioral treatment context does not seem to be productive because of the likelihood that most clients will not attend AA following behavioral therapy (p. 321). An earlier reference to the work of McCrady (1994) supports this position, despite the fact that there are many common treatments elements (p. 1165). What is of particular interest here, though, is that some subgroups of alcoholic clients may embrace the disease model, while others may respond to the behavioral perspective (p. 1166). This has implications in the search for a method of matching client to treatment.

On the other hand, Laundergan described a blending of behavioral science and AA which has produced the widely used Minnesota Model, wherein recovering alcoholics working their own 12-step program are utilized as counselors and co-members of a multidisciplinary treatment team (1993, p. 322). In this method, AA is woven into treatment in different ways: use of bibliotherapy, recitation of the Serenity Prayer, and group meetings where AA thinking and experience guides the discussion, or where specific AA group skills are practiced such as step groups, and where meetings follow the AA format. (p. 322.).

Psychoanalytic theory makes a meager contribution to the field of addictions, even from a co-treatment perspective, according to Morgenstern and Leeds (1993). Historically, according to the writers, psychoanalytic treatment was considered unsuitable for substance abusers who were considered to be patients with too little ego strength and too much acting-out defenses to profit from an insight-oriented therapy (p. 195).

However, modern psychoanalytic theorists who do encompass substance abuse disorders include those of Krystal, McDougall, Kohut, Kernberg, Khantzian, and Wurmser

for example. These theorists have common themes, such as the fact that substance abusers have special problems with affect tolerance and affect regulation, have difficulty maintaining narcissistic equilibrium, and describe drug and alcohol abuse as a substitute for "missing intrapsychic functions" (p. 195). The subtitle of the Morgenstern and Leeds article is "A Disorder in search of a Paradigm". A search of the literature seems to reflect that psychoanalysis is in search of a paradigm to fit the disorder. Morgenstern and Leeds say that insufficient attention has been paid to addiction (p. 205). John Chappel states that AA has been recognized as effective by psychoanalysts who are experienced in the addictions (1993).

Pharmacological treatments for alcoholism appear to be adjunctive to other treatment regimens such as AA (O'Malley, 1995). Antidipsotropic agents such as antabuse were the first drugs to be applied to alcoholism, and their purpose was to make the patient uncomfortable when they consume alcohol (p. S4). Naltrexone, a narcotic antagonist, has been recently approved for alcoholism treatment, and studies are encouraging, however the pharmacological system of treatment also requires a supportive therapy of some kind (p. S6).

MET (Motivational Enhancement Therapy) is a brief therapy treatment designed to mobilize the client's resources to change drinking behavior (O'Malley, 1995). The characteristics of MET that are distinctive are: providing feedback to the patient about risks of impairment; having the client accept responsibility for change; and providing clients with advice on how to achieve change (p. 54).

According to Nealon-Woods, Ferrari and Jason (1995), a recent form of alcoholism treatment is the Oxford House concept, a community- and peer-based approach to social support. Whether and why Oxford House residents choose to continue as AA members was the focus of their study. The results of the Nealon-Woods et al. study indicate that residents may be shifting from alcohol dependency to dependency on peers (p. 316).

Wheeler and Turner (1997) studied counselor's attitudes and experiences in working with alcoholics, as well as counselor's understanding of AA as a treatment. It was found that generic counselors tended not to feel competent working with patients with alcohol problems. As experience with client groups increased so did feelings of competence. This pattern continued, although to a lesser extent, with additional specialist training (p. 321). Wheeler and Turner also found that counselors who consumed more than eight units of alcohol per week were less likely to accept as clients those with alcohol problems when compared to counselors who drank less. Knowledge of Alcoholics Anonymous was measured by asking the subjects (n = 91) what they knew about AA. 71% of counselors thought that AA attendance could be successfully combined with therapy. Wheeler and Turner conclude that counselors would benefit from a greater depth of understanding about the AA program (p. 324). They recommend more course content in alcohol counseling in professional training courses (p. 325).

Le, Ingvarson, and Page, on the other hand, propose revamping the 12-steps of AA to conform more closely to counseling theory, and the resulting steps are then contrasted with the AA steps (1995). Le et al. claim as their motivation to "stimulate constructive thought and discussion" (p. 604). In this article, certain counseling models were selected to compare to the AA steps. Theoretical models included were Rogers, Maslow, Jung, Horney, Frankl, Perls, Hefferline, Goodman, Ellis, and Bandura, thus encompassing a variety of counseling theories and therapies (p. 604). Le et al. claim that "counseling theories and AA principles have become enmeshed and roles have grown confused", and conclude with the comment that to both client and counselor the treatment choice should be an individual one (p. 607) .

Humphreys (1993) takes a different approach from that of Le, et al. While acknowledging there are differences in philosophy, Humphreys advocates an attitude of *"Vive la difference!"* (p. 211). He points out that some basic differences make it impossible to reconcile the two philosophies and values without one or both of them

compromising, and suggests an approach between 12-step philosophy and psychotherapy based on mutual respect, independent control, and cooperation (p. 207). Making the distinction, Humphreys defines helping strategies as techniques a helper employs to facilitate a desired outcome, while helping values are more abstract and existential in nature. Humphreys argues that the strategies of 12-step programs can be integrated into psychotherapy without any loss of integrity, 12-step helping values cannot be so integrated (p. 208). Delineating a philosophical difference, Humphreys says that psychotherapy diminishes certain aspects of the ego, 12-step philosophy holds that substance abuse is an "egotistical delusion and should be strongly challenged" (p. 209). Making another distinction, Humphreys says that professional knowledge is based on university training, is analytical, and is grounded in scientific principles, while by contrast experiential knowledge is a reflection of one's personal experience of living through a problem (p. 210).

Riordan and Walsh (1994) also write on the subject of referral guidlelines for professionals. They cite labeling as one of the more prominent sources of philosophical differences which should be considered by helpers. Referring to the AA norm of introducing oneself as an "alcoholic", Riordan and Walsh point out that this practice can be stigmatizing. They go on to inform counselors that other language is available to AA members which does not violate the norm, and still provides the experience of relief, dignity and belonging. Such an example is to introduce oneself as a person who has "a desire to stop drinking" as opposed to "an alcoholic" (p. 352). Riordan and Walsh suggest that counselors attend a wide variety of open meetings to experience the diversity of groups and individuals members (p. 354).

Brandsma and Pattison make the point that group psychotherapy seems to be as effective, and is obviously more efficient than, individual psychotherapy (1985).

Research on AA Members

This section of the chapter will review the literature on research on AA members themselves, which is the thrust of this thesis. In one inquiry into AA members, Snow, Prochaska & Rossi (1994) focused on the process of change. A 66 item questionnaire was used to measure behavioral and cognitive change as well as self-efficacy (p. 364). Subjects (n = 191) were grouped on the basis of: (1) exposure to AA (never, past, current); (2) extent of involvement, as measured by current meeting attendance (low, medium, high); and (3) level of affiliation as measured by a composite of three qualitative indices related to an individual's AA experience (p. 365).

In this study, people who have changed on their own without AA assistance scored lower on problem severity than did AA members, although the results only "approached significance" (p. 368). However, AA was found to be more readily available, requiring less resources, and is more structured than is reliance on self-change by the individual (p. 370).

One sampling of a narrative inquiry into AA members was unique study conducted by Washburn, who chronicled the AA culture through the eyes of six older members (1995). She compares their experiences with the theories of Erikson and Kegan, and concludes that AA is valuable for its support of "each person's worth and dignity" (p. 201). Another example of this approach is an article in Alcohol Treatment Quarterly by Father O'Murchu (1996), in which the author considers the relationship between spiritual growth and recovery from addictive behavior, and finds them to be similar processes.

The major findings in research on AA members by Carroll was that the extent of practice of Step 11 correlates positively with both length of sobriety and the measure of purpose in life (1993). Step 11 is: *Sought through prayer and meditation to improve our conscious contact with God,* as we understood him, *praying only for knowledge of His will for us and the power to carry that out* (AA, p. 59). Carroll concludes that "what it is about AA that works so well could certainly contribute to an understanding of the process of recovery from the disease of alcoholism" p. 300).

Two self-help groups, AA and Rational Recovery, were examined in research by Reinert, Estadt, Fenzel, Allen and Gilroy (1995). Two AA groups were selected on the basis of involvement with AA, and compared with a group of Rational Recovery (RR) members to determine whether the AA-High Involvement group could be distinguished from the other two on a measure of "surrender". The results of this research suggest that there is more to the act of surrender than level of involvement, length of sobriety, or degree of dependence on alcohol (p. 49). It was found that the AA-High Involvement population could be distinguished from the other groups.

Montgomery, Miller and Tonigan found that AA attenders were not different from nonattenders when compared by pretreatment characteristics (1994). Further, they found that posttreatment attendance at AA meetings was not predictive of drinking outcomes. On the other hand, the higher the degree of involvement with AA the better were predicted outcomes (p. 241). Montgomery et al. noted that their research was conducted in a residential treatment program "for which AA was a strong guiding philosophy", as opposed to AA itself (p. 244). Montgomery et al. concluded that those who study AA based on outcomes should not only limit themselves to measuring attendance at meetings, but also the extent to which individuals are applying the 12 steps of AA (p. 245).

In a meta-analysis of the literature on 74 AA studies, Tonigan, Toscova and Miller concluded that AA experiences and outcomes are heterogeneous, and that it is probably futile to look for omnibus profiles of AA affiliates or outcomes (1996). The researchers urge that more comprehensive demographic data be gathered in future studies, as well as prior exposure and posttreatment participation (p. 69).

Hoffmann & Miller (1992) analyzed treatment outcome studies of inpatients and outpatients in an example of an evaluation study. This type of study can assist in the search for more effective client-treatment matching research, and in fact this study suggests clinical innovations to improve treatment effectiveness and demonstrate cost

effectiveness (p. 407). Some advantages of evaluation inquiry, and disadvantages of naturalistic studies such as limited generalizability and sample bias, are advocated (p. 408).

Few studies have looked at when, in relation to symptom occurrence, treatment is sought. Bucholz, Homan and Helzer (1992) undertook such a study using data from a sample of alcoholics identified from medical records. In a structured psychiatric interview, subjects were asked when they first discussed their drinking problems with a health professional. As a concurrent component of the research, comparisons were also made of this data to determine any differences in race or gender (p. 583). Bucholz et al. found that the proportion of those who acknowledged themselves as alcoholic differed significantly according to whether they had ever discussed the matter with a health professional (p. 584). In this study there was evidence that AA attendance was ranked lower by alcoholics than was contact with a health professional, a situation which Bucholz et al. propose may be the result of only one pathway to AA, that from professional referrals (p. 588). It should be pointed out that this was a retrospective study, subject to the limitations of poor recall and underreporting, and that the subjects were all survivors (p. 589).

In a 1996 study by Verinis, two groups were compared to test the effectiveness of orientation-to-treatment. One group of patients watched a video which demonstrated the AA style of therapy (i. e. self-disclosure, listening to feedback, etc.), the other group did not (p. 1428). The groups were demographically similar (p. 1429). Visits to the clinic in the month following discharge were recorded, and the results compared. The orientation-to-treatment method was found to be an effective, cost-efficient way to increase the likelihood that an alcoholic would follow through with treatment (p. 1430).

Isolating significant demographics was the subject of 1992 research by Emener and Dickman. Of particular interest was the make up of gender and age of members of AA (N = 229). The method called for nine in-recovery volunteers to attend AA meetings and request members to complete a questionnaire. The findings were presented to be

consistent with other research, specifically on age and gender, but were not comparable to other studies on race (white males were under-represented) (p. 4).

In the AA method, sponsorship is an integral component of recovery from alcoholism, according to Brown (1995). Brown also points out that the AA program has two independent parts, neither of which has therapeutic power without the other. The first of these two parts is the introduction to the program, including the literature, meetings and AA fellowship, which has as its purpose the achievement of sobriety. The second part involves working the steps and has as its purpose the achievement of recovery (p. 69). According to Brown, sponsorship is the bridge between sobriety and recovery, and therefore has the power of success or failure, and "the sponsor represents the closest counterpart to the therapist" (p. 70). He emphasizes that AA literature is clear that sponsor-sponsee should be the same sex, although this is an accepted belief or suggestion rather than a rigid rule (p. 77). For Brown, distinguishing between sobriety and recovery in the use of the AA program is important, as is the selection of a sponsor (p. 79).

The importance of having a sponsor was the subject of a survey by Nealon-Woods, Ferrari and Jason (1995). 88% of AA members felt that they had personally benefited from working with a sponsor. According to the most recent AA Member Survey (1996), 76% of members have a sponsor, and two thirds of those obtained a sponsor within 90 days of coming to the program (AAWS, 1996).

Other groups which use AA as their model have proliferated since the first one, Al-Anon, was started to address problems unique to the family of AA members in 1951 (Room & Greenfield, 1993). According to a 1990 interview survey (N = 2,058), 13.3% of the adult population of the U.S. have attended some form of 12-step meeting, whether alcohol-related or not (p. 555). Room and Greenfield make a long list of groups, with diverse purposes, which model their meeting format to some extent or other on the basis of AA. The broad list list ranges from Debtors Anonymous to Workaholics Anonymous, including a program for narcotics addicts, cigarette smokers, overeaters, etc. (p. 556).

Despite this proliferation, AA still accounts for the majority of 12-step attendance (p. 561). Johnson and Chappel (1994) claim that more than 150 parallel groups have sprung from the AA model. Research by Room and Greenfield (1993) shows that 9 % of the adult U.S. population have attended at least one AA meeting at some time, and 3.6% have done so in the past year. Room and Greenfield conclude with the argument that the growth of the movement outward from AA is part of a process which may restore alcohol issues to the prominent position they held in American history in the century before 1930 (p. 561).

The "Big Book" of AA itself makes the following claim, although it is without scientific substantiation:

> of alcoholics who came to AA and really tried, 50% got sober at once and remained that way; 35% sobered up after some relapses, and among the remainder, those who stayed on with AA showed improvement. Other thousands came to a few AA meetings and at first decided they didn't want the program. But great numbers of these - about two out of three - began to return as time passed (p. xx).

The Client-Matching Treatment Strategy

Galaif and Sussman devised a list of characteristics of people not likely to be helped by AA. These included those who are uncomfortable in large crowds or intimate meetings; those who are not religious; those who are members of minorities (including women); those who do not fit AA's definition of alcoholism; and those with dual addictions (1995, p. 173). They make the point that certain clients are good matches for specific treatments, or for specific treatments at specific phases in planned treatment (p. 180).

Investigating predictors of participation in aftercare treatment following intensive outpatient rehabilitation program (IOP), McKay, McLellan, Alterman, Cacciola, Rutherford, and Obrien (1998) found relationship between after treatment participation and more severe substance abuse histories. Generalizability of the findings was limited, however, because the subjects were all male veterans, most of whom were black and of lower socio-economic background (p. 159). This inquiry was not the test of a model, but

of several models of health care, specifically examining the retention of patients in the aftercare phase of outpatient rehabilitation, which is held to be an increasingly common form of treatment for alcohol abuse (p. 160).

Bristow-Braitman (1995) makes the point that when counseling an individual on an outpatient basis, it is imperative to assess the need for a broader based support system, and she asks "if not a step program then what?". Along these lines, Johnson and Chappel (1994) claim that, "AA is more important over the long term than professional treatment".

Whitfield, Davis, and Barker suggest that persons who are diagnosed as alcoholic should be given a "recommendation / prescription of attendance at 12-step meetings". They have formulated a list of 12 recommendations to alcoholic patients, which includes, besides attending one AA meeting per day for three months, getting involved with AA, talking to members before and after meetings, working the steps, etc. In addition, Whitfield et al. suggest that professionals provide considerable background information about AA to clients, thus alleviating anxieties (p. 141).

Le, Ingvarson and Page (1995) suggest that counselors be aware not only of the differences between counseling philosophies and AA, but also of those between AA groups themselves, for these can vary widely. Le et al. suggest that counselors attend open AA meetings to become familiar with groups in their community so that they can be better prepared to match groups to client needs. On the other hand, Margaret Bean-Bayog (1993) cautions that, "while helpful, this (AA attendance by counselors) may also be misleading: having someone throw a life preserver feels very different to someone standing on dry land than it does to the drowning swimmer".

Walsh, Hingson, Merrigan and Levenson (1992) describe the process of assessment and referral as a "black box", and say the treatment decision has been left largely for counselors to determine. Yet the research is unclear about answers. To study this problem, Walsh et al. randomly assigned newly identified alcohol abusers, taken from a population of 10,000 workers in a large manufacturing facility, to three alternative

alcoholism treatment regimens. The first treatment was the employee assistant plan system which had been in place for years and involved approximately three weeks of inpatient care. The second treatment mandated that employees attend AA meetings, and the third alternative offered choice among treatments including outpatient psychotherapy and no treatment at all (p. 142). In the course of the 5 year plus study, 227 subjects were assigned to these variables. The findings were that inpatients had the highest abstinence rates, while those assigned to AA had the lowest (p. 144). It is noteworthy that all treatments included AA as an integral component, and mandated AA has been found to be a bias against AA assessment (see Kurtz, 1994).

In a 1994 study, Tonigan and Hiller-Sturmhofel examined two questions: Who does well in AA? and, Why do they succeed? To find out, they examined 16 research studies conducted on AA involvement. Most found AA involvement as only a modest predictor of reduced alcohol consumption.

Research by Vaillant (1983) has shown that 7% of good clinical outcome is attributable to "stable adjustment, married, employed, never detoxified", but 28% of the variance to AA attendance of 300 meetings or more. Vaillant considered it prudent to refer all alcoholics to AA except those with significant psychopathology, which is similar to the findings of Project MATCH (1996).

Project MATCH is described as "the largest, statistically most powerful, psychotherapy trial ever conducted" (Project MATCH Research Group). In this project, subjects (N = 1,726), taken from two different populations (outpatients and aftercare patients) were randomly assigned to three treatment methodologies: Cognitive-Behavioral Therapy (CBT), Motivational Enhancement Therapy (MET), and Twelve-Step Facilitation Therapy (TSF). CBT and MET have been described earlier. The TSF Therapy was spiritually based, and had as its objective a fostering of acceptance of the disease of alcoholism, encouraging commitment to participate in the AA program, and beginning to work the 12 steps, (p. 13). Nowinski (1996) elaborates on this therapy by describing it as

"philosophically and pragmatically compatible with the 12 steps of AA" (p. 39). Nonetheless, the Project MATCH Research Group emphasize that TSF is individually delivered, and in this respect departs sharply from the AA program (p. 24). On the basis of the foregoing description, Project MATCH claims to be "the first demonstration in a randomized clinical trial, controlling for other treatment factors, of comparable outcomes from a 12-step-based approach and other treatment methods" (p. 24).

The first phase of Project MATCH, with the comparison of the three treatments listed earlier, had the following conclusions:

> The findings suggest that psychiatric severity should be considered when assigning clients to outpatient therapies. The lack of other robust matching effects suggests that, aside from psychiatric severity, *providers need not take these client characteristics into account when triaging clients to one or the other of these three individually delivered treatment approaches*, despite their different treatment philosophies (emphasis added) (p. 7).

The recent emphasis on the need for research on client matching has been supported by a call for additional counselor education and training. For example, Taleff and Swisher (1977) call for increased educational requirements for Masters degree level counselors including seven core functions, which includes (3) matching clients to selected treatments with precision (p. 7). They delineate the other core functions as (1) develop a proficiency to understand research and apply research findings; (2) develop a comprehensive client-assessment competency; (4) evaluate AOD (alcohol and other drug) treatment and program effectiveness; (5) conduct supervision in all aspects of AOD treatment; (6) provide leadership in all aspects of AOD treatment; and (7) develop a personal ethical code based on the integration of self-knowledge, professional skills, and professional growth (pp. 7-12). Taleff and Swisher cite the need for such additional professional training as increasing requirements to meet counselor specialty licensing by various government agencies (p. 9). They define patient-matching as choosing from among available alternatives the treatment that is most likely to facilitate a positive

outcome in a particular individual. Pointing out that patient-matching is not new to AOD, they say it is becoming a necessity because of increasingly competitive and financed field. In addition, previously matching was directed mostly by subjective judgment, leading to implicit bias (p. 8).

CHAPTER 3

METHODOLOGY

Several researchers have noted the difficulty of applying ideal research methodologies and procedures in the field of alcoholism (Miller & Kurtz, 1994; Nowinski, 1993) One difficulty is in locating subjects (Tonigan & Hiller-Sturmhofel, 1994; Page, 1986; Royce, 1989). Another lies in the ethical considerations and essentiality of maintaining anonymity (McMcrady, 1993; Bradley, 1988). The results of these difficulties and limitations can be understandable limitations of the generalizability of data (Emener & Dickman, 1992).

Based on reviews of the literature, this study employed a 23-item questionnaire designed by the researcher (see Appendix A). All respondents were self-described members of Alcoholics Anonymous, and all were resident in British Columbia. The questionnaire focused on knowledge about the program of Alcoholics Anonymous (AA) and belief in its efficacy. It also asked about other treatments, frequency of meeting attendance, adherence to AA suggestions about sponsorship and home meetings, likes and dislikes about AA, step difficulty, demographic information, and provided room for other comments. Ten questions were multiple choice, six were yes or no, and four were fill-in-the-blanks. Three questions were open-ended because of their usefulness in an otherwise quantitative study (Glesne & Webb, 1993). The questionnaire was pilot tested on three occasions before the final form was adopted.

Respondents

A total of 113 respondents were obtained by attending closed meetings of AA (the researcher qualifies as a member of AA) as well as an AA Roundup (a convention-like gathering of alcoholics) and asking attendees to complete the questionnaire. Twenty three such meetings and one Roundup were attended for such purpose.

Initially, the researcher briefly mentioned this research when "other announcements from the floor" were called for by the chairperson of the meeting being attended. It should

be noted that some discretion needs to be employed in approaching members of AA (hereafter referred to as AAs). AAs have traditions which should be respected, and the researcher was aware of possible sensitivity. For example, one of the 12 Traditions of the program (see Appendix D) is Tradition Ten: *Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy* (1955, Alcoholics Anonymous, p. 564). During the research, this tradition was cited on four different occasions as one reason why research should not be mentioned in meetings. In addition, "The Preamble" (see Appendix E) is read aloud at the beginning of almost every meeting. In part, this requests that members confine their comments to "matters relating to alcoholism". The matter of anonymity is likely a much more sensitive subject among AAs than other populations. Thus the mention of research, however briefly made, and in spite of the fact that AA and alcoholism is the subject of the inquiry, was objected to by some attendees.

For these reasons, at a point approximately half way through the data gathering, the announcement from the floor was discontinued and subjects were solicited only prior to and immediately following meetings. When agreement was forthcoming, a pen and the questionnaire and consent form were provided. The researcher waited while the participants completed the forms. Because many AAs claimed time constraints, after the twelfth meeting a stamped, addressed envelope was provided to participants, including those at the AA Roundup, held in Kamloops, B. C. More than half (58%) of all responses were obtained by mail. Of the 65 stamped envelopes provided to AA participants, 59 were received, yielding a response rate of 90.8%.

Instrument

A search of the literature reveals that, although questionnaires have been employed in researching AA and its members, none of these earlier questionnaires had examined the possible relationship between knowledge of the program and belief in its efficacy. Because that is one of the major research questions of this thesis, a questionnaire was designed and

subsequently tested. Some of the traditional recommendations for designing a questionnaire, and also for ensuring a high response rate, such as precontacting samples, writing cover letters, and following up with nonrespondents (Gall, Borg & Gall, 1996), were not possible to implement in this study because all of the participants were anonymous.

Pilot Study

For purposes of assessing armchair validity and internal consistency, the questionnaire was reviewed and edited three times. The initial version of the questionnaire was administered to a class of 24 Masters level students at University of Victoria. As a result of their responses and suggestions, and as a consequence of the low scores obtained on the knowledge section, certain modifications were made. A second version was carried out with eight Masters level students of the Counselling program at UVic. Again, in spite of the modifications, the knowledge section of the questionnaire yielded results little different from chance, and furthermore, many questions were answered "don't know." A third version was administered to three members of AA and three Counselling students, and as a result of this pilot version, the decision was made to proceed with the questions as they were.

Mention should be made here about the questions designed to measure "knowledge of the AA program". There were five such questions, each of them intended to measure knowledge of different aspects of AA, including its main purpose, one of its steps (see Appendix B), its group policy, one of its traditions, and the cost of membership. It was known from the results of the pilot questionnaires that the general academic population yielded correct answers little different from chance. It was also known that these same questions, when asked of members of AA, would probably result in very high scores. When this became apparent from the pilot studies, it was concluded that knowledge about AA can be considered an esoteric subject, that is: well-known to few and little known to others, in spite of the fact that as Chappel records (1993), "there is no

dogma, theology or creed to learn" in the AA program. The questions in the final survey form were retained in spite of, perhaps even because of, the esoteric nature of the subject. It should also be noted that, because of the marked contrast in correct knowledge answers between members of AA and non-AAs in the second pilot study, it was decided to "seed" the final questionnaire with plausible or cliché-like answer choices so that the correct answers would not necessarily be a foregone conclusion in every case. As the results will demonstrate, except for Question 2, the only responses recorded were either the correct answers or the seeded ones.

It was obvious before the study was launched that even those respondents who have been members of AA for the least period reportable on the questionnaire (less than one year) would score at or near perfect on the knowledge questions. It was also known that members of the general population would score only slightly better than chance. Yet no other questions occurred to the researcher which would adequately reflect knowledge about the AA program without resorting to questions of a highly specialized nature, such as on the history of AA, which would probably not measure what it was intended to measure. In summary, the questions which were intended to measure knowledge of AA are generally widely known to AA members, yet little known to non-members. There is a sharp, almost binary distinction between the two populations on this subject.

The balance of the questionnaire related in some way to belief in the effectiveness of the program. More details will be provided in the Results and Discussion sections of this thesis, however it is noteworthy that attitudes and beliefs about the AA program reflect a less pronounced, but nonetheless still present, esoteric flavor.

In all cases, AA literature is the absolute authority as to the correctness of answers to the questions.

CHAPTER 4

Results

This chapter will present the results of the survey (for example, Emener & Dickman, 1992; Room & Greenfield, 1993). The chapter following will discuss conclusions with respect to each of the research questions.

Data from the questionnaire were coded and analyzed using appropriate calculations. Frequencies, percentages and measures of central tendency were computed and displayed in tabular form. Only two demographic classifications were asked for in the survey (age and sex), and where the literature review suggests it is appropriate, the data are analyzed and presented comparing responses from these categories.

Knowledge of the AA Program

The following five tables represent the responses to Questions One through Five, which measured Knowledge of the AA Program.

TABLE 1:

Responses to Question 1 (N = 113)

(1) Which of the following is one of the 12 steps of AA?	Respondents n	%
Counted nothing but thoroughness and honesty about others.	0	0
Vowed that we would never again drink alcohol.	0	0
Made a searching and fearless moral inventory of ourselves.	112	99.1
Stood at the turning point.	1	.9
Don't know.	0	0

The correct response to this question is answer 3, "Made a searching and fearless moral inventory of ourselves", which is Step 4 of the Alcoholics Anonymous program

(AA, 1976, p. 59). **99.1%** (112 out of 113) of respondents correctly identified this answer, and only one of the 113 surveyed selected an incorrect answer, in this case selecting response number 4, "Stood at the turning point". This is not a step, however the phrase does occur in "How it Works", which is read aloud at some point in virtually every AA meeting (AA, pp. 58-60). Answer number 4 was the "seeded" answer to this question, as described in Chapter 3.

TABLE 2:

Responses to Question 2 (N = 113)

(2) What does AA charge its membership?	Respondents n	%
The present charge is $5 per week.	0	0
There are no dues or fees	111	98.2
There are no dues, but fees can cost up to $5 per hour	0	0
There are no fees, but dues are charged at $5 per month	0	0
Don't know	2	1.8

The correct answer to this question is the second choice, "there are no dues or fees" (This is AA, 1984). **98.2%** (111 of 113) answered the question correctly. Two participants answered *"don't know"*, neither of whom were in the category of the least reportable period of sobriety (less than one year). A plausible interpretation of the "don't knows" is that, by virtue of the implications of the choice of answers, the respondents may have thought that there was the possibility of some nominal charge for dues and / or fees of which they were not aware.

TABLE 3:

Responses to Question 3 (N = 113)

(3) What is stated as the primary purpose of AA?	Respondents n	%
To "stay sober and help other alcoholics to achieve sobriety".	107	94.7
To live life "one day at a time".	6	5.3
To "provide meeting facilities wherever they may be required".	0	0
To "assist in the diagnosis of alcoholism".	0	0
Don't know	0	0

The primary purpose of AA is stated in AA's Preamble, just as in the previous question (This is AA, 1984). **94.7%** (107 of 113) answered correctly. Of all of the Knowledge Questions, this one attracted the most wrong answers when six of the respondents (5.3%) chose the "seeded" response (*to live life "one day at a time"*). Whereas living life one day at a time is a well known philosophy of AA, one which has become a cliché to the general public, it is not the primary purpose of AA.

TABLE 4:

Responses to Question 4 (N = 113)

(4) AA utilizes a group format and states that:	Respondents n	%
Each group should be defined as four or more members	0	0
Each group should follow certain procedures	0	0
Each group should be chaired by an AA member	1	.9
Each group should be autonomous	112	99.1
Don't know	0	0

This question, like Question 1, attracted **99.1%** to the correct answer: "each group should be autonomous (except in matters affecting other groups or AA as a whole"), which is taken from Tradition Four (AA, 1976, p. 564). Only one person selected the wrong answer, a female in her first year of sobriety, and who rated herself as having the least knowledge on a five point scale. It should be noted that all of the answers *except* the right answer make more intuitive sense, in the absence of actual knowledge of AA's Traditions. It should also be pointed out that at most AA meetings these words are read aloud as part of the Preamble., which tends to explain the number of correct choices.

TABLE 5:

Responses to Question 5 (N = 113)

(5) Closed meetings are intended only for those:

	Respondents n	%
In the immediate family of alcoholics	0	0
Who are family or friends of alcoholics	0	0
With a desire to stop drinking	107	95.6
With a "substance abuse" or "chemical dependency" problem	5	4.4
Don't know	0	0

One of the answer choices to this question attracted the second most wrong answers in the measure of the Knowledge Questions (see Question 3). Four respondents (4.4%) selected the "seeded" answer ("with a 'substance abuse' or 'chemical dependency' problem), which was deliberately planted because it touches on an issue current in AA today, as it has been almost from the founding of organization. That subject is "dual" or "cross" addictions - more specifically, drug addictions. This subject will be dealt with in Chapter 5: Conclusions.

TABLE 6:

Self-perceived knowledge of the AA program

(6) How would you rate your knowledge *of the program of Alcoholics Anonymous?*

	Respondents	
	n	%
Quite knowledgeable	33	29.2
Somewhat knowledgeable	39	34.5
Know about an average amount	34	30.1
Know less than most AA members do	5	4.4
Have very little knowledge of the subject	2	1.8

The results of Question 6 may reflect a certain amount of modesty, given that this question followed on the heels of the first five questions, which were easily dealt with by the vast majority of respondents. Intuitively, it should be the case that the longer one attends meetings of an organization, the more one would acquire knowledge about it. A further discussion of the relationship between Questions 6 and 8 follows Question 8.

TABLE 7:

Ratings of alcoholism treatments (N = 113)

(7) Which of the following do you believe *is the most effective treatment for alcoholism?*

	Respondents	
Type of Treatment	n	%
Professional counseling	0	0
Membership in AA	52	46.0
Treatment by a family doctor	0	0
Combination 1 & 2	38	33.6
Combination 1, 2 & 3	16	14.2
Combination 2 & 3	3	2.6
Combination 1, 2 & other	3	2.6
Combination 1, 2, 3, & other	1	.9
No opinion	0	0

Note: 1 = professional counseling, 2 = AA membership, 3 = family doctor

This survey question asks for subjective opinions about the one most effective treatment for alcoholism. The results demonstrate that almost half of the AAs surveyed **(46%)** felt that AA alone is the most effective. The next highest percentage, one third **(33.6%)**, felt that a combination of AA and professional counseling is most effective. **14.2%** say combination of three treatments, including counseling, AA, and family doctor are the most effective. The remaining combinations are almost equally distributed between AA and family doctor; professional counseling, AA and other (pharmacology, spiritual training).

One major implication of these results is that, when AA members themselves were polled, more than half of them believed that *more than AA is required* in an effective

treatment against alcoholism. This should add to the knowledge in the search for a treatment protocol such as the one Project MATCH is undertaking. For if AA members say AA is not enough in itself, and AA is held to be the most effective treatment, as the literature review reveals, then it would appear that one of the treatment options should include two or more therapies. Another observation is that every respondent contributed an answer.

Question 7 will be dealt with in further detail in Chapter 5, when the results of a similar questionnaire item, Question 10, are reviewed and compared.

TABLE 8:

Duration of continuous sobriety (N = 113)

(8) How long have you been continuously sober?

	Respondents	
	n	%
Less than one year	24	21.2
One to five years	44	38.9
Five to 10 years	14	12.4
10 to 20 years	17	15.0
More than 20 years	14	12.4

This study reflects the findings in the literature that there is high attrition rate in AA. Although one to five years is the mode, with **38.9%** of the respondents, the next highest category, at **21.2%** of the population sampled, is the "less than one year", which represents a period of time less than one-fifth of the dominant category. In the same fashion, there are **12.4%** in the 5 year period 5-10 years, but only **15%** for 10-20 years, which is twice the span of time. Similarly, the last category of more than 20 years holds **12%** of the respondents, and to the knowledge of the researcher, this includes at least two

subjects who had achieved 35 years of continuous sobriety, making this category 15 years long.

Notwithstanding the attrition, in the medical model which dominates the research today, the five, and 10, and 20, and 35 years of remission from what is considered a fatal malady represents a noteworthy treatment.

TABLE 9:

Frequency of meeting attendance

(9) Approximately how often do you attend AA meetings?

	Respondents	
	n	%
Less than 5 times per year	0	0
Between 6 and 10 times per year	6	5.3
Approximately once a month	1	.9
Between once a week and a month	30	26.5
More than once a week	76	67.3

This question was designed to record frequency of participation in meetings, which is a measure of involvement according to the literature review. The most recent AA Membership Survey reported that members attend an average of two AA meetings per week (AA, 1996). These findings do not necessarily vary from AA's survey, however the answer choices differed in that the AA version provided a write-in answer. Either way or both, the vast majority of respondents set aside time each week to attend AA meetings.

TABLE 10:

Ranking of types of treatment

(10) Please rank order your opinion *of each of the following treatments for alcoholism on a scale of 1 to 4, with 4 as most effective and 1 least effective. Please use each number once only.*

	Ranking				
	4	3	2	1	**Totals**
Professional counseling	12	44	37	9	**102**
Membership in AA	101	3	0	5	**109**
Treatment by family doctor	1	14	37	39	**91**
Other (please specify)	3	17	3	3	**26**
Totals	**117**	**78**	**77**	**56**	**228**
No opinion	-	-	-	-	4

As it turned out, in spite of the pilot testing, this question was worded poorly. "Other" did not necessarily specify a treatment ranking. Some subjects may have interpreted the rank ordering from 1 to 4 as requiring all four rankings, whether a treatment was specified or not. The question may also have been overly confusing, with the result that some participants may have ranked in reverse order to what they intended. The data is reported as recorded, without any interpretation of intent other than these comments.

Despite the ambiguity of the question, which somehow survived the testing procedure in its final form, the data taken together at face value still render useful collective comment. For example, 101 of all subjects (**86.3%**), including those with no opinion, rank AA as the most effective alcoholism treatment. The second most effective was considered to be professional counseling (**10.3%**), which was the most common second-ranked treatment with **56%** of all such rankings. These results mirror the results of Question 7, which is similar.

TABLE 11:

Respondents with a home group

(11) Do you have a "home" group?

	Total		Males		Females	
	n	%	n	%	n	%
Yes	97	85.8	62	86.1	35	85.4
No	16	14.2	10	13.9	6	14.6

All respondents answered this question, with the vast majority (**85.8%**) responding that they did have a home group. This is one of the most emphasized recommendations of the AA program, both officially in AA literature, and at the level of meetings. For this reason, it is one of this study's criteria of compliance with the program. These findings parallel those of the AA Membership Survey, which found 86% of members belong to a home group. There is virtually no difference between male and female members on this question.

TABLE 12:

Respondents with a sponsor

(12) Do you have a sponsor?

	Total		Males		Females	
	n	%	n	%	n	%
Yes	8	77.9	57	79.2	31	75.6
No	25	22.1	15	20.8	10	24.4

Again, all respondents replied, with more than 3 out of four reporting that they have a sponsor. Acquiring a sponsor, like having a home meeting, is also highly recommended in AA literature and is urged at the practical level at meetings. This question also contributes to the degree of compliance to be found in this sampling of AA members. Once again there is little difference between male and female reporting on this

subject. The "yes" responses to this question are little different from the comparable question in the 1996 AA Survey (**77.9%** vs. AA's 76%). Again, male and female responses are similar.

TABLE 13:

Respondents who consider self to be alcoholic

(13) Do you consider yourself to be an alcoholic?

	Respondents	
	n	%
Yes	113	100
No	0	0
Sometimes	0	0

This question also served to contribute to the measure of compliance with the AA program. It is the position of AA that "once an alcoholic, always an alcoholic". The insertion of the alternative "sometimes" was intended to capture those in the program who did not necessarily subscribe to this position. As the results show, however, **100%** of the respondents adhere to the AA policy. There is little or no room for any other interpretation of the data from this sampling population than that they represent a universal endorsement, and acceptance of, the AA position that alcoholism is a lifetime affliction..

TABLE 14:

Respondents' likes about AA

(14) What do you like most about AA?

Sex	Social Aspects %*	Functional Aspects %**
Male	64	36
Female	70	30

Note: *Social aspects and functional aspects fell into readily distinguishable characteristics. Social aspects include "the fellowship" (most frequently mentioned, "the meetings", "the people", "sharing and caring", "acceptance", "tolerance", "absence of judgment", "support", "understanding", "honesty", "humor", "safety", "sense of hope", and "problems in common".

**Functional aspects are characterized by process and results, such as: "the steps", "the traditions", "it works", "the philosophy", "the wisdom", "sobriety", "main purpose", "universality" (AA is the same everywhere).

The types of comments by sex fell into similar patterns, with 64% of males and 70% of females writing in social comments. 36% of males and 30% of females made comments which fell into the functional category. All respondents made some comment in this question.

TABLE 15:

Respondents' dislikes about AA

(15) What do you dislike most about AA?

	Males	Females
No opinion	22	15
No dislikes	17	10
Smoking	14	10
Coffee	9	6
Gossip /cliques	6	9
Opinionated people	4	1
Bad language	2	2
Attitude to dual addicts	2	0

One third of respondents (**32.7%**) had no opinion on this question. Another one quarter (**23.9%**) said they had no dislikes. As a result, a total of **56.6%** offered no negative comments about the AA program.

Of the remainder who had complaints (some listed more than one), smoking at meetings topped the list. This is somewhat surprising because the vast majority of meetings listed in the Greater Victoria area are non-smoking. Of the twenty-four functions attended in this research, only one such meeting allowed smoking. This complaint was approximately evenly divided among the sexes.

"The coffee" was the next most frequently mentioned complaint. This researcher observed some occasions when meeting attendees brought thermal cups, and even paper cups of coffee from specialty shops. Once again, the gender split on this subject was approximately equal.

The next most frequently mentioned dislike was "Gossip" and "Cliques". These were combined here because of the context in which they were listed; so that to paraphrase the entries, what was disliked here were knots of people who also gossiped. In this category, females actually outnumbered men almost two to one, reversing the actual make up of the sexes (two to one for males). This may reflect a sociological factor at work.

"Opinionated people", "know-it-alls", "people who have all the answers" were grouped together to form the next most representative complaint about AA, with five mentions. This was followed by four objections to bad language, which was equally divided among the participants. The "attitude toward dual addicts" was mentioned twice. This issue was addressed earlier and will be raised again in the Discussion chapter.

The most significant finding was that more than half the respondents entered no objection to AA when asked. The majority of the balance, those who found fault with AA, named items which were environmental and avoidable (smoking), or for which a compensation could be made (bring own coffee). Those remaining listed complaints which could probably be found in any situation in which groups of people meet.

The main points about both of the last two questions is that they provide feedback, from those in recovery, about the treatment delivery package. These results could be analyzed to determine what works best and what does not work in a treatment protocol; it is direct feedback from the client. Together with an analysis of which steps are difficult, and which are easy, these answers and any that might result from similar research, can point the way to an improved program, whether that of AA or another treatment

TABLE 16:

Respondents choices of "simple" step

(16) Which step, if any, have you found to be the simplest to understand?

	Respondents	
Step	n	%
Step 1	81	71.7
Step 2	4	3.5
Step 4	1	.9
Step 5	2	1.8
Step 10	3	2.7
Step 12	1	.9
No opinion	21	18.6

The AA steps are reproduced in Appendix C. These results clearly demonstrate that this sampling of members of Alcoholics Anonymous considers Step 1 the simplest to understand (**72%** of all respondents, and **88%** of all those with an opinion) The five other steps mentioned, with frequency in parentheses, are Steps 2 (4), 4 (1), 5 (2), 10 (3), and 12 (1). The second biggest block of respondents chose "no opinion".

TABLE 17:

Respondents' choices of "hard" steps

(17) Which step, if any, have you found the hardest to understand?

	Respondents	
Step	n	%
Step 1	1	.9
Step 2	3	2.7
Step 3	8	7.1
Step 4	18	15.9
Step 5	1	.9
Step 6	16	14.2
Step 7	10	8.9
Step 9	1	.9
Step 10	4	3.5
Step 11	6	5.3
Step 12	1	.9
No opinion	44	38.9

The "no opinion" choice was the most frequently chosen in this question (**38.9%**). Of those who did select a step, Step 4 was most frequently chosen (**26.1%**), Step 6 was named next most often (**23.2%**), followed by Step 7 (**14.5%**), Step 3 (**11.6%**), Step 11 (**8.7%**), Step 10 (**5.8%**), and Step 2 (**4.3%**). Only Step 8 was not listed, and Steps 1 and 12 were each chosen once. Step 8 was not even mentioned as one of the "simple" steps, and in this question is not cited as a "hard" step, from which one might conclude that Step 8 is neither simple nor hard. Step 1 appears confirmed as the simple step, since it was mentioned only once in the category, and yet dominated the previous one. No previous mention in the literature about step difficulty has ever been found by the writer of this

thesis. Yet the relative ease or difficulty of the steps would appear to be a logical subject of inquiry. Discussion about Questions 16 and 17 will be addressed in the final chapter.

A final observation is that a significant number of people find some of the steps difficult to negotiate. Whereas this does not mean that they could not negotiate them, taken at face value it means that the treatment delivery system does not deliver them easily to everybody. This has positive implications for the one-on-one treatment method which also utilizes the 12 step format. The implications that Steps 6 and 7 are difficult for a significant proportion of the population is important. They will be addressed in the following chapter.

TABLE 18:

Respondents who have had a slip

(18) Since coming to AA, have you ever had a slip?

	Total		Males		Females	
	n	%	n	%	n	%
Yes	55	48.7	38	52.8	17	40.5
No	58	51.3	34	47.2	25	59.5

The significance of this question bears in part on the heart of this research, and ties in, directly or indirectly, with other questions on the survey. For example, Question 8 asks about the period of continuous sobriety, which by definition *must antecede* a "slip", which is a drinking occasion since joining AA, expressed in AA jargon. This is precisely similar to a client in any other treatment failing to abide by the treatment program, and yet who returns to the treatment with the intention to resume therapy. The answer to this specific question should be compared to a "false start" in any other treatment protocol, especially one relating to alcoholism / addiction. These results will be taken up again in Chapter 5, Conclusions.

TABLE 19:

Respondents who received treatment prior to AA

(19) Prior to coming to AA, did you ever receive any other type of treatment for alcoholism?

	Total		Males		Females	
	n	%	n	%	n	%
Yes	37	32.7	22	30.6	15	36.6
No	76	67.3	50	69.4	26	63.4

TABLE 20:

Respondents who now receive treatment other than AA

(20) Are you now receiving any other treatment for alcoholism?

	Total		Males		Females	
	n	%	n	%	n	%
Yes	26	23.0	15	20.8	11	26.8
No	87	77.0	57	79.2	30	73.2

TABLE 21:

Questions 19 and 20 Combined (percentages only):

	P.T.* Male	Now T.** Male	P.T. Female	Now T. Female	P.T. Total	Now T. Total
Yes	30.6	20.8	36.6	26.8	32.7	23.0
No	69.4	79.2	63.4	73.2	67.3	77.0

Note: P.T* = Prior treatment. Now T** = Now in other treatment.

The literature is alive with research inquiries looking into whether AA is a stand alone treatment method, or whether it requires supplemental therapy. Research is thriving on such research questions as "Is AA enough?", "Is AA for everyone?", "If not for everyone, who is it for?", "Who is it not for?". In examining these question in tandem, the

responses reveal a pattern of attrition from "treatment before AA" to "treatment now". One reason may indirectly measure AA effectiveness in that less participants use another treatment now than did previously. On the other hand, this may also reflect the fact that the previous treatment got the clients to AA in the first place, for example. However, what this pattern of responses does appear to measure directly is "what percentage of AA members make use of a second source of treatment recovery?" The answer, according to this sampling, is less now than previously. The differences overall are that almost one third of respondents (**32.7%**) previously made use of another treatment, while less than one quarter (**23%**) make use of such treatment now.

TABLE 22:

Age of respondents:

(21) Age

	No.	Mean Age	*AA Survey*
Male	72	46.1	
Female	41	45.5	
Total	113	45.9	*(44)*

AA Survey incorporates data (in Italics) from 1996 Membership Survey (AAWS, 1996).

The mean age of males is slightly higher than females. This is a consistent finding in research on AA subjects (Tonigan et al. 1994, Miller et al. 1993). Vaillant (1983) referred to alcoholism as a middle age disease, and his claim is borne out by the current finding (mean age **45.9**). The results of this study are similar to the overall findings in the 1996 AA Survey of Members (AA, 1996).

TABLE 23

Sex of respondents (N = 113)

(22) Sex

	n	%	*AA Survey*
Males	72	63.7	*(67)*
Females	41	36.3	*(33)*
Total	113	100	

Men outnumber women in almost every survey by a ratio of approximately two to one (Tonigan et al. 1994, Miller et al. 1993, AA, 1996). The one survey which differed the greatest was that of Emener and Dickman (1992), where the gender split was 53.4% male to 46.4% females (p. 4). The breakdown of males to females is strikingly close to the most recent AA Membership Survey (1996).

TABLE 24

Combined age and gender of respondents:

	Age											
	<31		31-40		41-50		51-60		61-70		>70	
Gender	n	%	n	%	n	%	n	%	n	%	n	%
Male	9	12.5	12	16.7	27	37.5	13	18.1	9	12.5	2	2.8
Females	5	12.2	12	29.3	12	29.3	8	19.5	3	7.3	1	2.4
Total	14	12.4	24	21.2	39	34.5	21	18.6	12	10.6	3	2.6
(AA Survey)	*(13)*		*(30)*		*(29)*		*(16)*		*(9)*		*(3)*	

AA Survey incorporates data (in Italics) from 1996 Membership Survey (AAWS, 1996).

In comparison to the AA survey, the female sample is strikingly similar. The male sample, however, has a large, distinct representation at age grouping 41-50, compared to AA's findings of an almost even distribution between ages 31-50.

TABLE 25:

Other comments by respondents:

(23) Are there any questions you would like to make about the subject of this questionnaire?

No response	101
What about God/spiritual issues?	5
Only been in program short time	2
No other program works	1
Good luck in research, etc.	4

This question was intended to provide space for respondents to add subjective comments to anything not covered in the preceding questions. The fact that there were no responses on the vast majority of questionnaires may be a reflection of time constraints rather than the lack of something to say.

The five comments on the lack of questions related to spirituality are understandable. The AA program is a spiritual one. In fact, a deliberate decision was made to exclude spirituality in the questions because the spiritual issue might tend to overwhelm the research questions of this particular thesis. Spirituality and the AA program is a specialty subject in itself, well represented in the literature.

The balance of the comments were not considered significant to this research.

CHAPTER 5

Discussion

Summary

By way of background, I was first introduced to AA in 1976. Since that time, I have attended probably more than a thousand meetings of every description: closed meetings and open meetings; men only and mixed gender; discussion groups and step meetings. I have listened to guest speakers, and been one; have chaired scores of meetings, and made coffee for as many more; have been elected as secretary-treasurer, and volunteered for such duties; have been a sponsor and a sponsee. I have most definitely been the "newcomer", and have probably fulfilled the role of "elder statesman". And I have attended AA meetings, conventions, and roundups in a hundred different locations, from western Canada to Australia. And somewhere along the way alcohol ceased to be the problem it once was in my life.

The foregoing experiences allow me to make some observations about research into AA. I am aware of many studies conducted, and papers written, which are highly relevant, and which reflect a high degree of accuracy. The same cannot be said of some others; they betray an ignorance of the subject. As I discuss the findings of this research, I will utilize the good examples, and the bad ones, to make my points.

This thesis examines several questions, some of which duplicate other studies, and some of which cannot be found in the literature. The main purpose of this study is to contribute to knowledge about matching alcoholism treatment to the client, which was described earlier as the *zeitgeist* of alcoholism research today. This study also investigates what factors contribute to the success of Alcoholics Anonymous, the dominant treatment methodology available today, and what might deter some alcoholism sufferers from participating in the program. To the extent this study accomplishes these ends, it does so by adhering to the primary reasoning which drives this thesis, "if you want to know about AA, ask the people who are in the program."

It seems logical to begin by asking questions which measure the knowledge of AA members about the program to which they subscribe. A series of statements was taken from AA literature and adapted into questions. These questions, which were earlier described as esoteric, serve to discriminate recovering alcoholics who are in the program from any other population. This identification process is carried one step farther by directly asking participants whether or not they are alcoholic. Subjects were also asked their opinion of how much they know about the AA program, which serves as further confirmation.

A major finding of this thesis is the difficulty some members report having with Step Six. This has never been isolated as a difficult step in previous literature, and the subject will be expanded upon when Research Question 6 is discussed.

Being capable of answering questions about AA is one thing, and applying the tenets of the program into their life is another. For purposes of gauging compliance with the program, respondents were asked about the frequency with which they attend meetings, whether they have adopted a home group, whether they have a sponsor, and whether they would describe themselves as alcoholic. Taken individually, the answers to these questions have armchair validity about program commitment by the AA subjects polled. Collectively, the answers are an indicator of such compliance.

The next area of inquiry relates to the beliefs of AA members in AA itself, as well as other treatment which they may have experienced. The aspect of this research which touches on client matching makes use of the same philosophy as the simple procedure of asking AA members about AA; some of these same AA members will also be veterans of, or current participants in, other types of treatment. Appropriate questions are therefore asked about their beliefs in these other treatments. These questions are framed in the past as well as the present to reveal any underlying trends. Such bottom up inquiries drive billion dollar businesses today.

Similarly, in the search for ideal client-matching strategies, there must be some aspects of AA that members like and some they dislike. Identifying these preferences and aversions adds to the knowledge of what works well or not at all. The advent and proliferation of variations on the Minnesota model of treatment, which was described in the literature review, is just one example of the application of such knowledge from the field.

In a related, yet different issue, this research sets out to discover, from AA members themselves, whether there are "difficult" and/or "easy" steps in the 12-step program. Having the answers in hand, what can be done to facilitate the more difficult steps? This is an obvious line of inquiry, yet one which has been largely overlooked according to a review of what literature there is on the subject. It should be self-evident that if there is a difficult phase to a treatment, some clients are going to require some assistance in negotiating it.

In summary, then, this survey sets out to identify members of AA, confirm their membership by self-reported behaviors, ask them of their beliefs, likes, dislikes and any problems they experience with the program. One final strategy is employed: to assess the confidence with which we can regard the answers to the questionnaire. For this purpose, a cross reference is made between this survey and the most recent data available from AA, where there are similar questions, and the results compared.

Research Questions

1. Is there relationship between knowledge about the program of Alcoholics Anonymous and belief in its efficacy?

The findings would tend to support a "yes" answer to this question. As mentioned in the Introduction, there is a binary division between answers to knowledge questions between AA members and nonmembers. The first five questions tested program-based knowledge. It is remarkable that 551 correct answers were recorded out of a possible 565, for a five-question score exceeding 97.5%. Two of the wrong answers were made by the

same individual, a person who had been in the program only two weeks, as a subsequent conversation with the researcher revealed.

As to the subject of belief in the efficacy of the program, this was measured by the question which rated treatments (Question 7), and subsequently confirmed by the slightly differently-worded Question 10, which asked for a rank order of the same treatments. Additional information can be garnered from Questions 19 and 20, which relate to previous treatment and inquire about current treatment, respectively. Although there is not every confidence that the trend between the two questions, showing less subjects employing another treatment now compared to prior to becoming a member of AA, the trend is nonetheless a significant one. The direction would at least suggest that AA is a sufficient treatment unto itself *for some people.*

The other side of the coin, of course, is the obvious fact that as many as 23% of subjects feel that they require adjunctive treatment for their condition.

This research confirms the findings of other inquiries, which show that AA is not an omnibus treatment. Some people come to AA and decide it is not for them. Others spend a while attending meetings before coming to the same conclusion. And some people never enter what would otherwise be their first AA meeting.

Whereas AA may constitute a powerful treatment methodology, one which dominates alcoholism treatment, the search for alternative therapies is entirely justified and appropriate.

2. To what extent does the self-reported behavior of members of Alcoholics Anonymous adhere to the suggestions of the AA program?

AA members evidence a high degree of compliance with the AA program according to their reported behaviors. Question 9, which measured meeting attendance frequency, showed that 93.8% of all members polled attend at least one meeting a month, while two-thirds attend more than once a week. These results should be placed in the

context of individual clients voluntarily taking the time to, in effect, administer their own treatment.

Another compelling piece of evidence lies in the responses to Question 11, which related to having a home group, as is recommended by the AA program. 85.8% reported program compliance with such behavior.

Of course there is a difference between attending a meeting and joining a home group. Belonging to a home group implies a degree of commitment not only to the program, but also to the group itself. Such a commitment can involve arriving at a meeting early to prepare coffee, staying to help clean up, taking part in the monthly business meeting, or working on such extra activities as the birthday committee, for example. Belonging to a group is a recommended activity of the AA program, and as such it is a reliable and valid measure of program compliance.

Question 12 concerned itself with sponsorship; AA recommends that members have a sponsor. A sponsor is an individual, almost invariably in the program longer than the sponsee, who acts as a mentor.

In actual AA practice, selecting a sponsor is something of a ritual. By tradition, the sponsee approaches the sponsor and requests that a relationship be established. The fact that the individual is thus set up for possible rejection is probably one reason why there is not a higher percentage of AA members with a sponsor. As it is, this inquiry shows that 78% of respondents have formed such a relationship. Given the sociological implications of such an interpersonal transaction, this is an impressive number, which is substantiated by similar, consistent findings over the years by the AA Membership Surveys. It is the position of this thesis that having a sponsor is a strong indicator of program compliance by members.

The response to Question 13 (are you an alcoholic?) can also be interpreted as compliance with and belief in the program. AA promotes the view that alcoholism is a "malady". Furthermore, the AA literature insists that treatment and abstinence from

alcohol are life-long necessities (once an alcoholic, always an alcoholic). Many researchers have pointed out the fact that the AA position on the medical model also serves to alleviate shame for its members.

The results of Question 13 are remarkable. Getting 113 individuals to agree on anything is a difficult task, perhaps made the more difficult in this case because of the requirement for self-stigmatizing. Nonetheless, this question received 100% "yes" answers. One is left with little room for doubt on this question, given the unanimous responses. This is one of the results which surprised me, for I believed that, given a sufficient sample size, there would be some participants who were not that comfortable with the label. What is even more surprising is that, even though an alternative to "yes" or "no" was provided in the questionnaire (namely "sometimes"), not a single subject selected it. The "sometimes" alternative was a reasonable one, and frankly was designed to capture those respondents who even occasionally entertained doubt about their condition. However, the results of this question was 100% consistent with the AA credo, which corroborates evidence of strong compliance with the program.

All of these factors, when taken alone, make a strong statement about the behaviors of the sampled population on the subject of compliance with the suggested program of AA. When taken together, they provide a powerful endorsement of the AA Program.

3. What are the self-reported behaviors of members of AA with respect to other alcoholism treatments prior to coming to the program?

Almost one third of AA members reported that they had received treatment prior to entering the AA program. Further research is suggested on this subject, because the inter-relationship between AA and other treatments, and other combinations of treatments, is the direction modern research on alcoholism is heading.

Specific treatments were not inquired about because they were felt to be beyond the scope of this research, which concerns itself with a bottom up snapshot of AA as a treatment. The questions, and the answers, are therefore generic.

The value of this question was in relation to other questions, specifically the next query: Question 19.

4. What are the self-reported behaviors of members of AA with respect to other alcoholism treatments today?

The number of AA members who are now receiving additional treatment (23%) is an indication that AA alone is not enough for a significant number of people. This confirms the findings of other studies. It also puts a number to the percentage of AA members who seek adjunctive treatment. The fact that AA in itself is insufficient for some, which has been confirmed in virtually all studies into alcoholism treatment, simply means that other treatment methodologies must be improved upon and / or created.

As the literature review showed, there are several treatment variations extant today which borrow their basic methodology from AA, and then change the delivery system in some way. This is often individually-delivered treatment such as was the subject of experiment in Project MATCH (see Chapter 3), or in the emerging variations referred to as the Minnesota Model. As mentioned in Chapter 3, this model employs AA veterans in group and one-on-one treatment situations.

There seems to be a definite demand for these variations. The Betty Ford Clinic type of treatment, which addresses shame and stigma, is more conscious of treatment environment than AA generally is. This is an example of a market-oriented 12-step model of treatment. It is also individually delivered, which will be dealt with in part during discussion of Research Question 6.

It would be an oversimplification to conclude that all clients likely to respond positively to AA should go there for treatment, and the balance of clients have a treatment tailored to their individual requirements. The effectiveness of other treatment methods

which employ techniques different from AA have proven their worth, and revealed their shortcomings.

The two most astonishing conclusions in current alcoholism research today are those of Project MATCH, which found that it did not matter which of three treatments were assigned, in the absence of serious psychopathology, the results were the same. The other is the recent findings of Vaillant and Hiller-Sturmhofel that "about 2% of alcoholics return to stable abstinence each year, with or without receiving treatment" (1996, p. 157).

5. What do AA members like and dislike about the program?

Like any consumer feedback, the information from these questions can be applied to the research on treatment-client matching. Any treatment program existant, or designed in the future, should include the information about what people like and do not like. If the research history is clear on anything, it is clear that client involvement and commitment should be encouraged in any alcoholism treatment. Heeding what the users say is one major way of encouraging this behavior.

One of the strongest expressed likes of AA members falls into the category of Social Aspects (see Table 14). These are generally characterized by such words and phrases as "fellowship", "the people", "the meetings", "acceptance", etc. Almost two-thirds of respondents chose such social terms. The balance almost all selected functional aspects, such as "the steps", "the traditions", "it works", etc.

On the other hand, when asked about dislikes, the majority either had no dislikes, or no opinion. Of those who did name a dislike, the majority of these were either smoking or the coffee, both of which are avoidable. The remainder of those polled made some social comment such as not liking gossip, cliques, opinionated people, bad language, or listening to other than alcohol-related problems (dual addicts).

This last mentioned, people who identify with substance abuse problems in addition to alcohol, was named by only two people. This was a surprisingly small number to me. Perhaps my experience is not representative, but I thought more people would

register annoyance at having to listen to stories which do not involve alcohol. Certainly I have observed occasions at meetings when such objections were verbalized.

In spite of these results, it is not an insignificant problem in AA. Further research on this subject is recommended. In the Pamphlet "Problems Other than Alcohol", AA co-founder Bill W. is quoted as saying:

> Now there are certain things that A.A. cannot do for anybody, regardless of what our several desires or sympathies might be.
>
> Our first duty, as a society, is to insure our own survival. Therefore, we have to avoid distractions and other multipurpose activity. An A.A. group, as such, cannot take on *all* the personal problems of its members, let alone the problems of the whole world.
>
> Sobriety - freedom from alcohol - through the teaching and practice of the Twelve Steps is the sole purpose of an A.A. group. Groups have repeatedly tried other activities, and they have always failed. It has also been learned that *there is no possible way to make nonalcoholics into A.A. members.* We have to confine our membership to alcoholics, and we have to confine our groups to a single purpose. If we don't stick to these principles, we shall almost certainly collapse. And if we collapse, we cannot help anyone (AA, 1958).

6. Which of the 12 steps do AA members record as "easy", and which "hard"?

The responses to this question are particularly important to those who deliver a 12-step based type of therapy, especially one that is individually delivered. Knowing which steps are difficult, and to whom, and helping to overcome the difficulty, can contribute to more efficacious treatment. Of course, the same can be said of the AA treatment, and group delivery is as much a problem here as it is an advantage in other situations. The current study confirms and quantifies the extent of this shortcoming. The need for understanding the steps is the underpinning of the recommendation that each AA member have a sponsor.

The answers to Question 16 are fairly straightforward and not surprising. Step One, as might be expected, dominates as the simplest step with 71% of respondents naming it. Another 18% had no opinion.

By contrast, Question 17 point out the vulnerability of the AA program. That Step Four is a difficult step could probably have been predicted by almost any veteran of the program. This step ("Made a searching and fearless moral inventory of ourselves") calls for insight beyond the experiences of most newcomers. Although the Big Book does describe this step, and in fact provides a fairly detailed description of how to proceed, in the final analysis it is up to the individual to interpret. It is not surprising that books have been written on this subject alone. Step Four is a complicated one.

What is surprising is that right next to Step Four in reported difficulty is Step 6 ("Were entirely ready to have God remove all these defects of character"). Step Four received 18 mentions, while Step Six received 16. I personally know of no special arrangements, made by AA or any of its offshoots, that concentrates on helping clients comprehend Step 6. This could be a major finding in AA research.

Step Seven, even more obscure than its predecessor, also attracted a substantial number of votes as the most difficult, with 10. The combination of the two steps are named by more than one third of those polled, outdistancing Step Four in reported difficulty.

It is likely that the reported difficulty with Steps Six and Seven are the result of a perceived threat to the identity of the person negotiating these two steps. The two steps go together, and read as follows:

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

I have personally heard members express reservations about these two steps. The main stumbling block seems centered on the comprehensive word "all" in describing the defects of character to be removed. Some members reason that they would like to hang on to some part of themselves, even if that is a "defective" part. Thus it may be that fear of losing one's identity is at the root of the "difficulty" of these steps.

7. Where there is similar data, how does the present research compare to the most recent AA Triennial Survey?

The results of this questionnaire are remarkably similar to the most recent AA Member Survey (1996) (N = 7,200) where the questions touch on similar data. For example, there was close similarity in length of sobriety, group membership, sponsorship, meeting attendance, age, and gender. It should be noted that the present questions and those of AA are probably not identical, but do touch on the same topics. The comparisons are as follows:

TABLE 26:

Comparison of present study with AA Member Survey:

Category	Present Study	AA Survey
Mean Age	45.9	44
Gender		
Male	63.7%	67%
Female	36.3%	33%
Have sponsor	77.9%	76%
Have home group	85.8%	86%

Limitations:

This study is probably generalizable to Canada and the U. S. Confidence in the results flow from the similar demographic findings to those of the AA Survey of Canadian and American subjects, as noted above. If there is a shortcoming to this study it lies in the methodology, for participant selection was more or less by convenience, and not random. Nonetheless, these results can probably be duplicated in North America.

Unfortunately, the nature of researching a subject such as AA, with its emphasis on anonymity, is difficult. At the same time, within the framework of these difficulties, the researcher has been attending AA meetings for more than 22 years, and has the advantage of being able to attend closed meetings. Open meetings, which are the subject of most research on AA, are different from closed meetings in that the attendees may or may not be members of AA. This researcher has observed a noticeable difference in the intensity between the two types of meeting. By definition, also, Open meetings may not be representative of AA meetings, depending upon the presence of AA members.

It should be pointed out that the present study contains two flaws. The first, already mentioned, is the complicated wording of Question 10. The second is that Question 8 (length of sobriety) should have been a write-in question.

Implications for Counselors

This research confirms that a significant percentage of AA members make use of, or have made use of, therapy outside of that of the AA program. This carries implications for counselors, other than those of the Behaviorist school, who have clients with alcoholism as the presenting problem. Such clients may be best served by counselors who are informed not only about the AA program, but also about the characteristics of some of the groups in the counselor's community. This suggests that therapists attend open meetings of AA.

This study concludes that non-specified, generic therapy is compatible with AA attendance for a significant percentage of AA members. Furthermore, one third of the sample population represented by this study received treatement other than AA prior to joining the program. Almost one quarter received such treatment at the time they were surveyed.

Implications for Further Research

This study contains new information, with strong implications, in that Steps Six and Seven are defined by AA members of this survey to be more difficult than what is reflected in the literature. Additional research should investigate this issue. Alcoholism therapists who deliver an individual 12-step treatment may be overlooking this possible impediment to recovery, as may those AA members who act as sponsors. Although this thesis offers an explanation which may account for the difficulty with Steps Six and Seven, further research to determine what it is that is found to be difficult about these steps should be very much worth investigating.

Questions 8 (length of sobriety) and 18 (ever had a slip) do not fit directly into the research questions, but contribute to this research indirectly by supplying insights and implications for this and other alcoholism research. Furthermore, the two questions are intertwined. Further research in other treatment methods is recommended to see to what degree initial failure (a slip) is followed by a further attempt at sobriety. The results of this study show that almost half the members (48.7%) had undergone such a setback, yet resumed their attempts at recovery. Much may be learned by comparing the results of a similar question asked of those undergoing therapies different from AA.

The question regarding likes and dislikes about AA revealed a small percentage of respondents who felt that discussing substance abuse problems other than alcohol was a problem. I believe that further inquiry into this subject is warranted. This could be accomplished by designing a question which focuses specifically on the reaction of AA members to discussion of non-alcohol-related subjects.

Implicit in this and other alcoholism treatment research is the matter of high attrition as experienced by AA. According to virtually every study on the subject, there is a steady decline in membership when measured by length of sobriety. Obviously some people go back to drinking, some die, and some stay sober without attending AA. A

tantalizing research subject is, "What happens to AA members over time? What happens to those who stop attending AA meetings?"

If, as AA maintains, AA is a program for living, study people living the program but not attending AA, in other words, AA dropouts. These people would fall into two categories, those who abstain, and those who continue to drink socially. How might these two populations compare to each other in terms of "degree of alcoholism", such as could be implied from the Johns Hopkins 20 Question Test? Research in this direction would potentially provide a wealth of implications for alcoholism treatment, and would tend to sustain or refute the AA position that "once an alcoholic, always an alcoholic."

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Appendix A

QUESTIONNAIRE

The purpose of this questionnaire is to contribute to research on the subject of alcoholism. The following questions are formulated from Alcoholics Anonymous literature. Please mark the box which contains the correct answer. If you do not know the answer, please mark "don't know".

(1) Which of the following is one of the 12 steps of AA?

- ❑ *"Counted nothing but thoroughness and honesty about others."*
- ❑ *"Vowed that we would never again drink alcohol."*
- ❑ *"Made a searching and fearless moral inventory of ourselves."*
- ❑ *"Stood at the turning point."*
- ❑ *don't know*

(2) *What does AA charge its membership?*

- ❑ *the present charge is $5 per week*
- ❑ *there are no dues or fees*
- ❑ *there are no dues, but fees can cost up to $5 per hour*
- ❑ *there are no fees, but dues are charged at $5 per month*
- ❑ *don't know*

(3) *What is stated as the primary purpose of AA?*

- ❑ *to "stay sober and help other alcoholics to achieve sobriety"*
- ❑ *to live life "one day at a time"*
- ❑ *to provide meeting facilities "wherever they may be required"*
- ❑ *to "assist in the diagnosis of alcoholism"*
- ❑ *don't know*

(4) *AA utilizes a group format, and states that:*

- ❑ *each group should be defined as four or more members*
- ❑ *each group should follow certain procedures*
- ❑ *each group should be chaired by an AA member*
- ❑ *each group should be autonomous*
- ❑ *don't know*

(5) *Closed meetings of AA are intended only for those:*

- ❑ *in the immediate family of alcoholics*
- ❑ *who are family or friends of alcoholics*
- ❑ *with a desire to stop drinking*
- ❑ *with a "substance abuse" or "chemical dependency" problem*
- ❑ *don't know*

Some of the following questions ask about your personal opinion or beliefs. Please respond with the answers that most closely match how you feel.

(6) How would you *rate your knowledge* of the program of Alcoholics Anonymous?

- ❑ quite knowledgeable
- ❑ somewhat knowledgeable
- ❑ know about an average amount
- ❑ know less than most AA members do
- ❑ have very little knowledge of the subject

(7) Which of the following *do you believe* is the most effective treatment for alcoholism?

- ❑ professional counselling
- ❑ membership in Alcoholics Anonymous
- ❑ treatment by a family doctor
- ❑ a combination of the above (please specify which)

  _____
- ❑ no opinion

(8) How long have you been continuously sober?

- ❑ less than one year
- ❑ between one and five years
- ❑ between five and ten years
- ❑ between 10 and 20 years
- ❑ over 20 years

(9) Approximately how often do you attend AA meetings?

- ❑ less than 5 times per year
- ❑ between 6 and 10 times per year
- ❑ approximately once a month
- ❑ between once a week and once a month
- ❑ more than once a week

(10) Please rank order *your opinion* of each of the following treatments for alcoholism on a scale of 1 to 4, with 4 as most effective and 1 least effective. Please use each number once only.

[ ] professional counselling
[ ] membership in Alcoholics Anonymous
[ ] treatment by a family doctor
[ ] other (please specify) -

_____

❑ no opinion

(11) Do you have a "home" group?

❑ Yes
❑ No

(12) Do you have a sponsor?

❑ Yes
❑ No

(13) Do you consider yourself to be an alcoholic?

❑ yes
❑ no
❑ sometimes

(14) What do you like most about AA?

_____
_____
_____
_____

(15) What do you like least about AA?

_____
_____
_____
_____

(16) Which step, if any, have you found to be the simplest to understand?

Step number _____

❑ No opinion

(17) Which step, if any, have you found to be the hardest to understand?

Step number _____
❑ No opinion

(18) Since coming to AA, have you ever had a slip?

❑ Yes
❑ No

(19) Prior to coming to AA, did you ever receive any other type of treatment for alcoholism?

❑ Yes
❑ No

(20) Are you now receiving any other type of treatment for alcoholism?

❑ Yes
❑ No

(21) Age _____

(22) Sex _____

(23) Are there any comments you would like to make about the subject of this questionnaire?

_____
_____
_____
_____
_____
_____
_____
_____

Appendix B

CONSENT FORM

FOR PARTICIPATION IN THE STUDY ENTITLED, *"EXAMINATION OF KNOWLEDGE OF AND BELIEF IN ALCOHOLICS ANONYMOUS PROGRAM"*

This research project is to examine whether there is a relationship between knowledge about the program of Alcoholics Anonymous and belief in its effectiveness. You will be asked some questions which have been taken from AA literature, and you will also be asked some questions about your opinions, beliefs, AA membership, alcoholism treatment, etc. Your participation should require approximately fifteen minutes. The total results of this questionnaire will form a part of a thesis which may be published.

Your participation is completely voluntary and you can withdraw from this study at any time without explanation. You have the right to refuse to answer any questions you do not wish to answer. Your name will not be recorded on the questionnaire, and signed consent forms will be stored separately in a locked cabinet, separate from any other data. Names of participants will not appear anywhere.

_____

Signature of participant

Date_____

Researcher: BOB BENSON, Phone: 250-721-0352
Academic Supervisor: DR. GEOFF HETT, University of Victoria. Phone: 250-721-7783.

Dear Fellow AA Member:

Thank you for taking the time to complete the Questionnaire and the signed and dated Consent Form. Please remember to include both in the stamped, addressed envelope. If you wish, you may sign the Consent Form with an "X". It is important that both be mailed not later than May 15 in order to be included in the research.

I assure you that your responses will be treated confidentially and that your anonymity is assured, consistent with the protocols agreed to with the Human Subjects Ethics Committee, University of Victoria. Upon receipt, the Consent Form and Questionnaire will be permanently separated.

Thanks again for contributing to this research.

Sincerely

Bob B.

Appendix C

The 12 Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of those steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

(Alcoholics Anonymous World Services, 1976)

Appendix D

The 12 Traditions of Alcoholics Anonymous

One - *Our common welfare should come first; personal recovery depends on A. A. unity.*

Two - *For our group purposes there is but one ultimate authority -a loving God as he may express himself in our group conscience. Our leaders are but trusted servants - they do not govern.*

Three - *The only requirement for A. A. membership is a desire to stop drinking.*

Four - *Each group should be autonomous, except in matters affecting other groups or A. A. as a whole.*

Five - *Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.*

Six - *An A. A. group ought never endorse, finance, or lend the A. A. name to any related facility or outside enterprise lest problems of money, property and prestige divert us from our primary spiritual aim.*

Seven - *Every A. A. group ought to be fully self-supporting, declining outside contributions.*

Eight - *Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.*

Nine - *A. A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.*

Ten -*Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.*

Eleven - *Our public relations policy is based on attraction rather than promotion; we need always maintain anonymity at the level of press, radio and films.*

Twelve - *Anonymity if the spiritual foundation of all our Traditions, ever reminding us to place principles above personalites.*

Appendix E

The Alcoholics Anonymous Preamble

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

- *The only requirement for membership is a desire to stop drinking. There are no dues or fees for A. A. membership; we are self-supporting through our own contributions.*

- *A. A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes.*

- *Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.*

VITA

Surname: **Benson** Given Names: **Robert Kenneth**

Place of Birth: Vancouver, British Columbia, Canada

Educational Institutions Attended:

University of Victoria	1995 to 1998
University of the State of New York	1995 to 1996
Camosun College	1994 to 1995

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Title of Thesis:

Going to the Source: A Survey of A.A. Members About A.A.

Author [redacted]

Robert Kenneth Benson
August 7, 1998