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Happy Joyous and Free An Exploration of the Relationship between Quality of Life and Affiliation with Alcoholics Anonymous

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HAPPY, JOYOUS, AND FREE:
AN EXPLORATION OF THE RELATIONSHIP BETWEEN QUALITY OF LIFE AND AFFILIATION WITH ALCOHOLICS ANONYMOUS

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DEDICATION

This work is dedicated equally to God, without His Grace, I would not be alive; to the Fellowship of A.A. that continues to express God's Love in every way; and to my loving wife, Maureen Elizabeth Leming who represents everything that is Good in this world.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Chapter I: Introduction

Introduction

This chapter begins with a brief summary of the effects of alcohol abuse, followed by a statement of the problem addressed by this study. The next section discusses the definitions of alcohol abuse and alcohol dependence and current rates of each in the United States. The final section provides data on the demographics of both alcohol abuse and dependence.

Statement of the Problem

Alcoholism and associated alcohol use disorders rank among the most prevalent mental disorders worldwide and are considered a major cause of disability burden in most regions of the world (World Health Organization [WHO], 2001). The WHO (2003) estimated the prevalence of alcohol use disorders at 1.7% globally and reported that these disorders account for 1.4% of the total world disease burden. In the US, the numbers are significantly greater and continue to rise with the number of adults who abuse alcohol or are alcohol dependent rising from 13.8 million (7.41 %) in 1991-1992 to 17.6 million (8.46 %) in 2001-2002 (National Institute on Alcohol Abuse and Alcoholism [NIAAA.], 2004).

While the negative effects of alcohol addiction and abuse are well documented (Grant et al., 2004; NIAAA, 2004) and include health problems, family dysfunction, emotional disorders, high arrest and incarceration rates, homelessness, and a multitude of larger economic costs, the prevalence and potency of these effects remain shocking. For example, Grant (2000) found that approximately one in four children under 18-years-old

in the US are exposed to alcohol abuse or dependence in the family. In fact, more than 50% of American adults have a family member who is currently suffering or has suffered from alcohol dependence (Dawson & Grant, 1998).

The effects of alcohol abuse certainly do not fall on the alcohol abuser and his or her family alone. Greenfield (1998) reported that almost 1 in 4 or 2.7 million of the 11.1 million victims of violent crime each year report that the offender had been drinking before committing said offense. It costs every man, woman, and child living in the US roughly $638 per year for a total of $184.6 billion to compensate for the damages and expense of alcohol abuse (Greenfield, 1998).

Alcoholism clearly represents an individual, familial, and social problem of a great magnitude, and any and all methods aimed at eradicating or minimizing the detrimental effects of alcoholism are of the highest value to the worldwide community. Although various effective treatment options exist for alcoholism (Babor & Del Boca, 2003), problem drinkers in the U.S. continue to choose Alcoholics Anonymous (AA) for treatment more frequently than all other forms of professional alcohol treatment combined (McCrady & Miller, 1993; Room & Greenfield, 1993; Weisner, Greenfield, & Room 1995). In fact, Americans make more visits to self-help groups for substance abuse and psychiatric problems than to all mental health professionals combined (Kessler, Mickelson, & Zhao, 1997). Although countless AA members and healthcare providers strongly attest to the Fellowship's value (Chang, Astrachan, & Bryan, 1994; Emrick, Tonigan, Montgomery, & Little, 1992; Humphreys & Noke, 1997) and empirical evidence suggests improved abstinence outcomes associated with AA. involvement (Emrick et al., 1992; Humphreys, 1999; Tonigan, Miller, & Connors, 2000;), researchers

and clinicians remain skeptical of the absolute value, methods, and theory of Alcoholics Anonymous (AA). Such skepticism is due in part to the difficulty researchers have experienced when attempting to investigate AA. According to Fuller and Hiller-Sturmhofel (1999), researchers have been deterred from studying AA by the extreme variance within and between AA groups, by the anonymity required of AA members and guests, and ultimately by the lack of any standard definition of AA membership.

In their attempt to measure the effectiveness of AA's Program of recovery, researchers have focused on affiliation with AA and it relationship to abstinence. However, both researchers and clinicians have failed to explore and utilize AA's definitions of alcoholism, affiliation, and recovery as written in its basic text, *Alcoholics Anonymous*, the book after which the Fellowship itself is named. In turn, researchers have been investigating AA as a method of treatment with little or no regard for what AA itself claims to treat, how AA claims to treat it, and what AA says it looks like when successfully treated.

The research completed to date has focused on AA attendance and/or superficial AA. behaviors as proof of affiliation, and when implementing these inappropriately constructed scales investigated only abstinence as proof of effectiveness. Therefore, we have a two-fold problem. Researchers have been investigating individuals that may or may not be alcoholic (as defined by *Alcoholics Anonymous*) and may or may not be affiliated with AA (as defined by *Alcoholics Anonymous*); and when doing so, operationalizing sobriety as the ability to stay away from alcohol, which is in fact not the stated purpose of *Alcoholics Anonymous*. Therefore, the true effectiveness of AA in delivering what AA itself promises has gone unexplored.

Current Rates of Alcohol Abuse and Alcohol Dependence

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*; American Psychiatric Association, 2001) describes alcohol abusers as those who drink despite recurrent social, interpersonal, and legal problems as a result of alcohol use. Harmful use implies alcohol use that causes either physical or mental damage. Those who are alcohol dependent meet all of the criteria of alcohol abuse in addition to some combination of the following: tolerance, withdrawal, drink-seeking behavior, the physical compulsion to continue drinking once started, and the inability to remain abstinent after repeated attempts to do so.

According to the NIAAA's ground breaking and nationally representative, 2001-2002 National Longitudinal Alcohol Epidemiologic Survey (NLAES) of 42,862 individuals, the 12-month prevalence rate of DSM-IV-TR alcohol abuse was 4.65%, representing 9.7 million adult Americans (Grant et al., 2004). According to the NIAAA, the prevalence of 12-month DSM-IV alcohol dependence in 2001–2002 was 3.81%, representing 7.9 million Americans (Grant et al., 2004). In addition, the NIAAA (2004) suggested the number of American adults who abuse alcohol or are alcohol dependent may be as high as 8.46%.

Significant Demographic Variables of Alcohol Abuse and Dependence

Gender. According to the NIAAA as reported in Grant et al. (2004), overall rates of DSM-IV alcohol abuse in 2001-2002 were substantially and significantly higher for males (6.93%) than females (2.55%), representing a ratio of about 2.72. This gender difference existed across Whites, Blacks, and Hispanics, and similar but non significant

differences were found among Asians and Native Americans. When considering age, this gender difference in the prevalence of alcohol abuse was significant within all age groups of the White, Black, and Hispanic subgroups, except for Hispanics 65 years of age and older, where the gender difference existed in the same direction but was not statistically significant. Prevalence rates of alcohol dependence demonstrated significantly higher rates for males (5.42%) than females (2.32%), representing a ratio of approximately 2.34. However, when considering race/ethnicity across gender, this difference was significant only for Whites, Blacks, and Hispanics.

Race/Ethnicity. To continue summarizing Grant et al. (2004), the NIAAA reported significantly greater rates of alcohol abuse among Whites (5.10%) compared to Blacks (3.29%), Asians (2.13%), and Hispanics (3.97%). When considering gender across race/ethnicity, White female rates significantly exceeded those of their Black, Asian, and Hispanic counterparts, but White male rates significantly exceeded only those of Black and Asian males. The prevalence of abuse was significantly greater among Native Americans (5.75%) and Hispanics (3.97%) compared to Asians (2.13%), but when evaluated by gender, only the Hispanic male rate (6.21%) was significantly greater than the Asian male rate (3.20%). Whites (3.83%), Native Americans (6.35%), and Hispanics (3.95%) had a significantly higher prevalence of alcohol dependence than Asians (2.41%) but no significant differences were found in the rates of dependence between any of the other racial/ethnic groups. When investigating the differences across subgroups, at ages 18–29, Whites (10.71%) had higher rates of dependence than Blacks (6.03%) or Hispanics (6.92%). Also, at ages 30–44, Asians (0.44%) had lower rates of dependence than all other racial/ethnic groups.

Age. A summary of Grant et al. (2004) also suggested the prevalence of alcohol abuse demonstrated a decrease across each successively older age group. In fact, all age groups exhibited significant differences except the decline from ages 18–29 to 30–44, which was significant only for women and Hispanics. When examined across race/ethnicity and gender groups, these age differences were less consistently significant. The prevalence of abuse among the 30–44 year-old age group, for example, was significantly lower than that of 18–29 year-old age group only among Hispanic males and Asian females. Rates of abuse for the 45–64 year-old age group compared to 30–44 year-old age group and rates among the oldest age group (i.e., 65 years and older) compared to the 45–64 year-old age group were significantly lower among all males, all females and Whites. Significant declines in prevalence between these age groups were also found when male and female Whites were considered separately. Among Blacks taken as a whole, and among Black males and Black females, the rates of abuse were only significantly lower among the oldest age group compared to the 45–64 year-old age group.

Grant et al. (2004) also reported a significant inverse relationship between rates of dependence across each successively older age group for the sample as a whole. This relationship continued when males and females were considered separately. The same significant relationship of age to rates of dependence was exhibited for White males and females. An investigation of other race by gender groups demonstrated a significantly lower prevalence rate for Black males among the oldest age group (1.10%) compared to the 45–64 year-old age group (3.98%). The prevalence of dependence for Hispanic males was significantly lower in the 30–44 year-old age group (5.33%) than in the

youngest age group (9.58%) and significantly lower in the 45–64 year-old age group (2.06%) than in the 30–44 year-old age group.

Demographic Summary. The NIAAA (2004) reported that overall, Native Americans display the highest rates of alcohol problems, followed by Whites, Hispanics, and Blacks. Both White males and females experience higher rates than Hispanic and Black males and females, and while White males ages 18 to 29 display the highest rates of alcohol abuse and dependence, all ethnicities and both genders display significant decreases as they age.

Alcoholism Treatment

More than 700,000 people in the US receive some form of alcoholism treatment in either inpatient or outpatient settings on any given day (Fuller & Hiller-Sturmhofel, 1999). The approaches currently used in the treatment of alcoholism stem from three primary sources of information: pharmacological research, research on human behavior; and the experiences of recovering alcoholics and the professionals treating them (Fuller & Hiller-Sturmhofel, 1999).

Currently, psychopharmacological treatment generally involves two types of medication for alcoholics in search of sobriety: aversive medications, which deter the patient from drinking by causing unpleasant physical effects when used with alcohol, and anticraving medications, which reduce the patient's desire to drink (Fuller & Hiller-Sturmhofel, 1999). The most commonly used aversive medication is Disulfiram (Antabuse), which has been available since the late 1940's. Though originally considered promising, Disulufiram has been shown to be much less effective than

originally presumed by more recent and rigorous research (Fuller et al., 1986). Currently, the most commonly used anticraving medication is Naltrexone (O'Malley et al., 1996). Naltrexone serves to prevent alcohol's pleasant effects by blocking the actions of endogenous opioids in the brain of the alcoholic, thus reducing the desire to drink. The Food and Drug Administration's approval of Naltrexone was based on two randomized clinical trials reporting that Naltrexone combined with psychosocial treatment reduced 3-month relapse rates from 50% among patients receiving a placebo to 25% among patients receiving the drug (O'Malley et al., 1996).

While detoxification, with or without pharmacotherapy, is the first step of treatment for many patients, behavioral treatment is the common thread for the overwhelming majority of those interested in alcohol consumption reduction or abstinence. The major behavioral approaches currently used in alcoholism treatment are cognitive-behavioral therapy (CBT), motivational enhancement therapy (MET), and Alcoholics Anonymous (AA).

Cognitive-behavioral therapy (CBT) is designed to help the individual identify high-risk situations for relapse, learn and rehearse strategies for coping with those situations, and recognize and cope with craving (Fuller & Hiller-Sturmhofel, 1999). Studies designed to investigate the efficacy of CBT in alcoholism treatment suggest that CBT is comparable to both MET and AA (Project MATCH Research Group, 1997).

Motivational enhancement therapy (MET) is a psychological-behavioral approach to alcoholism treatment based on the principles of motivational psychology. This method does not guide the individual through a step-by-step process but instead works to motivate the patient to use his or her own resources to change unwanted or unwelcome

behaviors (Fuller & Hiller-Sturmhofel, 1999). The MET practitioner first assesses the type and severity of the patient's drinking and then provides feedback designed to stimulate the individual's motivation to change. The Project MATCH Research Group (1997) also suggests that MET is comparable to both CBT and AA. as a treatment method for alcoholism.

While psychopharmacology, CBT, and MET have all been suggested as appropriate methods of treating alcoholism, none address the alcoholic from as holistic a standpoint as does Alcoholics Anonymous (AA). Psychopharmacology, for example, addresses only the individual's biology, ignoring his or her individual psychology and spirituality. While CBT and MET attempt to address the individual's psychology in pursuit of abstinence or moderation, they do little to enhance the alcoholics' connection and enjoyment of the world around them and their fellow cohabitants.

Regarding the overall effectiveness of psychopharmacology, CBT, MET, and AA, the Project MATCH Research Group (1997) has acknowledged the potency of AA and reported significantly higher continuous abstinence rates among members of its Twelve Step Facilitation group. However, it is my contention that the Project MATCH Research Group failed to properly address affiliation with AA as defined by *Alcoholics Anonymous* in addition to their failure to properly define sobriety as again clearly outlined in *Alcoholics Anonymous*. Therefore, while the Project MATCH Research Group's outcome may suggest the superiority of AA as a treatment method, it does little to properly define AA or its approach to the treatment of alcoholism. Poorly defined variables and a poor understanding of AA itself cast doubt on the legitimacy of the research group's findings.

Alcoholics Anonymous as a Treatment Method

Tonigan, Connors, and Miller (2003) defined a mutual-help program as a group of individuals who possess a common problem, who seek relief from the problem using a common plan, and who are not led by a professional. Alcoholics Anonymous (AA.) is the largest and most popular mutual-help program for people with alcohol problems. While the research has proven AA effective in helping people achieve sobriety (Emrick et al., 1992; Tonigan et al., 1996), these conclusions are based mostly upon single-group studies implementing less than rigorous scientific methods (Tonigan, Connors, & Miller, 2000).

While membership in AA is entirely voluntary, some individuals arrive at the basement doors of churches and community centers to attend meetings having been coerced by family members, friends, and counselors as well as mandated by the courts. Therefore, meeting attendees may not recognize themselves as members of AA. but instead go to meetings in order to ease relationships with family members or the law. True membership is free of charge and can be recognized by the individual alone. The only requirement for said membership, more properly defined as the right to attend closed meetings, is a desire to stop drinking. Although AA practices vary widely from meeting to meeting, a very clear and concise program of recovery is written and recorded in the Fellowship's basic text, *Alcoholics Anonymous* (Alcoholics Anonymous World Services [AAWS], 2001). In fact, the first 164 pages of the text have remained unchanged for nearly 70 years, four editions, and over 25,000,000 copies in English alone. The program of recovery clearly contained within the text states that the alcoholic stands to get sober if, and only if, he is able to find and connect with a power greater than himself

via a spiritual experience. *Alcoholics Anonymous* (AAWS, 2001, pp. 59-60) provides the individual with a method of action towards this experience in the 12 Steps:

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 experience as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Once the 12 Steps have been completed, which in the early days of Alcoholics Anonymous (AA) occurred in a matter of days, alcoholics are then obligated to do everything in their power to continue growing closer to the God of their understanding by being of service to others, including their fellow alcoholic (AAWS, 2001). Although the Program is largely based on Christian theism, AA has no affiliation with any religion, denomination or sect, and places no demands on the individual. However, *Alcoholics Anonymous* is very clear when it states that a willingness to believe in a Power greater than oneself is of absolute import if one is to make use of its recommended Program of action.

As a reward for taking the Steps, developing a relationship with the God of one's understanding, and "grasping and developing a manner of living which demands rigorous honesty" (AAWS, 2001, p. 145), each AA member is promised among other things freedom, happiness, and peace. Therefore, AA's program of recovery involves taking steps towards a way of life that results in far more than abstinence from alcohol. In fact, alcohol is seen as only a symptom of a deeper and more pressing spiritual malady, and true sobriety is seen as a quality of life far outweighing abstinence alone.

In turn, when assessing the effectiveness of AA as a treatment method for alcoholism, one must necessarily take into account the degree to which the individual has adhered to AA's Program of recovery and the quality of life they have enjoyed as a result. The current study aims at exploring the relationship of affiliation with AA, as defined by the text *Alcoholics Anonymous*, to quality of life as defined by both *Alcoholics Anonymous* and the Quality of Life Inventory (QOLI; Frisch, 1993).

Limitations of Existing Studies

Although various effective treatment options exist for alcoholism (Babor & Del Boca, 2003), problem drinkers continue to choose Alcoholics Anonymous (AA) for treatment more frequently than all forms of professional alcohol treatment combined (McCrady & Miller, 1993; Room & Greenfield, 1993; Weisner, Greenfield, & Room 1995). In fact, Americans make more visits to self-help groups for substance abuse and psychiatric problems than to all mental health professionals combined (Kessler et al., 1997). Although countless AA members and healthcare providers strongly purport the Fellowship's value (Chang et al., 1994; Emrick et al, 1992; Humphreys & Noke, 1997) and empirical evidence suggests improved abstinence outcomes associated with AA involvement (Emrick et al., 1992; Humphreys, 1999; Tonigan et al., 2000;), researchers and clinicians remain skeptical of the absolute value, methods, and theory of AA. This skepticism is wholly supported by the extreme variance within and between AA groups, the anonymity required of AA members and guests, and ultimately by the lack of any standard definition of AA membership.

While researchers have focused on affiliation with AA and its relationship to abstinence, both researchers and clinicians have failed to explore and utilize AA's definitions of alcoholism, affiliation, and recovery as written in its basic text, *Alcoholics Anonymous*, the book after which the Fellowship itself and the dozens of 12-Step movements since borne are named. In turn, researchers have been investigating AA as a method of treatment with little or no regard for what AA itself claims to treat, how AA claims to treat it, and what AA has found it to look like once treated.

The research completed to date has focused on Alcoholics Anonymous (AA) attendance and/or superficial AA behaviors as proof of affiliation, and when implementing these inappropriately constructed scales investigated only abstinence as proof of effectiveness. Therefore, we have a two-fold problem. Researchers have been investigating individuals that may or may not be alcoholic (as defined by *Alcoholics Anonymous*) and may or may not be affiliated with AA (as defined by *Alcoholics Anonymous*); and when doing so, operationalizing sobriety as the ability to stay away from alcohol, which is in fact not the stated purpose of *Alcoholics Anonymous*.

Meeting attendance has been the golden rule of AA affiliation research for much of history (Cloud, Ziegler, & Blondell, 2004, Emrick et al., 1992); however, researchers have failed to consider that visitors to AA meetings (alcoholic or not) are more than welcome to sleep at meetings, simply drink coffee, or chat with friends. While perhaps enjoyable, these behaviors certainly do not represent the foundation of AA's program of recovery. Furthermore, when speaking to abstinence as the ultimate measure of AA's effectiveness, *Alcoholics Anonymous* does not support one's ability to avoid alcohol consumption as a sufficient measure of sobriety. In fact, AA does not demand that visitors to meetings (alcoholic or not) or AA members (defined as individuals with a desire to stop drinking) necessarily must stop drinking. Instead, AA aims to introduce all visitors and members of the Fellowship to a faith in a Higher Power, a spiritual way of life, and "...a widening circle of peace on earth and good will to men" (AAWS, 2001, p.16). *Alcoholics Anonymous* speaks to weekly meetings (now known as Open meetings) designed to introduce "anyone interested" to "our way of life" (AAWS, p. 18). Surely, an investigation of whether or not these people stop drinking is a poor measure of AA's

effectiveness and still a poorer measure of their affiliation with the principles of *Alcoholics Anonymous*.

Though useful, the research completed to date has either completely ignored the definition of affiliation plainly written in the Fellowship's primary text or completely ignored the definition of sobriety as exhibited in the same text. *Alcoholics Anonymous* says little to nothing about attendance at meetings, sponsorship, celebrating sobriety birthdays, or "sharing." However, these superficial behaviors have been the focal points of affiliation scales throughout the greater history of Alcoholics Anonymous (AA) research, including those implemented by prominent alcoholism researchers such as Humphreys, Kaskutas, and Weisner (1998); Morgenstern, Kahler, Frey, and Labouvie (1996); and Tonigan et al. (1996). Regardless of whether or not their work has supported the efficacy of AA, these researchers have failed to explore the essence of *Alcoholics Anonymous* including what it looks like and how it expresses itself in the life of the alcoholic and his or her community. Furthermore, the limited definition of recovery as abstinence and the continual focus on the reduction of drinking behavior as the primary focus of alcohol treatment again ignores the program of recovery offered by *Alcoholics Anonymous*. According to *Alcoholics Anonymous*, abstinence is not the primary purpose of recovery itself, life after recovery, or the Program. Therefore, the research to date has investigated either affiliation with AA or recovery from alcoholism, or both from completely outside the text of *Alcoholics Anonymous* and its suggested program of recovery.

While various researchers have called for increased communion between professional researchers and recovery counselors (Policin, 1997), the greater professional

community remains largely unaware of or unwilling to acknowledge the definitions, methods of action, and overall recovery paradigm suggested by *Alcoholics Anonymous*. In addition, many recovery counselors who are familiar with Alcoholics Anonymous (AA) and its methods choose not to base their work on findings from the professional research literature. Therefore those professionals who continue to simply recommend AA attendance and attendance alone to those they serve fail to acknowledge the methods and mechanisms of action that AA itself and those finding solace in its Fellowship report to be the most reliable and effective. Such inconsideration serves to further jade recovery counselors who may already refuse to implement current research in practice, based on their oftentimes legitimate perception of a research community that has little respect for the specific methods and predominantly spiritual solution of *Alcoholics Anonymous*.

I contend that the greatest division between the professional clinical community and recovered community arises as a result of the professional community's unwillingness to acknowledge the single most important element of 12-Step recovery, the belief and reliance upon a Higher Power. My experience suggests that this resistance is exacerbated by the recovered communities heightened sensitivity towards the medical community and its disregard for AA's spiritual paradigm. In fact, when referencing the nature and purpose of *Alcoholics Anonymous,* AA's founders write:

> Its main object is to enable you to find a Power greater than yourself which will solve your problem. That means we have written a book which we believe to be spiritual as well as moral. And it means, of course, that we are going to talk about God (AAWS., 2001, p. 46).

Contrary to popular belief, Alcoholics Anonymous (AA) is absolutely not self-help and only partially a mutual-aid group. While AA members may support one another in recovery, if a particular AA group constantly and continuously claims only reliance upon one another, then that entire group has failed to achieve the spiritual awakening offered via the 12 Steps. In fact, *Alcoholics Anonymous* explicitly states, "Being convinced that self, manifested in various ways, was what had defeated us, we considered its common manifestations" (AAWS, 2001, p. 64). According to the principles set forth in *Alcoholics Anonymous*, principles that have worked for millions of alcoholics, AA is all about God-help.

The concept of God-help appears to be the major obstacle between a stronger union of the professional community and the Fellowship. Brown and Miller (2005) reinforced this position with the acknowledgement that American psychology emphasizes control, viewing the individual as the agent of "willful change" and self-control. Brown and Miller further state that clinical interventions and techniques are often directed at reinforcing self-regulation in order to once again have or for the first time take control. The American cultural ideal is, in fact, grounded in the progression from dependence to independence (Brown & Miller, 2005), putting those who rely on some power greater than themselves in the losers' camp.

However, recent movements in multicultural counseling have persuaded some researchers to investigate the experiences of diverse cultures from within their own context, paying special attention to the culturally-specific proposed methods of action and attempting to add greater understanding to these methods rather than confirm or deny their effectiveness. Rohner (1984) defined culture as a variable set of meanings learned

and shared by a group of people that is often transmitted from one generation to another. According to Rohner's definition, Alcoholics Anonymous (AA) represents such a culture, and as such deserves cultural competence on the part of the professional community when dealing with members of the Fellowship. The importance of culturally-competent care is highlighted by the ethical guidelines that have been developed for culturally competent care by the American Psychological Association (2002), and such care acknowledges and incorporates, at all levels, the importance of culture and language, the cultural strengths of people and their communities, the assessment of cross-cultural relations, vigilance to dynamics in cultural and linguistic differences, and the adaptation of services to meet culturally unique needs (Cross, Bazron, Dennis, & Isaacs, 1989). While research outside of AA has begun to incorporate a spiritual perspective and the integration of spiritual values into treatment processes (Richards & Bergin, 1997; Shafranske, 1996; Tan, 1996), AA has yet to enjoy such attention and culturally sensitive treatment.

While the primary purpose of this study is to provide scientists with a valid and reliable measure of AA affiliation, it also serves to begin building a bridge between the professional and AA communities by investigating a small portion of what AA has to offer those who approach alcohol problems and their solutions from a combined spiritual, scientific, and psychological vantage point. Therefore, while I have attempted to pay proper homage to the scientific advancements and statistical analyses available to the professional research body, I have also attempted to pay similar homage to the faith-based program of recovery that is *Alcoholics Anonymous*. Perhaps William D. Silkworth, M.D., dear friend of AA and contributor to its basic text said it best:

> We doctors have realized for a long time that some form of moral psychology was of urgent importance to alcoholics, but its application presented difficulties beyond our conception. What with our ultra-modern standards, our scientific approach to everything, we are perhaps not well equipped to apply the powers of good that lie outside our synthetic knowledge (AAWS, 2001, p.xxvii).

Research Questions

Using a review of affiliation, demographic, and Quality of Life Inventory (QOLI; Frisch, 1993) data gathered over the course of 3 months from participants across closed meetings of Alcoholics Anonymous (AA) in suburban and urban areas of Central New Jersey, this study explored the relationship of affiliation with AA as defined by *Alcoholics Anonymous* and quality of life as defined by both *Alcoholics Anonymous* and the QOLI. Specifically, the questions addressed by this study were as follows:

1. Does an instrument comprised entirely of items drawn directly from *Alcoholics Anonymous* reliably measure affiliation with AA, and is such a measure valid?
2. When statistically analyzed, do elements of affiliation with Service, Recovery, and Unity exist as three individual factors?
3. Assuming the reliability for the affiliation measure is acceptable, how effectively does affiliation with AA as defined in question 1 above predict quality of life as measured by the QOLI?
4. Assuming the reliability for the affiliation measure is acceptable, how does the degree of alcoholism as defined by *Alcoholics Anonymous* affect affiliation

with Alcoholics Anonymous (AA) and quality of life as measured by the QOLI?

5. Assuming the 9th Step Promises Questionnaire is itself a reliable measure, how strongly are scores on the fulfillment of the 9th Step Promises and the QOLI correlated?

Hypotheses

Based on the text *Alcoholics Anonymous* and the program of recovery therein, the hypotheses for this study were as follows:

1. The Reliability of Items Drawn from *Alcoholics Anonymous* as a Measure of Affiliation with AA:

   Due to the specificity of items chosen and the process of expert review initiated over the course of scale development it is expected that the current measure of AA affiliation will prove internally reliable.

2. The Factor Structure of AA's Three Legacies:

   Due to the commingling of elements of Service, Unity, and Recovery it is not expected that such elements will exist in three orthogonal factors, although some correlated factors may emerge.

3. The Relationship Between Affiliation with AA and Quality of Life:

   Alcoholics Anonymous recognizes the need for the alcoholic to hit "bottom" psychologically, physically, and spiritually before developing the degree of willingness necessary to carry through with the arduous Program of recovery suggested in the text. Given that *Alcoholics Anonymous* calls for this "complete willingness" (p.12) to do whatever is

required of the Program to achieve and maintain sobriety, it is expected that individuals who report higher overall affiliation scores will also report higher quality of life scores.

4. The Effect of Degree of Alcoholism on Affiliation and Quality of Life:
    a. Given that *Alcoholics Anonymous* recognizes despair as the great motivator for recovery in alcoholics, it is expected that individuals claiming both long- and short-term sobriety who report higher degrees of alcoholism will report higher levels of affiliation with Alcoholics Anonymous (AA).
    b. Because of the greater affiliation with AA, it is also expected that these individuals will report higher quality of life.
5. The Relationship of QOLI Scores and the 9th Step Promises:

    Given that the 9th Step Promises and QOLI relate to similar areas of the alcoholic's life, it is expected that QOLI scores and fulfillment of the 9th Step Promises will strongly correlate.

Definition of Terms

Alcoholics Anonymous/AA./The Fellowship. For the purposes of this study Alcoholics Anonymous, AA, and the Fellowship are used interchangeably to represent the individuals who constitute the society of men and women working together towards recovery.

Alcoholics Anonymous. *Alcoholics Anonymous* is the basic text and the origin of the Fellowship. It contains the specific Program of recovery that has helped millions of

men and women recover from alcoholism. First published in April of 1939 (over 300,000 copies), *Alcoholics Anonymous* has since been published in 1955 (1,150,500 copies), 1976 (11, 698,000 copies), and 2001 (25,000,000 copies). For the purposes of this study, *Alcoholics Anonymous* and the page numbers referenced will specifically refer to the Fourth Edition of *Alcoholics Anonymous.* Throughout the many printings of the text, there have been no changes to the first 164 pages, which constitute the Program of recovery. The remaining pages contain the stories of individual men and women who have found the "spiritual" solution (e.g., p. xvi, xxiv, xxvi, 14, 25, 28, 39, 42) of *Alcoholics Anonymous*. The authors describe these stories, "Each individual, in the personal stories, describe in his own language and from his own point of view the way he established his relationship with God" (p. 29).

Alcoholism. Alcoholism was defined according to Alcoholics Anonymous' (AA) description of the four degrees of alcoholism as written on pages 108-111 in *Alcoholics Anonymous* and further described in Chapter II of this study. For the purposes of this study, levels 1 and 2 will be considered lower levels of alcoholism and levels 3 and 4 will be considered higher levels of alcoholism.

Affiliation. Affiliation was defined according to *Alcoholics Anonymous*' description of involvement with the Legacies of AA, as agreed upon by a body of experts and included in this study's Alcoholics Anonymous Affiliation questionnaires. Scores will range from 0 to 84 on each of the three scales, with a score of 48 representing no affiliation or involvement with the principles of *Alcoholics Anonymous*, a score of 0 representing total objection to the principles of *Alcoholics Anonymous*, and a score of 84

representing absolute affiliation and adherence to the principles of *Alcoholics Anonymous*.

Recovery. Recovery was defined according to the degree to which the individual identifies with and has achieved or experienced the 9th Step Promises of *Alcoholics Anonymous*. Scores will range from 0 to 36, with a score of 0 representing no experience or identification with the 9th Step Promises and a score of 36 representing absolute experience and identification with the 9th Step Promises.

Sobriety. Sobriety was defined as total abstinence from any and all mind/mood altering drugs.

The Program. The Program was defined as the instructions for achieving sobriety and a life of usefulness, happiness, joy, and freedom as written and recorded in the basic text of the Fellowship, *Alcoholics Anonymous*. This Program is founded upon the 12 Steps.

Educational Level. Educational level was recorded as years of education, based on the highest grade or post-secondary year/degree completed.

Race/Ethnicity. The race/ethnicity of participants in the study were recorded at intake and based on the client's self-identification. Participants were asked to check off the category that best describes them as defined on the New Jersey Department of Human Services Unified Services Transaction Client Registry Form (USTF-1). These categories are as follows: American Indian/Alaskan Native; Asian/Pacific Islander; Black, Not of Hispanic Origin; Hispanic; White, Not of Hispanic Origin; and Other. Participants who checked off "Other" were given the opportunity to describe their race/ethnicity in their

own terms. Finally, participants were given the opportunity to report religious affiliation.

Significance of the Study

In recognizing the presence and influence of Alcoholics Anonymous (AA) worldwide and a growing body of empirical evidence suggesting improved abstinence outcomes associated with AA involvement (Emrick et al., 1992; Humphreys, 1999; Tonigan et al., 2000;), it follows that research on the Fellowship has international implications. This study did not attempt to prove AA's effectiveness, something millions of members and the medical community itself have recognized for years. In fact, the American Public Health Association presented Alcoholics Anonymous with the Lasker Group Award, America's highest scientific prize for medical progress in 1951. The Association stated, "The American Public Health Association presents a Lasker Group Award for 1951 to Alcoholics Anonymous in recognition of its unique and highly successful approach to that age-old public health and social problem, alcoholism"(AAWS, 2001, p. 571).

The overwhelming majority of research on AA suggests that AA attendance in addition to various other and oftentimes unsupported affiliation criteria improve abstinence outcomes. However, if success rates have dropped from the 75% estimate offered by the authors of *Alcoholics Anonymous*, perhaps the greatest change is visible in the way the program is worked, as a combined result of who now claims AA membership and how the Program is represented both inside and outside the Fellowship. While the vast majority of treatment professionals in the US attempt to provide some form of 12-Step facilitation and encourage affiliation with AA (Borkman et al., 1998; Humphreys,

1997; Mäkelä et al., 1996), they appear to be doing so outside the paradigm suggested by the Program itself, focusing on meeting attendance alone and resulting in a dissolution of Alcoholics Anonymous' (AA) effectiveness and worse yet the possible amplification of suffering for countless alcoholics, their families, and the larger community. Such dissolution is evidenced by the words so often heard by newcomers to AA, "Don't drink and go to meetings." Clearly, if not drinking was an option, the newcomer would not need AA.

A research study designed to validate an instrument to measure affiliation as defined by *Alcoholics Anonymous* and investigate the relationship of affiliation with AA and recovery from alcoholism as again defined by *Alcoholics Anonymous* may serve to enlighten professionals, alcoholics, recovery counselors, and the larger community with regards to the most necessary and potent elements of involvement with AA. Such a study may serve to begin bridging the chasm that currently exits between a secular, professional-research and clinical community and a more spiritual, faith-based 12-Step community while allowing each access to its preferred methods of operation. According to Tonigan et al. (2003), the research body has paid little attention to understanding how formal treatment may facilitate AA utilization, and this lack of attention has directly led to a popular uncertainty regarding which aspects of AA ideology and practice ought to be encouraged in formal treatment.

This study provides formal treatment methodologies with the most powerful aspects of AA affiliation which can then be introduced, explored, and re-visited throughout the course of treatment. In short, this study provides professionals with a useful instrument and the necessary clinical ammunition to begin an honest and

appropriate investigation into their clients' affiliation with AA and allow recommendations for increased or additional involvement when appropriate.

Limitations

Alcoholics Anonymous clearly states that 12-Step recovery is based on "God sufficiency" rather than "self-sufficiency" (p. 52) and any attempt to investigate the process or effectiveness of *Alcoholics Anonymous* without consideration of such principles is unfair and perhaps unethical. While "Inquiry by scientific, medical, and religious societies will be welcomed" (p. xiv), such inquiry is generally complicated and limited for various reasons. To begin, Alcoholics Anonymous' (AA) approach to recovery from alcoholism depends almost entirely on the willingness, honesty, and openness of the alcoholic in conjunction with his ability to believe in and rely on a God of his or her understanding. From the perspective of individual members of AA, there is no need to investigate the effectiveness of such an approach. AA works for those who work the program of *Alcoholics Anonymous*.

Although certain behaviors may suggest someone is "working" the Program, the underlying and more ambiguous experiences of willingness, faith in a Higher Power, and spiritual experience more legitimately represent the gestalt of recovery in AA. These concepts are difficult to measure in and of themselves. Moreover, when one considers the possibility that the aforementioned spiritual experience is for many "the educational variety" (AAWS, 2001, p. 567), the process of recovery in AA becomes still more difficult to measure as the individual's physical health, mental health, and spiritual health progress slowly and oftentimes along divergent paths. William James (1902),

psychologist, spiritualist, and oft-quoted source of inspiration by AA's founding fathers states:

> But solemnity, and gravity, and all such emotional attributes, admit of various shades; and, do what we will with our defining, the truth must at last be confronted that we are dealing with a field of experience where there is not a single conception that can be sharply drawn. The pretension, under such conditions, to be rigorously 'scientific' or 'exact' in our terms would only stamp us as lacking in understanding of our task. Things are more or less divine, states of mind are more or less religious, reactions are more or less total, but the boundaries are always misty, and it is everywhere a question of amount and degree.

Therefore, while the study implements both characteristics of affiliation and recovery (quality of life) directly from *Alcoholics Anonymous*, it is questionable whether or not these characteristics are capable of being analyzed by traditional statistical procedures. Instead, they are considered simple observations of spiritual truth, comments on what is necessary to achieve sobriety and peace in life as an alcoholic.

Nonetheless, the study factor analyzed the affiliation scale herein and correlated it to both a short measure of quality of life as written in *Alcoholics Anonymous* as well as a more traditional and statistically hardened measure of such. Scientific inquiry designed to uncover the degree of effectiveness and the process of recovery may serve to uncover the most potent elements of Alcoholics Anonymous' (AA) approach, therefore facilitating greater communication within and between the professional clinical community and those it serves. Furthermore, this communication must necessarily take

place more efficiently and effectively as managed healthcare companies continue to negatively affect the length and quality of care received (Druss, Miller, & Rosenbeck, 2002). As managed healthcare continues to shorten the number of sessions allowed in treatment, clinicians must necessarily tap into the most potent elements of recovery in pursuit of effective treatment.

In addition to these most basic limitations, the process of recovery as defined by *Alcoholics Anonymous* may necessarily be slower for some than others, regardless of the amount of Step work, Fellowship, or service in which the individual engages. According to Alcoholics Anonymous' (AA) spiritual principles, all things happen in God's time. In order to be most fully engaged in the process of life and recovery, acceptance of what *is* is absolutely necessary to find the peace that the willingness to work one's own Program and serve others can bring. Although quality of life is of absolute importance to a Fellowship that calls for its members to be "happy, joyous, and free," it is by no means the ultimate measure of effectiveness of AA's program. On the contrary, it is the ability to serve others and consider their needs before one's own that is most important. Therefore, many individuals of the Fellowship may in fact be fully affiliated with the program, but lack the significant levels of quality of life that the instruments involved in this study are designed to measure.

Finally, the nature of the instruments and the sampling method employed provide further limitations. Considering that all the instruments herein are self-report, limitations exist regarding the validity of individual reports and claims of affiliation, degree of alcoholism, and quality of life. However, current research does not provide clear and consistent measures that unambiguously correspond to this study's most relevant

categories of experienced emotion. There is no known, objective, and external measure of the subjective and internal events that human beings experience as sadness, fear, connectedness, and so on (Barrett, 2004). Therefore, if we want to know how people feel, we have to ask them. Self-report then is the most plausible method of data collection. Regarding the validity of self-reported levels of alcohol consumption, research suggests that the self-reports of substance use from help-seeking subjects are highly valid (Calhoun et al., 2000; Weiss et al., 1998), lending further support to this study's method of data collection.

In conclusion, sampling limitations exist due to the non-random nature of the sampling method chosen and self-selection bias may present a significant limitation were more active and highly affiliated members of Alcoholics Anonymous (AA) the first to volunteer for participation in the study. However, I have addressed these limitations via an attempt to disseminate study packets across as wide a range of socioeconomic, cultural, racial, and AA membership demographics as is possible

Chapter II: Review of Related Literature

Introduction

Before affiliation with Alcoholics Anonymous (AA), recovery from alcoholism, or quality of life can be measured or investigated, each must first be defined and understood. This chapter begins with a brief history of AA and a summary of research concerning affiliation with AA. The next section discusses the diagnosis and etiology of alcoholism as visited in both the professional research and *Alcoholics Anonymous*. Following this discussion, I will summarize the meaning of recovery as witnessed again in both the professional research and *Alcoholics Anonymous*.

A Brief History of Alcoholics Anonymous

The history of AA begins with the temperance movements of the mid 1800's. The first of these to have a profound effect on the development and theory of AA was the Washington Temperance Society or the Washingtonians (Daniels, 1878). Started by a handful of self-admitted drunkards and holding its court in a tavern of all places, the Washingtonians grew in leaps and bounds with its temperance pledges, parades, and hospital care centers. The society soon grew to be so popular that politicians, actors, and anyone else interested were recruited to "take the pledge," and before long what was first an organization started by alcoholics for alcoholics lost focus of its primary purpose. Political argument and conflicting religious affiliation soon fragmented the society to the point of its total dissolution in the late 1800's.

The Washingtonians were soon followed by the Oxford Group, beginning in 1908 (AAWS, 2005). Originally tagged a "First Century Christian Fellowship," the Oxford Group was started by Frank Buchman, a Lutheran minister from Pennsylvania. The

primary purpose of the Oxford Group was changing the world, "One Person at a Time." Group members were invited to surrender, on their knees, and give testimony of their deliverance from sin by the Grace of God. While the Washingtonians offered a plethora of do's and don'ts to the founders of Alcoholics Anonymous (AA)., the Oxford Group offered something far greater. Bill Wilson, co-founder of AA, was introduced to the Oxford Group and its unofficial 6 Steps to spiritual development (e.g., absolute surrender, guidance by the Holy Spirit, sharing bringing about true fellowship, life changing, faith, and prayer) through his childhood friend Ebby Thatcher. A sober Ebby visited a very drunk Bill in November of 1934 after "finding religion" in the Oxford Group and relief from a sizeable drinking problem of his own. Ebby himself had been referred to the Oxford group by Rowland Hazard., an AA pioneer and patient of Dr. Carl Jung. Rowland was told directly by Dr. Jung that only a spiritual experience could save an alcoholic of his kind and the Doctor referred him to the Oxford group to find such an experience. Alcoholics Anonymous co-founder, Bill Wilson would later exchange letters with Dr. Jung, the former writing:

> You frankly told [Rowland] of the hopelessness of…further medical or psychiatric treatment," [and also of the possibility of] "a spiritual awakening or religious experience – in short, a genuine conversion (AAWS, 2005, p. 54).

Bill later described these statements as "beyond doubt the first foundation stone upon which AA has been built," and Jung responds by confirming that the most appropriate antidote to alcoholism is spirituality (AAWS, 2005, p. 54).

After at least three failed hospitalizations and treatments for alcoholism, Bill Wilson stayed sober for six months while working with the Oxford group and attempting

to help other alcoholics recover. Although Bill failed to help any of his prospects recover via the Oxford Group principles alone, he stayed sober far longer than he had been capable in many years. Not only did the Oxford Group keep Alcoholics Anonymous'(AA) co-founder sober enough to begin the Fellowship, but it introduced him to the second of AA's first members. While on business in Akron, Ohio in April of 1935, Bill was suddenly stricken with the strong desire for drink after a business deal went terribly wrong. Knowing he was on thin ice, Bill called a local clergyman and asked for an alcoholic referral with whom he could spend some time and clear his own head. Bill was referred to a struggling alcoholic and local medical doctor by the name of Robert Smith, who had been working unsuccessfully with the Oxford Group for a number of years. Bill worked with "Dr. Bob" and his wife for nearly three months before Dr. Bob would achieve lasting sobriety. The date of Dr. Bob's last drink – June 10, 1935 – is marked as the day AA was born.

Bill, Dr. Bob, and several other alcoholics successfully stayed sober working with one another and the Oxford Groups they attended in New York and Akron respectively. However, despite a strong relationship with the Rev. Dr. Shoemaker, the Director of Calvary Church in Manhattan and leader of the local Oxford chapter, tension began to build between Bill's band of struggling alcoholics and the Group at Calvary Church. Bill and his group were accused of being "narrow and divisive" by the Reverend Dr., prompting Bill and his wife Lois's exit from the organization in 1937. By this time, Bill and Dr. Bob found some 40 of the many alcoholics with whom they had worked had been able to stay sober for two years.

In 1938, the fledgling society deemed it necessary to write a book in order to reach greater numbers of alcoholics beyond their respective New York and Akron headquarters. With the help of various conspicuously random characters, Alcoholics Anonymous (AA). was born of the efforts of its co-founders Bill Wilson and Bob Smith as well as Willard Richardson of the Rockefeller philanthropies; Albert Scott, Chairman of the Board of Trustees of Riverside Church in Manhattan; Frank Amos, an advertising executive with direct ties to John D. Rockefeller himself; and A. LeRoy Chipman, a Rockefeller associate. These men together with the handful of AA members established the Alcoholic Foundation and raised the necessary funds to begin production of *Alcoholics Anonymous.* With the book in production, Bill Wilson recognized the necessity of formulating a precise plan of action to help alcoholics recover as he and his fellows had done. In response, and by the Grace of God according to AA members around the world, Bill Wilson recorded the 12 Steps of recovery, the Program of action that has saved countless lives over the last 70 years.

While Bill Wilson and a band of rogue alcoholics were feverishly working to maintain their own sobriety, the Fellowship's owes a majority of its early growth to the response to a *Saturday Evening Post* article written by Jack Alexander and published on March 1st of 1941. The article stimulated AA membership to 2,000 members by the end of March and 6,000 members with 200 active groups across the country by November. The first women's group was soon established in 1941 and by 1943 AA crept into Canada and greeted French-speaking alcoholics in Montreal.

By the mid-1950's AA would claim 130,000 members attending 6,000 groups on five continents, including Europe, Asia, Africa, and South America. By the end of the

Fellowship's 3rd decade, meetings were taking place in some 7,000 groups in 70 countries, with membership estimated at approximately 200,000. By 1976, Alcoholics Anonymous (AA) membership would top 1,000,000 and an estimated 28,000 groups in 92 countries. The program and principles of AA are spoken in over 40 languages by the end of the 1970's, including sign language. By 1985, AA.'s 50th anniversary, over five million copies of *Alcoholics Anonymous* are in print. By 1989 the number reached 8,000,000; by 2000, 20,000,000; and by 2005 25,000,000. The new millennium also welcomed a worldwide membership of 2,160,013 attending over 100,000 groups. Specialty groups exist for gay men, lesbians, the hearing impaired, the blind, medical doctors, police officials, prisoners, and the mentally ill among others.

This brief history falls far short of the massive cross-cultural growth and effect AA has had upon the world. However, the numbers alone suggest a movement that motivates involvement, produces results, and brings together people of various cultures, ethnicities, orientations, abilities, and beliefs like few other have in the history of the human race.

Affiliation with Alcoholics Anonymous

Prior to a surge in AA research that took place in the early 1990's, meeting attendance was the standard measure of affiliation implemented in AA research (Cloud et al., 2004; Emerick et al., 1992). However, Emerick et al. (1992) and Montgomery, Miller, and Tonigan (1995) found additional 12-Step related involvement measures (e.g. leading meetings, having a sponsor, being a sponsor, practicing the 12 Steps) were more powerful predictors of drinking outcomes. Snow, Prochaska, and Rossi (1994) also

contributed to the expansion of Alcoholics Anonymous (AA) involvement research by developing a measure of AA affiliation using three self-report items: perceived importance of AA to recovery, degree that life revolved around specific AA activities, and number of friends who were active AA members. Snow, Prochaska, and Rossi (1994) found that the composite measure predicted more behavior change than did meeting attendance alone. Gilbert (1991) began implementing the Steps in research by factor analyzing a Steps questionnaire designed to asses participants' beliefs about the extent to which they had worked Steps 1-3. According to Gilbert, the factor reflecting Step 1 significantly predicted post-treatment abstinence.

These findings collectively prompted additional research and the development of three short instruments designed to more fully measure AA involvement (Humphreys et al., 1998; Morgenstern et al., 1996; Tonigan et al., 1996).

Humphreys et al. (1998) developed The Alcoholics Anonymous Affiliation Scale (AAAS) to enhance AA affiliation research by taking advantage of the aforementioned 12-Step related involvement measures. The AAAS consists of the following 9 items, with the first item being answered by choosing 1 of 5 possible number ranges, the second being answered quantitatively, and the remainder of the items being answered "no" or "yes."

1. How many AA meetings would you estimate that you've gone to during your lifetime?
2. How many AA. meetings have you gone to in the last 12 months?
3. Have you ever called an AA member for help?
4. Have you ever considered yourself a member of AA?

5. Do you now have an AA sponsor?

6. Have you ever sponsored anyone in AA?

7. Have you had a spiritual awakening or a conversion experience as a result of your involvement in AA?

8. In the past 12 months, have you read AA. literature?

9. In the past 12 months, have you done service, helped newcomers, or set up chairs, made coffee, cleaned up after a meeting etc.?

Investigating a sample of 927 alcohol treatment seekers and 674 untreated problem drinkers, Humphreys et al. (1998) reported good internal consistency across diverse demographic groups, multiple health services settings, and treated and untreated populations. The authors also support the scale's validity with findings that treatment seekers report significantly higher Alcoholics Anonymous (AA) affiliation than do untreated problem drinkers, and inpatients report higher affiliation than outpatients.

Humphreys et al. (1998) continue the aforementioned trend of reliance upon meeting attendance and superficial AA jargon as opposed to meaningful Program dialogue taken from the text of *Alcoholics Anonymous.* More importantly, the authors' attempt to measure affiliation with AA. anywhere outside of AA itself suggests a confused notion of willingness to act in accordance with AA principles. It is imperative that AA affiliation be measured by an honest investigation of behaviors suggesting adherence to the program of recovery plainly written in *Alcoholics Anonymous.* Research participants must necessarily claim AA membership to be legitimate subjects in a study designed to uncover the effectiveness of affiliation with AA. Humphreys et al. fail to acknowledge these simple limitations.

Morgenstern et al. (1996) designed the Recovery Interview (RI) to assess involvement in Alcoholics Anonymous (AA). The authors interviewed 103 individuals who had entered residential or intensive day treatment at two private hospital-based, chemical dependency treatment programs in New Jersey. Responses were recorded at entry into treatment and again one month following discharge. The RI is an interviewer-administered measure developed to assess 12-step behaviors. The authors constructed the interview based on previous AA affiliation research (Emrick et al., 1992; Sheeren, 1988; Tonigan et al., 1996) in an attempt to identify a diverse set of behaviors that would better represent AA affiliation. The authors identified a list of behaviors, which were reviewed by several individuals involved with AA. The following list of nine behaviors represents the RI, and the frequency of each is assessed using Likert scaling and response formats most appropriate to the behavior in question:

(a) AA meeting attendance

(b) Talking with a sponsor

(c) Attending Step meetings

(d) Engaging in 12-step service activities (e.g., setting up for a meeting)

(e) Reading AA or other recovery literature such as the Big Book or Hazelden Press publications

(f) Reaching out to other AA members

(g) Prayer or meditation

(h) The extent to which one's life revolved around AA activities

(i) Seeking advice from AA sources such as sponsors, the Big Book, or sharing in a meeting when making personal decisions

The authors concluded this list of behavior with two additional items measuring membership in Alcoholics Anonymous (AA) and working the Steps, which were answered using a categorical response format.

While Morgenstern et al. (1996) begin to touch on a couple of concepts more integral to the Program of recovery suggested by *Alcoholics Anonymous* when investigating step work and the use of prayer and meditation, they again fall far short of a measure truly designed to measure AA affiliation, in accordance with *Alcoholics Anonymous*. Again we see an emphasis on meeting attendance, talking behaviors, and advice seeking – useful actions but far short of the Program suggested by *Alcoholics Anonymous*. Perhaps the authors' reliance on previous AA affiliation research rather than an honest investigation of AA principles and text, led to a rather redundant construct. This reliance on past research may be a primary cause of the aforementioned dissolution of AA principles over time as each researcher takes a little bit from his or her predecessors, leaving less and less AA in the research. Morgenstern et al.'s definition of 12 Step service as setting up chairs represents such a dissolution. The importance and meaning of service is better understood by the following:

> For if an alcoholic failed to perfect and enlarge his spiritual life through work and self-sacrifice for others, he could not survive the certain trails and low spots ahead. If he did not work, he would surely drink again, and if he drank, he would surely die. (AAWS, 2001, p. 15).

Finally Tonigan et al. (1996) developed the Alcoholics Anonymous Involvement Scale (AAI) to measure lifetime and more recent participation in AA. The normative sample used for the development of the AAI included 1,726 clients participating in

Project MATCH (Babor & Del Boca, 2003), a national multi-site clinical trial of client-treatment matching, and the test-retest sample consisted of 82 participants (ranging from moderate drinkers to alcoholics) recruited to participate in a test-retest study of Project MATCH interview reliability. The AAI consists of the following 13 items with the 1st 8 of these items scored dichotomously (yes-no), and the latter five on continuous scales:

1. Have you ever attended an AA meeting?
2. Have you attended an AA meeting in the last year?
3. Have you ever considered yourself to be a member of AA?
4. Have you ever gone to 90 AA meetings in 90 days?
5. Have you ever celebrated an AA sobriety birthday?
6. Have you ever had an AA sponsor?
7. Have you ever been an AA sponsor?
8. If you have been in a alcohol treatment program (inpatient or outpatient), did they require that you "work" any of the AA steps?
9. What steps did you complete when you were in alcohol treatment?
10. Regardless of whether you have or have not been to alcohol treatment, which of the 12 Steps of AA have you "worked"?
11. How many AA meetings have you attended in the last year?
12. What is the total number of AA meetings that you have ever attended?
13. Have you ever had a spiritual awakening or conversion experience since your involvement in AA?

The AAI again falls far short of measuring anything akin to affiliation with AA according to *Alcoholics Anonymous*. The AAI represents yet another example of the

dissolution of Alcoholics Anonymous' (AA) principles. For example, 90 meetings in 90 days is not a suggestion of *Alcoholics Anonymous,* but instead it is popular alcohol rehabilitation jargon. Also, 4 of the 13 questions revolve around meeting attendance, while others investigate non-AA principles such as sobriety birthdays and inpatient/ outpatient treatment. Tonigan et al. (1996) also failed to acknowledge the simple necessity of recognized AA membership as a precursor to an investigation of the strength of such membership. This instrument, like the others, represents a regurgitation of older AA affiliation standards and research, all of which lies outside the purview of true AA principles and practices.

While these three scales have made progress towards a better measure of AA affiliation than meeting attendance alone, each fails to capture even a portion of the three legacies of Recovery, Service, and Unity suggested as the foundation of AA's program of recovery (AAWS, 2001). Each appears to be a summary and reduction of similar work. Cloud et al. (2004) suggest six themes that best summarize the topical content of these scales and their predecessors:

1.) Attending meetings.

2.) Working the 12 Steps.

3.) Identifying with AA (e.g., considering self a member, organizing life around AA, believing involvement is important to recovery).

4.) Experiencing a spiritual awakening (except Morgenstern et al., 1996).

5.) Using Program resources for help or guidance (e.g. other members, sponsors, meetings, literature, prayer or higher power)

6.) Involvement in higher-level activities (e.g., celebrating sobriety birthdays, being a sponsor, reading or studying program literature, interacting with recovering members outside meetings, providing volunteer services).

Cloud et al. (2004) further state that while all three scales are in agreement regarding activities and beliefs that equate to Alcoholics Anonymous (AA) involvement, the variety of specific beliefs and activities represented by the instruments further confound the true meaning of affiliation or disaffiliation with AA. To date, no scale has arisen that bases its content on *Alcoholics Anonymous* and its suggested program of recovery.

Affiliation with Alcoholics Anonymous According to the Text Alcoholics Anonymous

Merriam Webster (2000) defines *text* as "a source of information or authority." *Alcoholics Anonymous* is defined as the "basic *text* for our society" (p. xi) which "has helped such large numbers of alcoholic men and women to recovery, there exists strong sentiment against any radical changes being made in it" (p. xi). The authors of *Alcoholics Anonymous* continue, "To show other alcoholics precisely how we have recovered is the main purpose of this book. For them we hope these pages will prove so convincing that no further authentication will be necessary" (p. xiii).

While recent attempts to uncover the meaning of affiliation with AA above and beyond meeting attendance are significant, they have perhaps needlessly complicated matters in an attempt to better understand 12-Step recovery. For example while Cloud et al. (2004) attempted to reference the basic AA text, which in and of itself is a rarity in published research, they do so incorrectly. According to the authors, the basic AA text

emphasizes three elements of affiliation: identification and fellowship with recovering members, working the steps, and initiating and maintaining a spiritual condition. However, *Alcoholics Anonymous* is very clear that the disease of alcoholism is three-fold, mental, physical, and spiritual (p. 64) and *Alcoholics Anonymous* offers a three-fold solution, Recovery, Unity, and Service, also known as the Three Legacies of Alcoholics Anonymous (AA). These legacies are defined in *Alcoholics Anonymous Comes of Age*, first published in 1957:

> The chief inheritances of the first twenty years of Alcoholics Anonymous are the Legacies of Recovery, of Unity, and of Service. By the first we recover from alcoholism; by the second we stay together in unity; and by the third our society functions and serves its primary purpose of carrying the AA message to all who need it and want it.

These legacies respectively represent the 12-Steps, the Fellowship, and the dedication to service that are necessary to recover from the aforementioned elements of the disease as prescribed by *Alcoholics Anonymous*. Therefore, any measure of affiliation with AA. must necessarily measure affiliation with all three elements of AA's recommended program of recovery in order to fully explore the nature of the individual's connection to AA, its program of recovery, and its methods of operation. These elements of the Program (Unity, Service, and Recovery) will be more fully explored and defined in the following chapter.

Diagnosis of Alcohol Problems

The diagnosis of alcoholism has been greatly influenced by the various theories of etiology purported by the professional and lay communities (Polcin, 1997). Over the course of recent decades, clinicians have emphasized physiological symptoms, psychosocial consequences, cultural influences, or underlying psychopathology in the assessment and diagnosis of alcohol problems. Although professional clinicians are most often required to diagnose alcohol use disorders according to the *Diagnostic and Statistical Manual* qualifications, Polcin reports that recovery counselors continue to rely primarily on 12-Step principles for assessment and treatment. Various authors have suggested that the conflicts over diagnosis reflect larger divisions in the field involving theoretical differences among professional clinicians and recovery counselors. Khantzian (1994) suggested that the very motivation for the development of self-help groups is the failure of professional assistance to provide effective methods of change and therefore, members of such groups are inclined to be distrustful of professional perspectives, diagnoses, and rhetoric. Brown (1985) suggested nearly 10 years earlier that individual members of Alcoholics Anonymous (AA), who are helped by affiliation with the Fellowship after years of unsuccessful psychotherapy, are equally disinclined to trust the professional community. In turn, recovery counselors, many of whom lack formal training and are recovered alcoholics and members of AA, support this distrust either covertly by avoiding the use of professional research and terminology or overtly by speaking negatively about the professional research and clinical community.

Nonetheless, the *Diagnostic and Statistical Manual of Mental Disorders Text Revision* (*DSM-IV-TR*; American Psychiatric Association, 2001) provides rather clear guidelines for the diagnosis of alcohol use disorders. According to the *DSM-IV-TR*, alcohol use disorders fall into two categories: 303.90 Alcohol Dependence and 305.00 Alcohol Abuse. Alcohol Dependence, the more severe of the two, follows the general guidelines of Substance Dependence, defined as:

> A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:
>
> (1) tolerance
>
> (2) withdrawal
>
> (3) the substance is taken in larger amounts or over a longer period of time than was intended
>
> (4) there is a persistent desire or unsuccessful efforts to cut down or control use
>
> (5) a great deal of time is spent in activities necessary to obtain the substance
>
> (6) important social, occupational, or recreational activities are given up or reduced because of use
>
> (7) use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Alcohol Abuse follows the general guidelines of Substance Abuse:

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home

(2) recurrent substance use in situations in which it is physically hazardous

(3) recurrent substance-related legal problems

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Diagnosis of Alcoholism According to the text Alcoholics Anonymous

Although *Alcoholics Anonymous* acknowledges the influence of the medical community regarding the potency and usefulness of clinical diagnosis and its effect on the suffering alcoholic, the primary process of self-diagnosis is strongly preferred. The authors suggest, "If his own doctor is willing to tell him that he is alcoholic, so much the better" (AAWS, 2001, p. 92); however, such an exchange is preferred in conjunction with the individual's admission of alcoholism with the assistance of a recovered member of the Fellowship. In fact, *Alcoholics Anonymous* suggests that the recovered person share his or her experience regarding the "hopeless feature of the malady" and when working with the individual, "Be careful not to brand him an alcoholic. Let him draw his own conclusion" (p. 92). The importance of self-diagnosis is summarized on page 30, "We learned that we had to fully concede to our innermost selves that we were

alcoholics. This is the first step in recovery." *Alcoholics Anonymous* has much to say about this process of self-diagnosis:

> We do not like to pronounce any individual as alcoholic, but you can quickly diagnose yourself. Step over to the nearest barroom and try some controlled drinking. Try to drink and stop abruptly. Try it more than once. It will not take long for you to decide, if you are honest with yourself about it (AAWS, 2001, p. 31).

Alcoholics Anonymous does not require the individual to drink for long periods of time nor take the quantities that more advanced alcoholics have taken. *Alcoholics Anonymous* suggests a method of personal discovery on page 34:

> If anyone questions whether he has entered this dangerous area, let him try leaving liquor alone for one year. If he is a real alcoholic and very far advanced, there is scant chance of success. We think few, to whom this book will appeal, can stay dry anything like a year. Some will be drunk the day after making their resolutions; most of them within a few weeks.

Alcoholics Anonymous continues:

> But the actual or potential alcoholic, with hardly an exception, will be absolutely unable to stop drinking on the basis of self-knowledge. This is a point we wish to emphasize and re-emphasize, to smash home upon our alcoholic readers as it has been revealed to us out of bitter experience (p. 39).

Therefore, *alcoholism*, as witnessed by *Alcoholics Anonymous* is defined by the personal experience of powerlessness over alcohol, and this powerlessness is experienced first and foremost as a peculiar mental twist precluding the first drink. The alcoholic,

according to *Alcoholics Anonymous*, suffers from a "curious mental phenomenon that parallel with our sound reasoning there inevitably ran some insanely trivial excuse for taking the first drink" (AAWS, 2001, p. 37). The authors continue:

> The alcoholic at certain times has no effective mental defense again the first drink. Except in a few rare cases, neither he nor any other human being can provide such a defense. His defense must come from a Higher Power (p. 43).

Alcoholics Anonymous views the alcoholic as either someone who honestly wants to quite drinking entirely but cannot or who when drinking has little control over the amount taken. However, unlike the DSM-IV-TR, *Alcoholics Anonymous* suggests four degrees of alcoholism:

> (1) "He enjoys drinking" (p. 111). The lowest grade of alcohol abuser is defined as a "heavy drinker" (p. 108). This individual's drinking may be constant or may be heavy only on certain occasions. This individual's drinking may be an embarrassment at times and he may spend too much money on alcohol. This person considers his drinking as a necessary part of his job or life situation. This individual would probably be insulted if called an alcoholic and may be capable of stopping all together because of health issues, personal difficulties, or a doctor's warning.
>
> (2) "He wants to want to stop" (p. 109). This individual is clearly showing a lack of control and is unable to stay away from alcohol even when he wants to. This individual often gets entirely out of hand when drinking, recognizes this fact, and promises to do better in the future. This individual has begun to try various methods of moderating or staying dry, but after doing so for only a short while

begins to think that he can handle drinking again. He may drink in the morning to hold nervousness in check and may begin to worry about actually having the ability to stop. This individual may tend to business fairly well and certainly has not lost everything.

(3) "He desperately wants to stop but cannot "(p. 110). This individual has lost his friends, is unable to hold down a job, and his home life is a wreck. While he admits he cannot drink like other people, he does not know why, and he clings to the notion that he will some day find a way. This individual may have already visited the hospital or a rehabilitation clinic as the result of his drinking.

(4) "He has been placed in one institution after another" (p. 110). This individual appears insane when drunk and may be violent. She may have suffered from delirium tremens, been hospitalized, and drank on the way home from the hospital. Perhaps doctors have advised committing this drinker and hospitalizations may be frequent.

To summarize, the diagnosis of alcoholism is self-directed according to *Alcoholics Anonymous*, and must necessarily be so in order to provide sufficient motivation to enter recovery. Alcoholism is characterized by a mental obsession to begin drinking followed by a physical compulsion or craving to continue doing so thereafter. While diagnosis is defined as an internal process, alcoholism itself is defined in four stages of intensity according to both internal and external criteria. As alcoholism progresses, the individual begins to experience greater degrees of loss of control internally and greater degrees of unmanageability externally. The program of Alcoholics Anonymous (AA) is best suited for alcoholics that meet the criteria of the aforementioned

definition. Therefore, research aimed at uncovering the effectiveness of Alcoholics Anonymous (AA) with regards to the modification of alcoholic drinking behavior, ought to focus on those members of AA that meet these criteria for alcoholism. Because AA's Third Tradition clearly states that "The only requirement for AA membership is a desire to stop drinking" (AAWS, p. 562), it is not necessarily true that everyone attending an AA meeting is, in fact, alcoholic. In turn, research aimed at uncovering AA's ability to bring relief to the self-acknowledged alcoholic ought to first investigate and establish the individual's degree of alcoholism. I attempt to do exactly that via the use of the Degree of Acknowledged Alcoholism Questionnaire described in Chapter 3.

Etiology of Alcohol Problems

The etiology of alcoholism has been debated for decades, and this debate has centered on the importance and influence of genetic, biological, psychological, and social perspectives (Royce & Scratchley, 1995). To begin, biological aspects of addiction, including mechanisms of tolerance, withdrawal, and the existence of genetic predisposition have been the focus of early research (Royce & Scratchley). While no specific gene has been found for alcoholism, a substantial amount of data exists supporting the genetic influence for some individuals who are alcohol dependent (Cloninger, Bohman, & Sigvardisson, 1981; Goldman, 1993; Goodwin, 1979; Kendler, Walters, Neale, & Kessler, 1995). Simply put, adult offspring from families with alcoholism have elevated levels of alcohol problems compared with peers with no family history of alcoholism (Finn et al., 1997). Furthermore, biochemical research suggests that drinking behavior is maintained by substantial changes in neurotransmission

(Froehlich & Li, 1993; Gorelick, 1993; Royce & Scratchley, 1995), lending additional support to the biological perspective.

While these biological causes and conditions are well researched, they do not completely occur without the consent of the individual as expressed in his or her psyche and as influenced by his or her environment. In turn, researchers have investigated the individual's impact on the development of alcoholism as well as the impact of the individual's larger sociocultural context on said development. For example, several researchers have investigated the nature and existence of the alcoholic personality, but broad consensus exists that the term has little validity (Bates, 1993; Royce & Scratchley, 1995; Vaillant, 1995). There is little evidence to suggest any significant correlation between personality constructs among alcoholics. However, while a wide variety of personality types and dispositions are capable of developing alcohol dependency, certain emotional issues appear to be stronger risk indicators than others. For example high levels of aggression and conduct problems (Bates, 1993; Buckstein, 1995; Kaminer, 1994) as well as deficits in self-regulation and emotional reactivity (Caspi, Moffitt, Newman, & Silva, 1996) have been reported as risk factors for children and adolescents to subsequently develop alcohol problems.

While psychological elements and predispositions play a part in the development of alcoholism, these elements do not develop in a vacuum. According to the National Institute of Alcohol Abuse and Alcoholism (NIAAA; 2000), familial alcoholism and environment influence the individual's risk of developing psychological characteristics associated with risk for alcoholism, suggesting that both genetic and environmental factors play a role in the development of alcohol problems.

For decades, researchers have been aware of and explored environmental, social, and cultural factors leading to alcoholism, including social norms, values, roles, and peer and family influences (Dick, Agrawal, and Schuckit, 2006; Heath, 1993; Jessor 1987; Kandel, Simcha-Fagan, and Davies, 1986; Seale, Shellenberger, and Rodriguez, 2002; and White, 1993). This research strongly supports the potential influence of the environment on the manifestation of alcohol problems. The Center for Substance Abuse Prevention (CSAP; 1993) has suggested that the environment plays such a strong role in the development of alcohol problems that non-substance-using social and recreational activities for youth are significant deterrents to alcohol abuse. Such outcomes suggest that while biology plays a role in the development of alcohol problems, social solutions offer the opportunity to minimize the damage done to the alcoholic, his family, and the larger community. Alcoholism counseling is such a solution.

In consideration of these diverse etiological perspectives, the NIAAA (2000) suggested that there is an overwhelming consensus for the multiple pathways perspective. According to the NIAAA, multiple biological and psychosocial factors mutually influence each other in the etiology of alcoholism. Thus we have the currently accepted biopsychosocial perspective on the development of alcoholism.

Etiology of Alcoholism According to the Text Alcoholics Anonymous

While *Alcoholics Anonymous* does not directly address the etiology of alcoholism, it does offer some valuable information. To begin, *Alcoholics Anonymous* refers to the development of alcoholism as a "self-imposed crisis" (AAWS, 2001, p. 53). The authors

later refer to "selfishness" and "self-centeredness" as the "root of our troubles" (AAWS, 2001, p. 62), and they summarize:

> So our troubles, we think, are basically of our own making. They arise out of ourselves, and the alcoholic is an extreme example of self-will run riot, though he usually doesn't think so. Above everything, we alcoholics must be rid of this selfishness. We must, or it kills us! God makes that possible (p. 62).

Alcoholics Anonymous approaches the cause of alcoholism from a combined perspective. While the alcoholic is asked to acknowledge the "...flaws in our make-up which caused our failure" (AAWS, 2001, p. 64), the authors further state that the "body of the alcoholic is quite as abnormal as his mind" (p. xxvi). While it is stressed that alcoholics cannot control their drinking because they may be "maladjusted to life, in full flight from reality, or were outright mental defectives" (p. xxvi), the authors also report, "we are sure that our bodies were sickened as well" (p. xxvi). Psychiatrist, William D. Silkworth, summarizes *Alcoholics Anonymous'* approach to the disease model of alcoholism:

> We believe, and so suggested a few years ago, that the action of alcohol on these chronic alcoholics is a manifestation of an allergy; that the phenomenon of craving is limited to this class and never occurs in the average temperate drinker. These allergic types can never safely use alcohol in any form at all; and once having formed the habit and found they cannot break it, once having lost their self-confidence, their reliance upon things human, their problems pile up on them and become astonishingly difficult to solve (AAWS, 2001, p. xxviii).

In turn, *Alcoholics Anonymous* approaches the etiology of alcoholism from a combined psychological-biological-moral perspective. The authors suggest, "we have been not only mentally and physically ill, we have been spiritually sick" (AAWS, 2001, p. 64).

Methods of Alcoholism Treatment

The excessive use of alcohol costs the US over $140 billion a year (Harwood, Fountain, & Livermore, 1998). While a number of treatment methods have been identified, researched, and shown to be effective, current research suggests that no single best practice has been identified (Miller & Hester, 1995). As researchers have uncovered more effective methods of treating alcoholism, they have begun to investigate the validity of matching individuals to treatment methods based on personality, symptom intensity, and world view. Though fairly new to the scene of alcoholism treatment, patient-treatment matching has been thoroughly investigated (Institute of Medicine, 1990; Mattson et al., 1994; Project MATCH, 1997), but has shown little promise towards the enhancement of alcoholism treatment. Although Project MATCH (1997) established significant improvements in drinking outcomes across 12-step facilitation (TSF), Cognitive Behavioral Therapy (CBT), and Motivational Enhancement Therapy (MET), only 1 of 10 matching predictions was supported. While Project MATCH also reported greater number of days abstinent for patients participating in TSF when compared to either CBT or MET, the field of alcoholism treatment has not evolved to the point at which one treatment method can be chosen over another on the basis of research-supported efficacy alone. Therefore a brief review of current methods of treatment and

reported levels of efficacy is warranted as a part of any study attempting to add to the literature on alcoholism treatment.

In an attempt to further dissect the grossly broad treatment methods mentioned in both Chapter I of this paper and Project MATCH (1997), I will focus on four general types of treatment approaches that are currently among the most widely used and researched outside of Alcoholics Anonymous. Read, Kahler, and Stevenson (2001) referred to these types as individual skill-based treatments, motivational enhancement treatments, environmental and relationship-based treatments, and psychopharmacological treatments.

Individual Skill-Based Treatments

Grounded in social learning theory, individual skill-based treatment approaches are designed to increase the individual's capacity to interact with the environment without the use of alcohol. Among the most commonly used and researched methods of individual-skill based treatments, coping and social skills training (CSST) teaches basic skills designed to enable the individual to either quit or decrease drinking while managing life more effectively without alcohol (Read et al., 2001). When considering cost and treatment efficacy, skills training has proven to be among the most well supported of treatment methods (Miller et al., 1995), and it has demonstrated superior outcomes when compared to other common treatment methods (Eriksen, Bjornstad, & Gotestam, 1986; Monti et al., 1990).

According to Read et al. (2001), the primary objectives of CSST include the conditioning of more adaptive responses to drinking-related cues and the establishment of

basic skills for coping and achieving and maintaining sobriety. The primary methods used to achieve these objectives include behavioral self-control training, social skills, cue exposure, relapse prevention, drinking triggers assessment, and functional analysis.

Motivational Enhancement Therapy

Miller and Rollnick (1991) defined MET from a client-centered perspective, and suggest its primary purpose is to encourage clients to explore their drinking and its consequences in a supportive and non-threatening environment. As a form of brief intervention, motivational enhancement approaches, including motivational interviewing, have grown more and more popular and distinguished themselves as easily administered and effective means of decreasing problematic drinking (Heather, 1995; Miller, Benefield, & Tonigan, 1993). Motivational approaches implement six basic elements portended to facilitate changes in drinking behavior. Miller and Sanchez (1994) suggest the following six elements as part of their FRAMES intervention:

1. Feedback of personal risk or impairment
2. Responsibility for change
3. Advice to change
4. Menu of alternative change options
5. Empathy on the part of the therapist
6. Self-efficacy on the part of the client

Read et al. (2001) listed the following as primary methods used to achieve the aforementioned elements of FRAMES: open-ended questions, reflective listening, avoiding labeling and argumentation, decreasing resistance, affirmation, eliciting self-

motivational statements, expressing empathy, and the cost-benefit analysis of drinking behavior. Miller et al. (1995) suggested that MET is among the treatments with the strongest evidence of positive and specific treatment efficacy. Furthermore, Project MATCH (1997) demonstrated similar reductions in drinking behaviors for members of MET groups to those of participants in TSF and CBT and did so with fewer sessions than were provided by the others, further suggesting the validity of MET as an effective form of brief therapy.

Environmental and Relationship-Based Treatments

Community reinforcement and behavioral marital and family therapy represent the primary modalities of environmental and relationship-based treatments. It is widely noted that significant others play critical roles in a client's drinking and recovery from alcoholism. Sobell, Sobell, and Leo (1993) reported that over 60% of self-recovered alcoholics identified spousal support as most important to their success. It has been suggested that ignoring the partners and families of alcoholics in treatment is akin to providing an "unstable framework" for recovery (Bowers & Al-Rehda, 1990).

The Community Reinforcement Approach (CRA) is a largely cognitive-behavioral and broad-based treatment that emphasizes the identification and enhancement of clients' existing support systems and the examination of the interaction between drinking and the environment (Meyers & Smith, 1995). For nearly four decades, CRA has been shown to be an effective method of alcoholism treatment (Azrin, 1976; Hunt & Azrin, 1973); and the research suggests that CRA leads to better drinking outcomes, family functioning, and work-related outcomes when compared with traditional state

hospital treatments (Hunt & Azrin, 1973). In addition to its efficacy and comfortable fit as an adjunct to other treatment modalities (including psychopharmacological treatment), CRA is among the treatment approaches with the strongest cumulative evidenced and rigorous methodological support (Finney & Monahan, 1996; Miller et al., 1995).

The primary methods of CRA are skills training (e.g., sobriety sampling, functional analysis, social skills training, mood monitoring, recreational counseling, vocational counseling, drink refusal training), relationship counseling, treatment compliance monitoring, and the establishment of "buddy systems" (Read et al., 2001).

Behavioral marital and family therapy (BMFT) is designed to work with both the individual and the spouse or family of the alcoholic to decrease or eliminate abusive drinking and drinking-related consequences (O'Farrell, 1995). Research has supported BMFT's positive affect on drinking outcomes as well as relationship-related outcomes. Furthermore, such favorable outcomes have been shown when BMFT has been compared with individual treatment (O'Farrell, Cutter, & Floyd, 1985) as well as non-behavioral couples therapy (Bowers & Al-Redha, 1990). These findings strongly support both the family and behavioral components of BMFT.

The primary objectives of BMFT are the reduction or elimination of problem drinking by including partners and families in treatment, the improvement of dyadic and family functioning, and the delineation of structural roles of the patient and family in and through the recovery process (Read et al., 2001). The methods used to achieve these objectives include the development of "house rules" for recovery, the reduction of "relationship triggers" for drinking, participation in communication and problem-solving skills training, and the reinforcement of positive dyadic and family interaction.

Psychopharmacological Treatments

Since the late 1980's there has been a substantial increase in research focused on the neuronal processes in alcohol dependence, and this research has led to tremendous gains in our understanding of biological contributions to the development and maintenance of addictions. Currently, researchers, medical professionals, and individuals suffering from alcohol addiction are investing greater and greater levels of hope in psychotropic medications that alter the way that the brain reacts to alcohol. Recent advances in brain imaging techniques have led to almost universal agreement on what addiction looks like, although there is still little agreement on how to fix it (Denizet-Lewis, 2006). According to the authors, addiction appears to be a complicated disorder affecting the brain's parts and processes responsible for motivation, decision making, pleasure seeking, inhibitory control, as well as how we learn and consolidate information and experiences. These never-before-seen images and the equally valuable agreement stemming from them have stimulated tremendous amounts of research from scientists and pharmaceutical companies to develop medications and vaccines to treat addiction.

Currently, there are two primary schools of addictive brain chemistry research: the dopamine school and the gamma-aminobutyric acid (GABA) school. For the greater part of the 1980's, 1990's, and the new millennium, neuroscientists exploring the physiological basis of addiction have spent much of their time investigating the neurotransmitter dopamine. Dopamine is involved in a variety of critical brain functions, including learning, memory, movement, emotional response, and feelings of pleasure and pain. Originally, dopamine's role in addiction was thought to revolve around its function as a pleasure signal in the brain; however, scientists now believe that

it is more a predictor of salience in that it helps us to recognize and remember the thing or things on which we ought to focus (Denizet-Lewis, 2006). Denizet-Lewis suggested that alcoholics suffer from a dopamine deficiency, resulting in the abuser's ability to remember the effects of alcohol abuse. Dongier, Vachon, and Schwartz (1991) suggested over a decade earlier that alcoholics may have low levels of dopamine in some of the brain regions important for reward or reinforcement, and also that acute administration of low doses of alcohol might result in an increase in dopamine activity. Alcoholics may be self-medicating in an attempt to elevate dopamine activity or sensitivity.

Because we now know much more about exactly how disruptive addiction is to the brain of the alcoholic, scientists have begun looking outside of dopamine for help in understanding the brain chemistry of addiction. The "new frontier" of research involves GABA, the brain's major inhibitory transmitter, and glutamate, the brain's main excitatory transmitter. Some researchers are suggesting that it is the balance of GABA and glutamate that affects the addicts experience of craving, and that by modifying or controlling said experience we may be able to dramatically affect the individual's chance of achieving and maintaining sobriety.

While our understanding of what addiction looks like from a neurobiological logical level has increased, our ability to modify the brain chemistry of the alcoholic towards a longer lasting and higher quality of sobriety has not improved accordingly. Currently, there are only three medications approved by the Food and Drug Administration (FDA) for the treatment of alcohol dependence: Disulfiram, Naltrexone, and Acamprosate.

Disulfiram (commonly known as Antabuse) is the most popular and well-researched of the antidipsotropic medications, which are designed to cause physical illness when alcohol is consumed. Disulfiram's method of action involves the inhibition of the enzyme aldehyde dehydrogenase (ALDH) which then prevents alcohol from being broken down in the blood stream (Schuckit, 1996). When alcohol is ingested by an individual being treated with disulfiram, any number of aversive reactions can occur, including flushing of the face, headache, nausea, vomiting, and chest pain. While earlier studies suggested the effectiveness of disulfiram in decreasing alcohol use (Kewentus & Major, 1979; Liebson, Bigelow, & Flamer, 1973) and more recent studies confirmed a slightly positive evidence score (Miller, et al., 1995), still stronger evidence suggests that compliance with Disulfiram is a major issue in treatment. For example, a controlled study by Fuller et al. (1986) reported that only 20% of patients taking Disulfiram did so with any regularity. Furthermore, these patients showed only modest improvements and often suffered from side effects that all but negate the drugs usefulness as a treatment method.

Naltrexone, the second of the FDA approved medications for the treatment of alcohol abuse, works by blocking the opiate receptors in the brain, making alcohol consumption less pleasurable and less rewarding (Read et al., 2001). Naltrexone has shown strong potential in the treatment of alcohol dependence (Garbutt et al., 1999), and it has been suggested that it reduces alcohol craving as well (Volpicelli et al., 1992). One of Naltrexone's most potent effects appears to be its ability to reduce the number of drinking days and preventing relapse to problematic drinking levels among those who do resume drinking (O'Malley et al., 1996; Volpicelli et al., 1992). Researchers have

proposed that it is exactly Naltrexone's ability to reduce craving that allows for the aforementioned effects, and studies have shown the drug to be most effective amongst drinkers who report higher levels of craving (Jaffee et al., 1996). In April of 2006, the FDA approved a once-monthly and injectable form of Naltrexone called Vivitrol.

The third of the three currently approved psychopharmacological treatments for alcohol abuse is Acamprosate. Acamprosate was approved for use in the US in July of 2004. Acamprosate is a substance structurally similar to gamma-aminobutyric acid (GABA), and it has shown great potential in the treatment of alcohol dependence. While researchers are unclear as to the exact nature of Acamprosate's effects on the alcoholic brain, it appears to serve as a blocking agent of some kind (Read et al., 2001). Acamprosate has been shown in numerous clinical trials to be associated with improved drinking outcomes, namely increased abstinence, fewer drinking days, and improved treatment compliance (Paille et al., 1995; Poldrugo, 1997).

In addition to these more traditional and FDA approved medications, researchers have begun to investigate still more creative neurological pathways towards the treatment of alcohol dependence. For example, Prometa, consists of a number of medications and therapies not traditionally associated with the treatment of alcohol dependence. More specifically, Prometa includes Flumazenil, approved by the FDA to treat overdoses of Valium and Xanax, and gabapentin, approved to relieve neuropathic pain (Denizet-Lewis, 2006). Prometa appears to reduce anxiety and craving by enhancing the brain's GABA receptors, and although no double-blind research has been completed to date, clinicians currently making use of the combination in treatment report encouraging results (Denizet-Lewis, 2006).

While it is clear that scientists have made tremendous progress regarding the psychotropic treatment of alcohol dependence, it is not yet as clear exactly how effective drug treatments are in the battle against alcoholism. Nearly all of the studies mentioned and nearly all of those carried out to date addressing the efficacy of Disulfiram, Naltrexone, and Acamprosate as well as other psychotropic medications have been conducted in conjunction with more traditional psychotherapeutic approaches (O'Malley et al., 1992). The design of these research studies makes it difficult to decipher the elements of treatment most responsible for behavior change. Therefore, while progress has clearly occurred in the psychopharmacological treatment of alcohol abuse, it is still unclear exactly how helpful these drug treatments are in the modification of drinking behavior.

Recovery from Alcoholism

The professional research conducted on the process of recovery from alcoholism has traditionally relied on measures of consumption as the primary outcome measures in their work (Babor et al., 1994; Humphreys et al., 1998; Morgenstern et al., 1996; Tonigan et al., 1996). These measures have included such variables as percentage of days abstinent and number of drinks consumed per drinking day. While these measures may do justice to the medical descriptions and definitions of alcoholism, described earlier and supported by *DSM-IV-TR* (American Psychiatric Association, 2001), they relate poorly to the descriptions and definitions of alcoholism offered by *Alcoholics Anonymous*. Although abstinence is an integral part of the recovery process, it does not speak to the experience of the recovering alcoholic as he or she begins a life without alcohol. Perhaps

the current day emphasis on behavior reduction and the need for visible proof of change when dealing with managed care have infiltrated the professional research body, resulting in the cessation of alcohol consumption as the primary measure of treatment effects.

While *Alcoholics Anonymous* assumes abstinence as the very beginning of recovery, more recent professional research has already begun to back away from such an assumption. According to Miller and Longabaugh (2003), contributors to Project MATCH (Babor & Del Boca, 2003), the largest treatment study ever conducted with alcoholics, "Although total and continuous abstinence is too severe a standard for success, Project MATCH data do point to abstinence as a central outcome measure for research with alcohol-dependent, treatment-seeking clients." Here we see a major shift away from what was already an extremely narrow view of recovery towards an even more limited and hopeless future for the alcohol-dependent. The hope for long-term sobriety is no longer held as researchers begin to simply count number of days between drinks and average number of drinks per day in search of positive treatment outcomes.

Recovery from Alcoholism According to Alcoholics Anonymous

> Sometimes we hear an alcoholic say that the only thing he needs to do is to keep sober. Certainly he must keep sober, for there will be no home if he doesn't. But he is yet a long way from making good to the wife or parents whom for years he has so shockingly treated (AAWS, 2001, p. 82).

Alcoholics Anonymous clearly defines the recovery from alcoholism as something far greater than the ability to stop drinking. In fact, according to *Alcoholics Anonymous*' view of alcoholism, "...liquor was but a symptom" (p. 64) of the disease, "So we had to

get down to the causes and conditions" (p. 64) if recovery is to be possible. *Alcoholics Anonymous* speaks to "...happiness, peace, and usefulness" (p. 8) as synonymous with *recovery* and "...a way of life that is incredibly more wonderful as time passes" (p. 8) as an adjunct to such. Bill Wilson, co-founder of Alcoholics Anonymous (AA) and contributing author to its text continues:

> There is however, a vast amount of fun about it all. I suppose some would be shocked at our seeming worldliness and levity. But just underneath there is deadly earnestness. Faith has to work twenty-four hours a day in and through us, or we perish. Most of us feel we need look no further for Utopia. We have it with us right here and now. Each day my friend's simple talk in our kitchen multiplies itself in a widening circle of peace on earth and good will to men (AAWS, 2001, p. 16).

While *Alcoholics Anonymous* offers a plethora of descriptions, conditions, and promises that can be expected of recovery, there are Twelve Promises made to those members of the Fellowship who choose to complete the first nine Steps of the Program of recovery (AAWS, p. 83):

1. If we are painstaking about this phase of our development, we will be amazed before we are half way through (with the 9th Step).
2. We are going to know a new freedom and a new happiness.
3. We will not regret the past nor wish to shut the door on it.
4. We will comprehend the word serenity and we will know peace.
5. No matter how far down the scale we have gone, we will see how our experience can benefit others.

6. That feeling of uselessness and self-pity will disappear.
7. We will lost interest in selfish things and gain interest in our fellows.
8. Self-seeking will slip away.
9. Our whole attitude and outlook upon life will change.
10. Fear of people and of economic insecurity will leave us.
11. We will intuitively know how to handle situations which used to baffle us.
12. We will suddenly realize that God is doing for us what we could not do for ourselves.

The authors of *Alcoholics Anonymous* continue, "Are these extravagant promises? We think not. They are being fulfilled among us – sometimes quickly, sometimes slowly. They will always materialize if we work for them" (AAWS, 2001, p. 84).

Alcoholics Anonymous speaks to the quality of life of recovered alcoholics and the extent to which they add to the quality of life of those around them as the truest measures of the effectiveness of the Program and the extent to which the individual is affiliated with and "working" said Program. The *DSM-IV-TR* (American Psychiatric Association, 2001) emphasizes the need for evidence that drinking is causing problems in other areas of life function when appealing to a diagnosis of alcohol abuse or dependence. Still earlier definitions and diagnostic criteria for alcoholism emphasized a decrease in quality of life and function in areas such as emotional, vocational, social, family, and physical spheres (Babor et al., 1994). Research has, in fact, repeatedly confirmed the assumption that quality of life declines with alcohol abuse and dependence. Volk et al. (1997) reported that individuals with frequent, heavy drinking patterns had significantly lower scores in the areas of role functioning and mental health. Okoro et al. (2004) concluded

that frequent episodic heavy drinking is associated with significantly worse health-related quality of life.

In general, people abusing alcohol have lower quality of life ratings than do cohorts without substance use disorders (Morgan et al., 2003). Implicit in the assumption (though firmly grounded in research as well) that the individual's quality of life will decline across the development of alcohol related disorders is the assumption that quality of life improves with treatment and recovery. However, the attitude that achieving abstinence alone will automatically improve quality of life has been challenged by researchers for decades (Maisto & McCollam, 1980; Pattison et al., 1977). As a result, quality of life has taken its place as both a target of intervention and a measure of treatment efficacy amongst alcoholism researchers. However, quality of life and its presence or absence in the lives of alcoholics has received limited attention when compared to research in other areas such as the relationship of quality of life and mental and physical health (Gladis et al., 1999).

Alcoholics Anonymous (AA) specifically targets quality of life as the truest measure of recovery. Although abstinence is a necessary condition for recovery, it is far from sufficient. Unlike all others methods of treatment, AA addresses the physical, mental, and spiritual aspects of the alcoholic. While the Steps help the individual to recovery mentally (from the obsession to drink) and the Fellowship helps the individual to recovery physically (from the isolation of alcoholism), Service assists the individual to recover from the most painful aspects of alcoholism (the spiritual sickness). According to AA, drinking was only a symptom of a deeper and spiritual disease. Therefore, at its

roots, Alcoholics Anonymous (AA) is a spiritual program and it is spirituality that leads to abstinence, recovery, and increased quality of life.

Spirituality and Quality of Life

According to Carl Jung (1933), all of his patients over the age of 35 "...fell ill because he had lost that which the living religions of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook" (p. 229). While AA is not a religious program and deciphering between religiosity and spirituality is beyond the scope of this paper, Dr. Jung refers here to the power of faith in the lives of human beings and faith is a fundamental requirement of Alcoholics Anonymous' Program of recovery. Spiritual matters and concerns are generally understood to transcend ordinary physical limits of time, space, matter, and energy; although some features of spirituality can be experienced via the physical senses (Miller & Thoresen, 2003).

According to Gallup and Lindsay (1999), about 95% of Americans profess a belief in God or a higher power, and many Americans report that their faith is a central and guiding force in their lives (Gallup, 1995). Such popularity and importance suggest a usefulness and purpose to spirituality; however, research has often ignored spirituality despite strong evidence that spirituality plays an important role in quality of life (Ellison & Smith, 1991), coping (Pargament, Van Haitsma, & Ensing, 1995), and a search for meaning (Maugans, 1996). More specifically, spirituality has been negatively correlated with anxiety in cancer patients (Kaczorowski, 1989), positively correlated with physical well-being in cancer patients (Highfield, 1992), and positively correlated with adjustment

to aging and physical decline in the geriatric population (Pargament et al., 1995). In addition, spiritual well-being is positively related to both psychosocial adjustment and acceptance of uncertainty in individuals suffering from chronic illness (Landis, 1996) positively correlated with psychological hardiness (Carson & Green, 1992) and hope (Carson, Soeken, Shanty, & Terry, 1990) among HIV-positive individuals. Regarding alcoholism and spirituality, Conners et al. (1996) and Oakes, Allen, and Ciarrocchi (2000) have shown that spirituality supports and is a frequent mediator of successful long-term recovery. Furthermore, Corrington (1989) reported that alcoholics with higher levels of spirituality were more effective in coping with stress, and Hudson (1982) found a significant correlation between degree of spirituality and life contentment.

So it seems that spirituality is a powerful force against the struggles of humanity, including alcoholism. *Alcoholics Anonymous* makes full use of spiritual strength and members of AA depend upon the seen and unseen for the strength, insight, and change necessary to live life fully without the use of alcohol.

A Summary of the 12 Steps

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

Step One is often called a "God given Step" in that it is a realization of alcoholism. The realization is often prompted by suffering, loss, and humility. Therefore, the way one "works" the first Step is by becoming alcoholic and creating an unmanageable life, inside and out. Once the alcoholic recognizes the inevitable result of

active alcoholism (e.g., jails, institutions, and death), despair often follows, but the admission of alcoholism is all that is necessary to move onto Step 2.

Step 2: Came to believe that a Power greater than ourselves could restore us to sanity.

Step Two is the second of three "God given Steps." It too is a process of receiving faith through works, but all that is necessary to officially "work" the Second Step is to answer the following question: "Do you now believe in, or are you even willing to believe in a Power greater than yourself?' If the alcoholic can answer "yes" to this question, which is not too difficult when standing in the presence of a group of sober alcoholics (the group often represents the alcoholics first Higher Power), then quickly moving to Step Three is recommended. Step Two will continue to "happen" to the alcoholic as they work through the remaining 10 Steps.

Step 3: Made a decision to turn our will and our lives over to the care of God as we understood him.

Step Three is the final "God given Step" in that it involves very little action on the part of the recovering person. Making a decision takes very little time, especially when the research has been carried out as thoroughly as the active alcoholic carries out his or her experiment of self-will when it comes to drinking and more importantly, life overall. Step Three asks that the alcoholic only decide to turn his or her will over to the care of God. The actual turning of one's will and life takes doing each and every moment of every day. To fully provide the spiritual awakening promised by the 12 Steps, the turning of one's will and life over to the care of God probably ought to happen quite often. However, making the decision to start doing it for the first time takes place only once, and that is what the 3rd Step represents. The "will" referenced in the third step is

the power of choice. By turning our will over to the care of God, we are committing to doing what we believe best serves God's interests rather than our own. In turning our "lives" over, we are committing to accept the results of God driven action as the way it ought to be, resulting in far less struggle with our external world. Step Three includes the reciting of a prayer similar or identical to that printed on page 63 of *Alcoholics Anonymous*.

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

The 4th Step is the first of the action steps and involves four written inventories. The first is a list of all the people, places, and institutions that the alcoholic resents. This inventory affords the alcoholic the opportunity to express what it is that these people, places, and institutions have done to them; exactly how their lives where affected by these actions; and most importantly what the alcoholic did to perhaps motivate these actions and develop a resentment in the first place. The second inventory includes all the people that the alcoholic has harmed and the exact nature of the harm. The third inventory is a complete sexual history of the alcoholic, and the fourth inventory is a list of all the alcoholic's fears. In the earlier and some would say more successful days of Alcoholics Anonymous (AA), such an inventory was completed within the first days of recovery.

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

While the 4th and 5th Steps are the alcoholics first opportunity to turn their will and lives over to the care of God, the 5th Step, like all those that follow, is the culmination of the Steps that came before. Step Five represents the alcoholic's first overt act of faith.

The Step is completed with an understanding person, usually the alcoholic's sponsor. The "talk" often takes several hours, and can result in a spiritual awakening in and of itself. Step Five is followed by an hour of quiet time, during which the alcoholic reviews their work and prays for the awareness of any as of yet undisclosed material.

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

Step Six, like all of the steps, involves a realization of the need for change, motivated largely by despair. After reviewing the nature of their defects of character and the consequences of living according to self-will, the alcoholic is highly motivated (though perhaps for only a short time), to have these defects removed so that he or she may live in peace and ultimately become more useful to others. If one is not ready to have a defect removed, one is invited to continue living in it, until it causes enough pain, separation, and loss that the motivation to move follows. Step Six is to immediately follow the completion of Step Five, with Steps Five thru Seven often being completed in the same day.

Step 7: Humbly asked Him to remove our shortcomings.

The 7th Step, like the 3rd, involves saying a prayer for the first of what will be many times. The opportunity to "live in a defect" will arise on a daily basis for the alcoholic, and whether or not they have the strength to pray for right action often depends on their spiritual fitness on that day. The 7th Step like all others can and should be carried out on a daily basis, and perhaps, many times more than once each day. While the alcoholic may be ready to have character defects removed, some of these defects are said to perhaps serve God or others and, therefore, they are expected to remain. The more "glaring" defects are often removed first, leaving behind the more covert and

oftentimes more painful. It has been suggested that these defects serve to remind the alcoholic of how badly he or she needs God and the support of others to live a joyful and fruitful life.

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

The 8th Step can and should be effortless in that this list of those the alcoholic harmed was first written during the 4th Step. The "becoming willing" piece speaks to the alcoholic's efforts to now live a God driven life, leaving behind self-serving ideas and methods to better connect with and serve others. It is suggested that the alcoholic write a list of those with whom they are prepared to make amends immediately, those that may perhaps need to wait (for reasons of danger of harm to others or lack of preparedness), and finally a list of those to whom amends cannot be made (due to death or definite harm to others). This list will not contain only those affected directly by the alcoholic's drinking, but will include all those persons harmed by any of the alcoholics defects recognized in the 4th Step. As with all the steps, the constant presence and help of a Sponsor and God as well, is a must in order to prevent further damage to others first and foremost and secondly, to the alcoholic. Should an alcoholic be unwilling to make amends to any person on the list, they are strongly urged to pray for said strength lest they jeopardize what is often a fragile state of sobriety at this time.

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

The making of "amends" is often suggested as the opportunity for the first real awareness of God in one's life. While an amends may involve an apology, it more

importantly involves the attempt to give back to a person what was once taken by the alcoholic. This effort to give back represents the change in behavior that constitutes the truest meaning of an amends. The alcoholic is not to ask for forgiveness during an amends, as it has been suggested that to do so would add insult to injury – first the alcoholic takes something from another only to follow it up with a request for perhaps the most difficult and painful of all spiritual practices, the act of forgiveness. Regarding the "except when to do so" clause, alcoholics are wise to seek the counsel of sponsors, God, and others in the Fellowship before contacting or confessing anyone or anything that may cause anyone involved or not any additional pain. The alcoholic must necessarily be willing to make all amends, but is asked only to make those that avoid any additional burdens being placed on anyone and everyone, except the alcoholic of course.

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

The 10th Step involves constant self-supervision and a growing sensitivity to moments when one has the chance to do as God wishes or as the alcoholic wishes. The suggestion to admit when one is "wrong" is often overlooked and translated into the need to explain one's behavior. It is again often suggested that the alcoholic keep it simple and simply admit when they are wrong and attempt to give back what may have been taken (e.g., security, trust, money, respect, etc.). Alcoholics are directed toward a nightly inventory during which the day's events are reviewed and a list of "need-to-amends" is generated along with a list of "done-wells".

Step 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.

The 11th Step directs the recovered alcoholic to continue growing spiritually by among other things, improving their connection to the God of their understanding via prayer (talking to God) and meditation (listening to God). Alcoholics Anonymous (AA) does not say much about the will of God, but it is very clear that a connection to something larger and wiser is necessary to survive alcoholism, and perhaps even so for the non-alcoholic.

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

The 12th Step first confirms that the alcoholic by now has experienced a spiritual awakening, and exactly that, an awakening. The real work can now begin, and this work involves carrying the AA message to alcoholics whenever and wherever needed as well as practicing all the principles (Steps) with everyone we meet, know, love, and otherwise. The life of recovery begins in AA but when carried out according to *Alcoholics Anonymous*, it spreads quickly to the larger community and family of the recovered alcoholic.

Chapter III: Methods and Procedures

Introduction

This chapter will discuss the study participants, data collection procedures, study design and analysis procedures, and power analyses for the statistical procedures used for each hypothesis.

Selection of Participants

Participants were adult men and women (age 18+) attending Alcoholics Anonymous (AA) meetings in the greater Central New Jersey area. Recruitment occurred within a local Fellowship of AA and included individuals who attend meetings in rural, suburban, and urban areas. An effort was made to recruit members of AA of various ages and from a wide range of socioeconomic, cultural, and racial backgrounds.

Data Collection

Prior to the beginning of a local AA meeting, the principal investigator read a short script (Appendix E), requesting participation in the study. Potential participants were recruited sequentially in groups of 20 unique participants per meeting. After 20 participants were collected from each meeting, recruitment efforts halted in order to reduce potential selection bias. Each packet administered contained a confidentiality statement (Appendix F), Quality of Life Inventory (QOLI; Frisch, 1993), Alcoholics Anonymous Affiliation Questionnaire (Appendix A), Degree of Acknowledged Alcoholism Questionnaire (Appendix B), 9th Step Promises Questionnaire (Appendix C),

demographic questionnaire (Appendix D), and a stamped envelope addressed to the author.

Instruments

Alcoholics Anonymous Affiliation. The Alcoholics Anonymous Affiliation Questionnaire (Appendix A) is a 36-item, self-report paper and pencil instrument designed for this study to measure participants' affiliation with Alcoholics Anonymous (AA). The scale includes three subscales, designed to measure affiliation with each of AA's three Legacies: Recovery, Unity, and Service. Each subscale consists of 12 items that have been taken directly from *Alcoholics Anonymous* and considered the best possible descriptors of AA's suggested program of recovery. Participants are directed to place a check mark or "X" within the column that corresponds to the descriptive statement that best describes their most common experience with the specific concept. All items are scored on a 7-point scale, where 1, *completely disagree*; 2, *seriously disagree*; 3 *somewhat disagree*; 4, *no opinion or experience*; 5, *somewhat engage*; 6, *seriously engage*; and 7, *completely engage*; with the concept. Thus, each subscale ranges from a low score of 12 to a high of 84 and the total Affiliation scale score ranges from a low of 36 to a high of 252.

Instrument development included assessment of content validity, through review of all items by 10 active members of AA. These content experts were thoroughly familiar with AA literature and AA history, each reporting a minimum of 7 years of continuous sobriety, with an overall mean of 13 years. Throughout the course of development, several items from the Affiliation questionnaire were modified while others

were excluded. A unanimous decision favoring the use of the item was required for item inclusion. Notably, as *Alcoholics Anonymous* is written at the 6th grade reading level and because all of the Alcoholics Anonymous (AA) related instruments in this study are drawn directly from the Book, it is assumed that the overwhelming majority of the Fellowship had no difficulty reading or understanding the various questionnaires. In order to establish the psychometric properties of the instrument, reliability data was calculated as a component of this study and is presented in the Results.

Degree of Alcoholism. The Degree of Acknowledged Alcoholism Questionnaire (Appendix B) is a single item, self-report paper and pencil instrument designed for this study to measure the participants' perceived level of alcoholism according to the four Degrees suggested in *Alcoholics Anonymous*. Study participants were required to choose the degree of alcoholism with which they most strongly identify, ranging from the *least severe* (#1) to the *most severe* (#4).

9th Step Promises. The 9th Step Promises Questionnaire (Appendix C) is a 12-item, self-report paper and pencil instrument designed for this study to measure participants' experience or identification with the 9th Step Promises, suggested as concordant to recovery in *Alcoholics Anonymous*. All items are scored from 1 to 4, with 1 representing *no experience* with the suggested promise; 2, *some experience*; 3, *much experience*; and 4, *complete experience*. Total scale scores range from 12 to 48. As mentioned previously, establishing the reliability of specific elements of *Alcoholics Anonymous* as a measurement of affiliation and recovery is a major focus of the present study. Therefore, the reliability of this instrument will be calculated as part of this study.

Quality of Life Inventory (QOLI; Frisch, 1993). While *Alcoholics Anonymous* is described as a basic text for those individuals interested in recovery from alcoholism and describes in detail how individuals experience their affiliation with Alcoholics Anonymous (AA)., it is not a valid instrument for the assessment of quality of life. Although the 9th Step Promises begin to address some of the changes suggested as proof of recovery in *Alcoholics Anonymous*, a more detailed and comprehensive instrument is necessary to better translate AA's model of Recovery into a widely recognized paradigm of well-being.

The QOLI is a 32-item, self-report paper and pencil instrument designed to measure participants' life satisfaction in the following 16 areas of life: Health, Self-Esteem, Goals-and-Values, Money, Work, Play, Learning, Creativity, Helping, Love, Friends, Children, Relatives, Home, Neighborhood, and Community. Based on Frisch's (1989) Quality of Life Theory, the QOLI employs the combined cognition-and-affect approach to defining subjective well-being, in which life satisfaction and negative and positive affect are viewed as components of the broader construct of subjective well-being or happiness. Frisch's model is linear and additive in that it assumes a person's overall life satisfaction consists largely of the sum of satisfactions in particular areas of life considered important.

The QOLI takes approximately five minutes to complete. The instrument, also developed at the sixth-grade reading level, is believed to be understandable across the range of Alcoholics Anonymous (AA) members. According to Frisch (1994), the QOLI is well-suited for planning and evaluating psychological treatment and has potential as a universal outcome measure. In addition to being widely used in general medical and

psychiatric hospitals, the QOLI is currently used in employee assistance programs and alcohol and drug rehabilitation programs as a measure of treatment outcome. The QOLI has been proven to be an effective measure of quality of life and changes in quality of life across a wide range of psychological functioning. Frisch (1994) suggested strong clinical sensitivity and minimal floor or ceiling effects.

As the QOLI is unique in that it incorporates a subjective assessment of the importance of various needs being met or unmet for an individual, scoring the instrument involves the calculation of weighted satisfaction ratings. Rating range from –6 to 6, which are the products of Satisfaction ratings (on a scale of –3 to 3) multiplied by Importance ratings (on a scale of 0 to 2). A raw score is calculated by averaging the weighted satisfaction ratings, and these raw scores can be converted into *T* scores and percentiles.

The QOLI has been shown to have at least a moderate level of convergent validity with at least two other measures of life satisfaction. The QOLI was significantly and positively correlated with Diener et al.'s (1985) Satisfaction With Life Scale ($r = .56, p < .001$) and Ferrans and Powers' (1985) Quality of Life Index ($r = .75, p < .001$).

The QOLI professional manual reports significant temporal stability, with a test-retest reliability coefficient of 0.73 ($p < .001$) over a two-week period. Internal consistency reliability (coefficient alpha) computed for the sum of the weighted satisfaction ratings was 0.79.

Study Design and Statistical Analysis

The overall design of this study is non-experimental and as such, is considered exploratory in nature. All statistical analysis will be performed using SPSS for Windows,

Version 11.5 The following is a brief summary of each hypothesis and a description of the data analysis procedures that were implemented for each:

Hypothesis I. The initial study hypothesis assessed the reliability of the Service, Unity, and Recovery subscales of the overall Alcoholics Anonymous Affiliation Questionnaire. This hypothesis used a coefficient alpha as an estimate of test-retest reliability.

Hypothesis II. The second study hypothesis employed a factor analysis to examine the factor loadings of each of the subscales of the Alcoholics Anonymous Affiliation Questionnaire. The goal was to assess intercorrelations between the three subscales and to determine if all scales were better accounted for by a single construct.

Hypothesis III. The third study hypothesis expected that Alcoholics Anonymous (AA) members reporting higher Affiliation scores would experience higher Quality of Life scores. This relationship was evaluated using a bivariate correlation with the overall Affiliation score and Quality of Life scores both entered into the analysis. Initially, a multiple regression procedure was proposed however, as revealed within Results, factor loadings indicated that the subscales are highly correlated and should not be examined independently.

Hypothesis IV. This fourth study hypothesis expected that there would be a significant relationship between degrees of alcoholism, Affiliation scores, and QOLI scores. These relationships were initially proposed to employ a one-way MANOVA, with level of alcoholism (1-4) as the independent variable and overall Affiliation scores and QOLI scores as the dependent variables. As described in Results, however, the frequency of participants reporting very low (1) and very high (4) degree alcoholism was

low within this sample. Thus, severity groups were collapsed into two groups. Therefore, the MANOVA employed an independent variable with two levels, instead of the four initially proposed. Further, as close examination of study demographic variables revealed significant age differences, age was added to the model; thereby supporting the use of MANCOVA over MANOVA in order to control for this potentially confounding variable.

Hypothesis V. Given that the 9th Step Promises and QOLI relate to similar areas of the alcoholic's personal, familial, and greater social life, it was expected that QOLI scores and fulfillment of the 9th Step Promises would strongly correlate. A bivariate correlation was implemented to explore the relationship between these variables.

Power Analysis

Cohen (1988) defined "power" as the probability that a test will yield statistically significant results given that the phenomenon being tested is actually present. Power is also described as 1-Beta, Beta being the probability of mistakenly failing to reject the null hypothesis (Type II error). A power analysis is typically employed prior to data collection in order to determine the number of participants necessary to achieve significant study results when they exist. Power analysis for the present study was conducted using GPOWER (Buchner, 1992), which is publicly available as freeware on the Internet.

In order to ensure that a sufficient number of participants were provided to appropriately test study hypotheses an *a priori* power analysis was conducted to determine if there was sufficient sample size to test the primary study hypothesis using

multiple analysis of variance. Using customary alpha of .05, power of .80, and effect size of .25, power analysis using Cohen methodology revealed that no fewer than 54 participants would be required within a per protocol sample of participants to test the null hypotheses. The collected sample of 82 participants, therefore, was ample for the present study and proposed analyses.

CHAPTER IV: Results

Demographic Characteristics

Demographic Statistics. The present study utilized a survey methodology in which 82 of 400 potential participants elected to respond, yielding a response rate of 20.5%. The final per protocol database was comprised of 82 participants ranging in age from 21 to 80 years ($M = 47.2$, $SD = 10.8$). As displayed in Table 1, the sample was predominantly Caucasians ($n = 63$, 76.8%), and about half of all respondents reported Christianity ($n = 41$, 50.0%) as their religious/spiritual affiliation. Number of years of education in this sample ranged from 10 to 23 years ($M = 15.10$, $SD = 3.3$). The sample was evenly split with regard to education, with approximately one-third having earned either a high school ($n = 32$, 39.0%), Bachelors ($n = 22$, 26.8%), or Masters degree ($n = 20$, 24.4%), and a small proportion earning a doctoral degree (MD, PhD; $n = 4$, 4.9%).

Chi-square analyses of the of the sample demographic characteristics produced significant results for several of the categorical variables. Specifically, chi-square analysis indicated significant differences in the number of participants across Race [$X^2(81) = 119.1, p < .001$], Religious Affiliation [$X^2(81) = 92.3, p < .001$], and Self Report Severity of Alcoholism [$X^2(81) = 7.00, p < .01$]. In short, the sample included significantly larger numbers of Caucasians, Christians, individuals reporting no religious affiliation, and individuals reporting lower degrees of alcoholism.

Table 1

Sample Demographic Characteristics and Recovery Status (N = 82)

	f (%)	*M* (*SD*)	Range	X^2	p
Age (years)	--	47.2 (10.8)	21-80	-	-
Race				119.1	< .001
Caucasian	63 (76.8)				
Black	10 (12.2)				
Hispanic	7 (8.5)				
Mixed	2 (2.4)				
Religious affiliation				92.3	<.001
Christian	41 (50.0)				
None	34 (41.5)				
Islam	4 (4.9)				
Jewish	2 (2.4)				
Quaker	1 (1.2)				
Number of years of education	--	15.1 (3.3)	10-23	-	-
No Degree	4 (5.0)				
High School	32 (39.0)				
Bachelor's Degree	22 (27.0)				
Master's Degree	20 (24.0)				
Doctoral Degree[1]	4 (5.0)				
Years of sobriety	--	9.9 (8.8)	0-41	--	--
Years enrolled in AA	--	11.7 (8.9)	0-41	--	--
Number of relapses	--	1.0 (2.4)	0-12	--	--
Self-report severity of alcoholism				7.0	< .01
Low Severity	53 (64.6)				
High Severity	29 (35.4)				

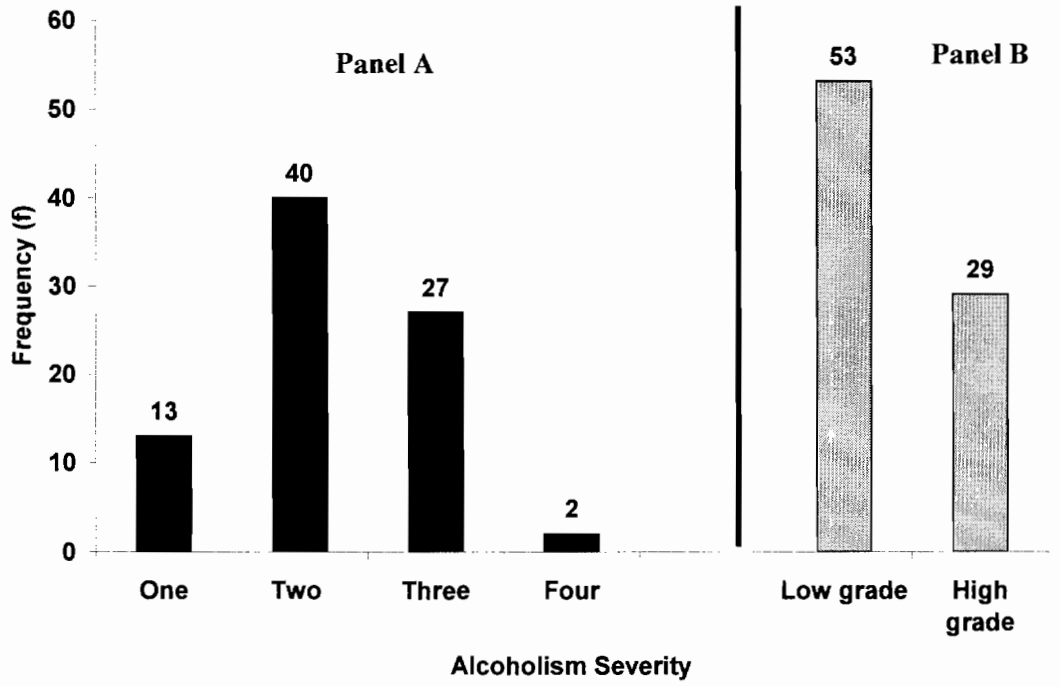
Note. AA = Alcoholics Anonymous.

[1]Doctoral degree included doctor of medicine (MD) and doctor of philosophy (PhD).

All participants were in recovery. Years of continued sobriety ranged from 0 to 41 years ($M = 9.9$, $SD = 8.8$), consistent with years enrolled in AA which also ranged from 0 to 41 years ($M = 11.7$, $SD = 8.9$). Most participants had no reported relapses ($n = 56$, 68.3%), with the remainder of participants reporting between 1 and 12 relapses ($M = 1.0$, $SD = 2.4$). Severity of alcoholism was assessed using a self-report instrument that ranked disease severity from a low of 1 (*minimal severity*) to a high of 4 (*severe severity*). Figure 1 (Panel A) displays frequency counts for the number of participants within each of the four degrees of alcoholism. Visual inspection of these data indicates few participants reporting *low degree* (1) or *severe degree* (4) alcoholism. Therefore, in order to better consolidate these data and to improve power to detect differences in severity of alcoholism, participants were collapsed into two groups: (a) *low grade alcoholism* (i.e., scores of 1 or 2) and (b) *high grade alcoholism* (scores of 3 or 4). Figure 1, Panel B displays the number of participants within each of the two categories of alcohol severity. While better matched in number of participants, chi-square analysis indicated significantly more participants in the *low degree* group than in the *high degree* group, $X^2(81) = 7.00$, $p < .01$.

Figure 1

Degree of Alcoholism



Descriptive Statistics

Prior to testing study hypotheses, descriptive statistics were calculated for the primary study variables and are presented as Table 2. As observed in the Table, participants reporting high and low degree of alcoholism were well-matched across primary study variables. The singular exception was the recovery subscale, which had significantly higher scores for participants reporting high degree alcoholism compared to participants reporting low degree alcoholism [$F(1, 80) = 3.9, p = .05$].

In order to test for interrelationships between primary study variables and to examine shared variance, bivariate Pearson correlations were employed to correlate each of the study variables. Table 3 summarizes the intercorrelations.

Table 2

Descriptive Statistics for Primary Study Variables (N=82)

	Low Degree Alcoholism *M (SD)*	High Degree Alcoholism *M (SD)*	Total Group *M (SD)*	*F*
Scale				
Recovery	71.4 (10.6)	76.0 (9.3)	73.0 (10.3)	3.9*
Unity	70.5 (9.0)	72.6 (9.9)	71.2 (9.3)	0.33
Service	66.3 (11.1)	69.1 (12.2)	67.3 (11.5)	0.30
Affiliation	208.2 (27.6)	218.2 (29.0)	211.8 (28.4)	0.13
Promises	37.7 (9.1)	38.9 (9.3)	38.1 (9.2)	0.56
QOLI	2.5 (1.5)	2.3 (1.8)	2.4 (1.6)	0.54

Note. * $p = 0.05$. *F* test for differences between high and low degree of alcoholism.

Table 3

Intercorrelations Between Primary Study Variables

Variable	1	2	3	4	5	6
1. Recovery	1.00	0.74	0.63	0.86	0.78	0.47
2. Unity		1.00	0.86	0.95	0.70	0.44
3. Service			1.00	0.92	0.53	0.33
4. Affiliation				1.00	0.73	0.45
5. Promises					1.00	0.64
6. QOLI						1.00

Note. $p < .001$ for all comparisons.

Tests of Hypotheses

Hypothesis I. The initial study hypothesis examined the reliability of items drawn from *Alcoholics Anonymous* as a measure of affiliation with Alcoholics Anonymous (AA). Specifically, due to the specificity of items chosen and the process of expert review initiated over the course of scale development, it was posited that the measure of AA affiliation used within this study would have acceptable internal consistency, thereby suggesting the reliability of the instrument. In order to examine this hypothesis, Cronbach's coefficient alpha was calculated for the entire scale as well as each of the three subscales (e.g., Recovery, Unity, and Service) of the AA instrument. Coefficient alpha is an index that describes the internal consistency of a measure, where the higher the intercorrelation among scale items the greater the proportion of "true score" being assessed by the measure. Internal consistency, therefore, is regarded as an estimate of scale reliability.

The results of the intercorrelation analyses indicate that the entire scale as well as each of the three subscales produced excellent internal consistency. Specifically, coefficient alpha for the overall Affiliation scale was $r = .97$, while the Recovery and Unity scales produced $r = .93$, followed by $r = .91$ for the Service scale. Thus, each of these scales would be expected to consistently assess associated constructs over repeated administration. In addition, the 9th Step Promises Questionnaire produced excellent internal consistency with a coefficient alpha of $r = .96$

Hypothesis II. The second study hypothesis examined the Factor Structure of AA's Three Legacy subscales. Specifically, it was hypothesized that due to commonalties among the three constructs (e.g., Recovery, Unity, and Service), principal

components analysis (PCA) of the individual scale scores would yield one factor upon which all of the Legacy subscales would load. While the scale scores are expected to be factorially complex, the overall resulting factor structure will be orthogonal in nature.

In order to examine this hypothesis, a principal components analysis was conducted. As observed in Table 4, a thirty-factor solution explained 100% of the variance, however, 58.6% of the variance was associated with two components (Eigenvalues = 17.1 and 4.0 respectively), thereby suggesting that items from the three scale indices are likely components of two underlying constructs (Figure 2).

Table 4

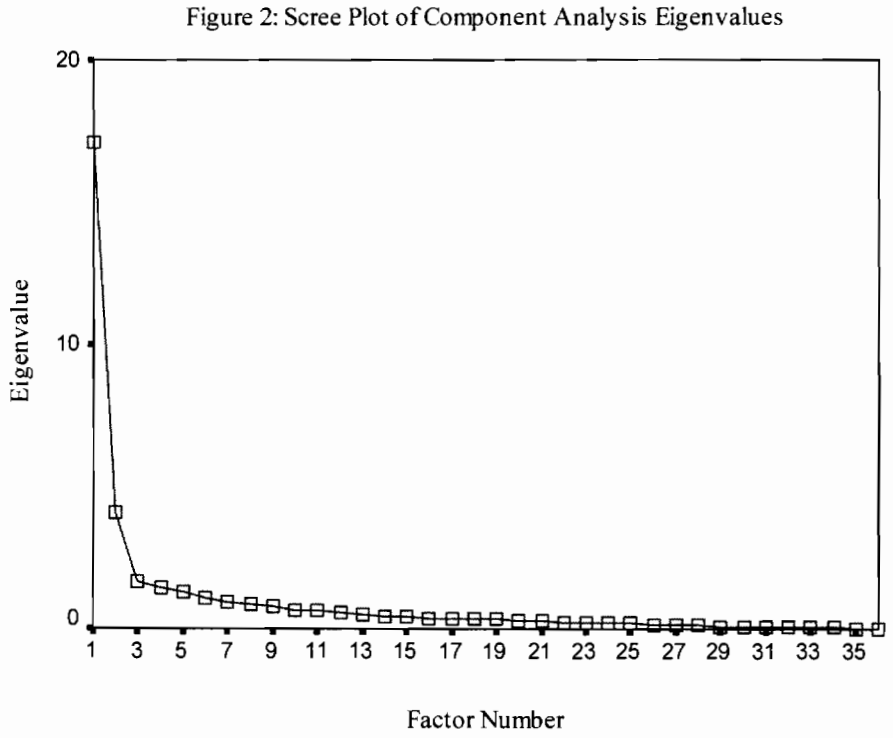
Variance Explained by Individual Legacy Item Scores

Component	Eigenvalue	% of Variance	Cumulative %
1	17.088	47.468	47.468
2	4.008	11.134	58.602
3	1.640	4.554	63.156
4	1.447	4.020	67.176
5	1.263	3.509	70.686
6	1.061	2.946	73.632
7	.905	2.514	76.146
8	.868	2.410	78.556
9	.778	2.162	80.719
10	.663	1.843	82.561
11	.632	1.755	84.316
12	.559	1.552	85.868
13	.518	1.438	87.306
14	.440	1.224	88.529
15	.393	1.091	89.620
16	.382	1.060	90.680
17	.366	1.018	91.698
18	.348	.966	92.664
19	.340	.944	93.609
20	.285	.793	94.401
21	.267	.743	95.144
22	.219	.610	95.754
23	.205	.571	96.324
24	.200	.557	96.881
25	.187	.519	97.399
26	.168	.467	97.866
27	.158	.440	98.306
28	.122	.339	98.645
29	.096	.265	98.910
30	.082	.228	99.138
31	.076	.210	99.348
32	.066	.184	99.532
33	.056	.155	99.688
34	.049	.136	99.824
35	.034	.095	99.919
36	.029	.081	100.000

Note. Extraction Method was Principal Component Analysis.

Figure 2

Scree Plot of Principal Component Analysis Eigenvalues



As a follow-up to the initial principal components analysis, an exploratory factor analysis (EFA) using the Maximum Likelihood methodology and Varimax rotation was employed. In this analysis, a two-factor solution was specified due to the results from the initial PCA. The resulting two-factor solution explained 56.3% of the variance in three iterations. Thus, Hypothesis II was only partially supported by this data in that as hypothesized, the three subscales did not exist as three individual factors but did in fact suggest the existence of two independent factors. Table 5 provides the EFA factor matrix for this analysis.

Table 5

Rotated Factor Loadings for Individual Legacy Scale Items

	Factor	
	1	2
I am powerless over alcohol and my life is unmanageable when drinking	**.58**	.06
I believe in a power greater than myself and that this power can restore me to sanity.	.50	**.53**
I have turned and continually turn my will and my life over to the care of God.	.37	**.53**
I have made a searching and fearless inventory as outlined in Alcoholics Anonymous.	.22	**.76**
I have admitted to God, to myself, and to another human being the exact nature of my wrongs.	.17	**.82**
I am entirely ready to have God remove all my defects of character.	.21	**.75**
I have humbly asked Him to remove my shortcomings.	.24	**.85**
I made a list of all persons I had harmed and I am willing to make amends to them all.	.15	**.77**
I have made direct amends to such people wherever possible, except when to do so would injure them or others.	.12	**.80**
I continue to take personal inventory and when I am wrong I promptly admit it.	.15	**.73**
I seek through prayer and meditation to improve my conscious contact with God, praying only for knowledge of His will for me and the power to carry that out.	.26	**.73**
I have had a spiritual awakening as the result of these steps and I try to carry this message to alcoholics and to practice these principles in all my affairs.	.30	**.83**
I have a working knowledge of the book *Alcoholics Anonymous*, including the 12 Steps.	.32	**.69**
I have a working knowledge of the 12 Traditions.	.21	**.66**
I have a working knowledge of the 12 Concepts for World Service.	**.40**	.31
To watch people recover, to see them help others, to watch loneliness vanish, to see a fellowship grow up about me, to have a host of friends-this is an experience I value.	**.59**	.41
Frequent contact with newcomers and with fellow AA.'s is the bright spot of my life.	**.80**	.32
I place Principles before personalities in my dealings with the Fellowship.	**.60**	.40
I find release from care, boredom, and worry in the Fellowship.	**.59**	.31
The Fellowship has given my life new meaning.	**.60**	.51
I have made life-long friends in the Fellowship.	**.60**	.56
I have learned the meaning of "Love thy neighbor as thyself" in the Fellowship.	**.69**	.34
I have experienced the presence of a loving God within the Fellowship.	**.68**	.38
Meeting attendance is vital to my recovery and the survival of the Fellowship.	**.74**	-.14
As an alcoholic I must continually strive to perfect and enlarge my spiritual life through work and self-sacrifice for others.	**.47**	.42
I am obligated to fit myself to be of maximum service to God and the people about me.	**.51**	.50
When praying I must necessarily ask especially for freedom from self-will, and I am careful to make no request for myself only.	**.67**	.32
My very life as an ex-problem drinker, depends upon my constant thought of others and how I may help meet their needs.	**.85**	.05
Being a sponsor and working the steps with my sponsee(s) as written in the book *Alcoholics Anonymous* is vital to my recovery.	**.61**	.30

(Table 5 continued)

I must necessarily be willing to share my money and my home, counsel frantic wives and relatives, make innumerable trips to police courts, sanitariums, hospitals, jails and asylums, and experience disruptions in my business, sleep, and leisure time in the name of helping another alcoholic.	**.59**	.20
Helping others is necessarily the foundation stone of my recovery.	**.80**	.30
I am obligated to show unselfishness and love with my entire family.	**.52**	.40
Nothing will so much ensure immunity from drinking as intensive work with other alcoholics.	**.81**	.20
Speaking commitments are vital to my recovery.	**.64**	.38
Sharing in meetings is vital to my recovery.	**.65**	.29
Maintaining a service commitment is vital to my recovery.	**.75**	.13

Note. Extraction method was Maximum Likelihood. Rotation method was Varimax and converged in three Iterations.

Hypothesis III. The third study hypothesis held that participants reporting higher Affiliation scores would experience higher Quality of Life scores. Initially, a multiple regression procedure, with individual scores on each of the Service, Unity, and Recovery subscales entered as predictors was proposed. However, given the outcome of Hypothesis II which revealed a strong inter-correlation among these factors, the overall Affiliation scores were used as the sole predictor and the Quality of Life aggregate score as the criterion. Given this, a bivariate Pearson correlation was used to examine the relationship between these two variables.

The results indicate that the Affiliation score is significantly, positively correlated with Quality of Life score, $r(80) = 0.45$, $p < .001$, with the two factors sharing 20% of the variance. The data strongly supported Hypothesis III as higher Affiliation scores were associated with improved perceived Quality of Life.

Hypothesis IV. The fourth study hypothesis expected that participants reporting high degrees of alcoholism will have significantly higher mean scores for both the affiliation and the QOLI scale scores. Prior to testing this hypothesis, it was first necessary to examine the characteristics of the two severity groups for equivalence across other collected demographic and alcohol-related variables. Table 6 presents collected study variables aggregated by reported severity of alcoholism. A series of one-way univariate analyses of variance were conducted to examine for significant mean differences. Among the variables assessed, only age was significantly different between the two groups [$F(1, 80) = 11.7, p < .001$], with low degree alcoholics being significantly older ($M = 50.1$, $SD = 10.5$) than high degree alcoholics ($M = 42.0$, $SD = 9.5$). Given the significant group differences in age, the present hypothesis shall include age as a

covariate in order to eliminate this factor as a potential confound to the clear interpretation of the inferential statistic.

Table 6

Demographic Variables and Degree of Alcoholism (N=82)

	Low Degree Alcoholism *M (SD)*	High Degree Alcoholism *M (SD)*	*F*
Age	50.1 (10.5)	42.0 (9.5)	11.7*
Years Sobriety	10.7 (9.3)	8.4 (7.7)	1.2
Years in AA	11.9 (9.4)	11.2 (7.9)	0.11
Number of Relapses	0.80 (2.2)	1.3 (2.7)	0.91
Years of Education	15.4 (3.5)	14.5 (2.9)	1.4

* $p < .001$.

In order to test this fourth study hypothesis, a one-way, Multiple Analysis of Co-Variance (MANCOVA) was conducted with QOLI and Affiliation scores entered as dependent variables, degree of alcoholism (Low Degree vs. High Degree) entered as independent variables, and age entered as a continuous covariate.

As observed in Table 7, MANCOVA results indicated no significant differences between low and high degree alcoholics on either dependent measure, $F(2, 78) = 123.4$, $p = .19$. Further, the age covariate was not a significant factor within this model, $F(1, 79) = .05$, $p = .82$. Thus, Hypothesis IV was not supported within this sample of participants in recovery.

Table 7

Descriptive Statistics from a MANCOVA Examining the Effect of Degree of Alcoholism on Affiliation and Quality of Life (N=82)

	Low Degree Alcoholism *M* (*SD*)	High Degree Alcoholism *M* (*SD*)	*F*
QOLI Score	2.5 (1.5)	2.3 (1.8)	0.43
Affiliation Score	208.2 (27.7)	218.2 (29.0)	1.50

Note. No significant differences observed.

Hypothesis V. The fifth and final study hypothesis posited that since the 9th Step Promises, and perceived quality of life relate to similar areas of the alcoholic's personal, familial, and greater social life; it is expected that the QOLI and Promises scores will be significantly correlated. In order to test this hypothesis, a bivariate Pearson correlation was conducted.

The results of the statistical analysis indicated that, as predicted, the two factors are significantly correlated, $r(80) = .64$, $p < .001$. Specifically, as the Promises subscale scores increase perceived Quality of Life scores also increase and the two factors share 41.0% of the variance.

Chapter V: Discussion

Introduction

As discussed in Chapter 1, alcoholism and associated alcohol use disorders rank among the most prevalent mental disorders worldwide, and they are considered a major cause of disability burden in most regions of the world (WHO, 2001). The negative effects of alcohol addiction and abuse are well documented, including major health problems, family dysfunction, emotional disorders, high arrest and incarceration rates, homelessness, increased violence, and a multitude of larger economic and social exigencies (Grant et al., 2004). The prevalence of alcohol abuse in the US alone is shocking, with more than 50% of American adults reporting a family member who is currently suffering or has suffered from alcohol dependence (Dawson & Grant, 1998).

While there are various treatment options available to those suffering from alcoholism, problem drinkers in the US continue to choose Alcoholics Anonymous(AA) for treatment more frequently than all other forms of professional alcohol treatment combined (McCrady & Miller, 1993; Room & Greenfield, 1993; Weisner, Greenfield, & Room, 1995). Although various studies have shown the effectiveness of AA relative to abstinence (Tonigan et al., 2000; Humphreys, 1999), clinicians continue to struggle with the truest nature of AA affiliation and the solution it offers for the problem of alcohol addiction. The research completed to date has mistakenly focused on attendance at AA meetings and/or superficial AA behaviors as proof of affiliation and furthermore, when implementing these inappropriate measures of affiliation have focused solely on abstinence as proof of AA's effectiveness. Such inconsistencies have served to divide non-AA affiliated clinicians from their recovered alcohol and drug counselor

counterparts. This divide has proven nearly insurmountable as researchers outside of Alcoholics Anonymous (AA) continue to miss the mark, likely due to their inability to penetrate popular AA jargon and non-AA related rehabilitation talk to uncover the truest nature of AA affiliation.

This study serves to bridge this gap by providing clinicians with a new and better measure of AA affiliation while at the same time relating it not only to abstinence but to quality of life, a measure far more valuable in a Fellowship that promises a "...new freedom and new happiness" (AAWS, p. 83.) The present study attempted to determine the reliability of a new measure of affiliation, its relation to quality of life, and the effects of self-acknowledged degree of alcoholism on both of the aforementioned. This chapter reviews the results for each hypothesis and their implication for the clinical utility of the AA Affiliation Scale. Following this is a brief discussion of the current study's limitations as well as suggestions for future research.

Reliability of the Alcoholics Anonymous Affiliation Scale

The primary purpose of this research study was to establish the reliability of an instrument designed to measure affiliation with AA and comprised entirely of items drawn directly from *Alcoholics Anonymous*. The Alcoholics Anonymous Affiliation Scale presented proved to be highly reliable, yielding an overall Cronbach's Alpha of .97. Each of the three subscales also produced excellent reliability with both the Recovery and Unity scales producing a coefficient alpha of $r = .93$ and the Service scale producing a coefficient alpha of $r = .91$. In addition, the 9th Step Promises scale proved to be strongly reliable, producing a coefficient alpha of $r = .96$.

While additional validation may be necessary, it appears that the AA Affiliation scales represent legitimate tools with which clinicians may better assess the depths to which clients struggling with alcohol addiction have or have not taken hold of what AA has to offer. Furthermore, such reliability suggests that the truest measure of affiliation with AA ought to come from AA itself, rather than any one individual or group's interpretation of the Program.

Factor Structure of AA's Three Legacies

While the basic text of *Alcoholics Anonymous* may represent the truest nature of AA affiliation, it was clearly not designed in and of itself to measure said affiliation in any specific manner. That being said, it is not surprising that the three legacies of AA, namely Recovery, Unity, and Service are not clearly represented in the text as three individual factors of a larger construct. As mentioned in Chapter 3, the AA Affiliation scales were constructed by a group of experienced AA members who attempted to isolate the most potent examples of AA's three legacies as represented in the basic text. While it was assumed that participation in each of the Three Legacies would be necessary to most fully achieve affiliation with AA, it was not assumed that the aforementioned method of scale development would successfully achieve three significantly independent factors. The results of this research study confirmed the lack of a three-factor solution when conducting a Principle Components Analysis of the individual scale scores. While a thirty-factor solution did explain 100% of the variance, 58.6 % of said variance was associated with two factors, thereby suggesting that the three scale indices are likely components of two underlying constructs.

Many of the scale items clearly cross over from one Legacy to another, with selflessness and service to God and others as the primary motivation and consequence to all of what Alcoholics Anonymous (AA) has to offer. However, inspection of the rotated factor loadings of individual subscale items (see Table 5) strongly suggests the Recovery Scale does in fact, represent a unique construct. Eleven of the 12 Steps that make up the Recovery scale load more strongly on Factor 2, with ten of the aforementioned strongly loaded on said Factor. In addition to the 12 Steps, the first two items of the Unity scale, both representing knowledge of the book *Alcoholics Anonymous*, also load strongly on Factor 2. All of the remaining items load more heavily on Factor 1 with 18 of the 23 loading strongly on said Factor.

These results suggest that the instrument developed within this study contains items representing 2 distinct constructs with the first focused primarily on attitudes and behaviors aimed at serving others and the second more strongly focused on personal development via individual work on the 12 Steps and knowledge of the book *Alcoholics Anonymous*.

The Correlation of Affiliation and Quality of Life

As mentioned in Chapter 2, AA speaks to alcohol consumption as a symptom of a deeper problem; therefore, "putting the plug in the jug" is but a bare beginning on the road to recovery. Simply put, recovery in AA is about improving your life and the lives of those around you when possible. In turn, this research study hypothesized that those who are more strongly affiliated with AA would also report greater degrees of life satisfaction. The results strongly supported this claim, indicating that the Affiliation

score is significantly and positively correlated with Quality of Life score, $r(80) = .45$, $p < .001$, with the two factors sharing 20% of the variance. As originally hypothesized, higher affiliation scores were associated with improved perceived quality of life.

Armed with this information of this kind, clinicians may more confidently refer clients suffering from alcoholism to AA as a specific program of action aimed at increasing one's experience of connectedness to others and self-acceptance. Clinicians who are aware of AA's Three Legacies and the relationship between affiliation with AA. and Qualitiy of Life are better equipped to confront client resistance towards life without alcohol. For those interested in AA's Program of recovery, putting the drink down is possible and only the beginning to a better life. If not pragmatic, AA's suggested Program of recovery is nothing.

Degree of Alcoholism, AA Affiliation, and Quality of Life

AA views despair as a gift. "Hitting bottom" often provides the motivation the alcoholic needs to proceed through the 12 Steps and experience the ego deflation therein. One may naturally assume then that alcoholics who experience more intense levels of alcoholism may be more motivated to work the Program of AA and in turn reap the rewards of a stronger affiliation with AA. While the present study hypothesized that alcoholics reporting higher degrees of alcoholism would also report both higher affiliation and quality life, the results did not support this claim. In fact, there was no significant differences between low and high degree alcoholics on either dependent measure, $F(2, 78) = 123.4$, $p = .19$. Therefore, alcoholics who experience more intense levels of alcohol addiction are not necessarily more inclined to practice AA's overall

program more vigilantly, and perhaps may even have additional obstacles preventing such affiliation such as mental illness, greater loss of connection to others, and more intense physical problems.

It should be noted, however, that when compared to lower degree, higher degree alcoholics did report a significantly stronger correlation to the Recovery scale within the Alcoholics Anonymous Questionnaire, $F(1, 80) = 3.9, p = .05$ as shown in Table 2. The fact that 11 out of the 12 items from the Recovery scale existed on a single factor substantiates the significance of these findings. Of the three Legacies, Recovery, represented by the 12 Steps, is said to be the foundation of AA and it appears that alcoholics who perceive their illness to be of a greater intensity show greater affiliation to these principles when compared to those members of AA reporting lower perceived degrees of alcoholism. Although additional research is necessary, the current sample suggests that alcoholics of a higher degree must necessarily adhere to AA's 12 Steps more rigorously than their less intensely alcoholic counterparts in order to achieve similar levels of sobriety and quality of life.

Although unable to confirm the original hypothesis, it appears that the lack of significant differences between low and high degree alcoholics regarding overall strength of affiliation represents important data nonetheless. It appears that while alcoholics may need to "hit bottom" to develop the motivation necessary to complete the 12 Steps, the depth of said bottom is relative. That is to say alcoholics who have not yet progressed to stages 3 and 4 of AA's definition of alcoholism can in fact possess the motivation necessary to strongly affiliate with the all Legacies of Alcoholics Anonymous. From a

clinical standpoint, it appears that alcoholics of every degree, from potential to fully actualized, have access to AA's program and its promises.

9th Step Promises and QOLI Correlation

As stated earlier, the book *Alcoholics Anonymous* was not written as a clinical assessment or a collection of psychometrically sound instruments. However, because the 9th Step Promises encompass many of life's most potent elements it was hypothesized that they would significantly correlate to the Quality of Life Inventory (QOLI; Frisch, 1993), a more valid and time-tested scale. The results supported this claim with the two variables significantly correlated, $r(80) = .64$, $p < .001$. Specifically, as Promises subscale scores increase perceived quality of life scores also increase and the two factors share 41.0% variance. It appears then that elements within the text of *Alcoholics Anonymous* can be used to reliably assess both the degree of affiliation with AA and the perceived outcome of said affiliation. Although additional research is necessary to establish the validity of the present study's affiliation scale, it appears that the 9th Step Promises are both reliable and valid, as suggested by their correlation to and convergence with the QOLI.

Methodological Limitations

The current study strongly supported the most important hypothesis, namely the reliability of the affiliation scale(s) and the correlation between these scales and perceived quality of life. However, due to the nature of AA there are some significant shortcomings. To begin, the sample size though sufficient for statistical power was

relatively small at $N = 82$. Perhaps the skepticism of many alcoholics regarding the protection of their anonymity and the sanctity of the Fellowship seemed to prevent many potential subjects from taking part in the study. While the participant pool was significantly skewed towards members of AA who were Christian, well-educated, and/or of a lower acknowledged degree of alcoholism, the sample represented a more racially diverse group than the Fellowship itself. According to the AA Grapevine (AAWS, 2005), a 2004 North American survey of AA members reported a membership that was 89.1% White, 3.2% Black, 4.4% Hispanic, 1.8% Native American, and 1.5% Asian and other. Althought the current sample represented a greater degree of diversity, more research is clearly needed into the minority experience of AA as well as any potential barriers to minority membership. In addition, there were very few subjects reporting the highest degree of alcoholism ($n = 2$), preventing any legitimate analysis of the relationship between alcoholism severity and AA affiliation and/or quality of life.

While the difficulties of researching AA related topics were discussed in Chapter 2, this study further substantiates the aforementioned. To begin, sober (mentally, physically, and spiritually) members of AA are more likely to participate in a study such as this in their efforts to serve others and support scientific inquiry. Less actualized members of the Fellowship may be more likely to shun interaction with strangers asking for their help and a good deal of personal information. Furthermore, because AA has very few rules, no one really has the right to say what AA affiliation is or isn't. Even the authors of the book *Alcoholics Anonymous* admitted that they knew little and were not opposed to new and better information. These ideological soft spots coupled with the heavy emphasis that AA places on the oftentimes unseen spiritual realm make traditional

scientific inquiry very difficult. Nonetheless, investigation is possible and as this study suggests, fruitful as well.

Areas for Future Research

The present study has begun to bridge the gap between the professional research community and the AA community. By presenting a reliable instrument designed to measure affiliation with AA and comprised entirely of elements taken directly from *Alcoholics Anonymous*, this research project provides the clinical community with a powerful tool to both assess current levels of AA affiliation with clients and provide direction for increased levels of affiliation. However, there is much more to be done if the professional clinical community is to have as firm a grasp as possible on the incredibly pragmatic and at the same time ethereal Program of AA. To begin, additional research is needed into what well grounded members of AA feel are the most prominent and potent elements of AA affiliation. While the current study implemented a team of 10 active members of AA, there is much room for interpretation and additional input is needed before an AA affiliation scale is finalized.

While the current study suggests the existence of two individual factors within the construct of AA affiliation, additional research is needed to both substantiate this data as well as more fully explore the potency of individual items. Research designed to confirm the relative importance of individual AA affiliation items would serve the professional clinical community well in their search for a short but meaningful instrument designed to measure affiliation with the single most popular treatment method for alcoholism in the United States today.

In addition, more research is needed into the experience of minority AA members across race, level of education, and religion. The founding fathers of AA were White, Christian, wealthy, and well-educated. Although AA has clearly expanded its horizons, this study has done little to further explore the experience of minority members of AA with or without higher education and economic fortitude.

Finally, while self-perceived quality of life is important in recovery as well as in AA, many AA members would argue that other perceived quality of life is more important. That is, active members of AA may not clearly see how they affect others and their quality of life. Therefore, additional research is needed into the correlation between AA members' perceived quality of life and the perceptions of those who know them best. Research designed to measure AA members' perceived quality of life as well as significant others, family members, and fellow AA members' perceived quality of life for said AA member would better substantiate this study's findings.

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APPENDIX A: ALCOHOLICS ANONYMOUS AFFILIATION SCALE

Alcoholics Anonymous Affiliation (Recovery)

The following scale consists of various elements of Alcoholics Anonymous' suggested program of recovery as written and recorded in the book *Alcoholics Anonymous*. Please place a check mark or X in the column that corresponds with the descriptive statement that best describes your most common experience with the specific concept.

	Completely Disagree With This Concept	Seriously Disagree With This Concept	Somewhat Disagree With This Concept	No Opinion or Experience With This Concept	Somewhat Engage In This Concept	Seriously Engage In This Concept	Completely Engage In This Concept
I am powerless over alcohol and my life is unmanageable when drinking.							
I believe in a Power greater than myself and that this Power can restore me to sanity							
I have turned and continually turn my will and my life over to the care of God.							
I have made a searching and fearless moral inventory as outlined in the book Alcoholics Anonymous.							
I have admitted to God, to myself, and to another human being the exact nature of my wrongs.							
I am entirely ready to have God remove all my defects of character.							
I have humbly asked Him to remove my shortcomings.							
I made a list of all persons I had harmed and I am willing to make amends to them all.							
I have made direct amends to such people wherever possible, except when to do so would injure them or others.							
I continue to take personal inventory and when I am wrong I promptly admit it.							
I seek through prayer ***and*** meditation to improve my conscious contact with God, praying only for knowledge of His will for me and the power to carry that out.							
I have had a spiritual awakening as the result of these steps and I try to carry this message to alcoholics and to practice these principles in all my affairs.							

Alcoholics Anonymous Affiliation (Unity)

The following scale consists of various elements of Alcoholics Anonymous' suggested program of recovery as written and recorded in the book *Alcoholics Anonymous*. Please place a check mark or X in the column that corresponds with the descriptive statement that best describes your most common experience with the specific concept.

	Completely Disagree With This Concept	Seriously Disagree With This Concept	Somewhat Disagree With This Concept	No Opinion or Experience With This Concept	Somewhat Engage In This Concept	Seriously Engage In This Concept	Completely Engage In This Concept
I have a working knowledge of the book *Alcoholics Anonymous*, including the 12 Steps.							
I have a working knowledge of the 12 Traditions.							
I have a working knowledge of the 12 Concepts for World Service.							
To watch people recover, to see them help others, to watch loneliness vanish, to see a fellowship grow up about me, to have a host of friends-this is an experience I value.							
Frequent contact with newcomers and with fellow AA's is the bright spot of my life.							
I place Principles before personalities in my dealings with the Fellowship.							
I find release from care, boredom, and worry in the Fellowship.							
The Fellowship has given my life new meaning.							
I have made life-long friends in the Fellowship.							
I have learned the meaning of "Love thy neighbor as thyself" in the Fellowship.							
I have experienced the presence of a loving God within the Fellowship.							
Meeting attendance is vital to my recovery and the survival of the Fellowship.							

Alcoholics Anonymous Affiliation (Service)

The following scale consists of various elements of Alcoholics Anonymous' suggested program of recovery as written and recorded in the book *Alcoholics Anonymous*. Please place a check mark or X in the column that corresponds with the descriptive statement that best describes your most common experience with the specific concept.

	Completely Disagree With This Concept	Seriously Disagree With This Concept	Somewhat Disagree With This Concept	No Opinion or Experience With This Concept	Somewhat Engage In This Concept	Seriously Engage In This Concept	Completely Engage In This Concept
As an alcoholic I must continually strive to perfect and enlarge my spiritual life through work and self-sacrifice for others (p.14)							
I am obligated to fit myself to be of maximum service to God and the people about me (p.77).							
When praying I must necessarily ask especially for freedom from self-will, and I am careful to make no request for myself only (p. 87).							
My very life as an ex-problem drinker, depends upon my constant thought of others and how I may help meet their needs (p.20).							
Being a sponsor and working the steps with my sponsee(s) as written in the book Alcoholics Anonymous is vital to my recovery.							
I must necessarily be willing to share my money and my home, counsel frantic wives and relatives, make innumerable trips to police courts, sanitariums, hospitals, jails, and asylums, and experience disruptions my business, sleep, and leisure time in the name of helping another alcoholic.							
Helping others is necessarily the foundation stone of my recovery.							
I am obligated to show unselfishness and love with my entire family (p. 127).							
Nothing will so much ensure immunity from drinking as intensive work with other alcoholics.							
Speaking commitments are vital to my recovery.							
Sharing in meetings is vital to my recovery.							
Maintaining a service commitment is vital to my recovery.							

APPENDIX B: ACKNOWLEDGED DEGREE OF ALCOHOLISM

Acknowledged Degree of Alcoholism

According to the book *Alcoholics Anonymous*, there are at least four degrees of alcoholism (pp. 108-111). Please read the following summaries and check off the description that best fits your personal experience with alcoholism at its most intense level.

_____ (1) "He enjoys drinking" (p. 111). The lowest grade of alcohol abuser is defined as a "heavy drinker" (p. 108). This individual's drinking may be constant or may be heavy only on certain occasions. This individual's drinking may be an embarrassment at times and he may spend too much money on alcohol. This person considers his drinking as a necessary part of his job or life situation. This individual may be capable of stopping all together because of health issues, personal difficulties, or a doctor's warning.

_____ (2) "He wants to want to stop" (p.109). This individual is clearly showing a lack of control and is unable to stay away from alcohol even when he wants to. This individual often gets entirely out of hand when drinking, recognizes this fact, and promises to do better in the future. This individual has begun to try various methods of moderating or staying dry, but after doing so for only a short while begins to think that he can handle drinking again. He may drink in the morning to hold nervousness in check and may begin to worry about actually having the ability to stop. This individual may tend to business fairly well and certainly has not lost everything.

_____ (3) "He desperately wants to stop but cannot "(p. 110). This individual has lost his friends, is unable to hold down a job, and his home life is a wreck. While he admits he cannot drink like other people, he does not know why, and he clings to the notion that he will some day find a way. This individual may have already visited the hospital or a rehabilitation clinic as the result of his drinking.

_____ (4) "He has been placed in one institution after another" (p. 110). This individual appears insane when drunk and may be violent. He may have suffered from delirium tremens, been hospitalized, and drank on the way home from the hospital. Perhaps doctors have advised committing this drinker and hospitalizations may be frequent.

APPENDIX C: 9TH STEP PROMISES

9th Step Promises

The following scale consists of various elements of Alcoholics Anonymous' suggested program of recovery as written and recorded in the book *Alcoholics Anonymous*. Please place a check mark or X in the column that corresponds with the descriptive statement that best describes your most common experience with the specific concept.

	No Experience of this Promise	Some Experience of this Promise	Much Experience of this Promise	Complete Experience of this Promise
If we are painstaking about this phase of our development, we will be amazed before we are half way through.				
We are going to know a new freedom and a new happiness.				
We will not regret the past nor wish to shut the door on it.				
We will comprehend the word serenity and we will know peace.				
No matter how far down the scale we have gone, we will see how our experience can benefit others.				
That feeling of uselessness and self-pity will disappear.				
We will lose interest in selfish things and gain interest in our fellows.				
Self-seeking will slip away.				
Our whole attitude and outlook upon life will change.				
Fear of people and of economic insecurity will leave us.				
We will intuitively know how to handle situations which used to baffle us.				
We will suddenly realize that God is doing for us what we could not do for ourselves.				

APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Please provide the following information by filling in the blank or placing an X next to the category that applies to you:

(1) Age: _____

(2) Years of continuous sobriety (currently): _____

(3) Years of involvement with AA: _____

(4) Number of relapses during involvement with AA: _____

(5) Highest grade or post-secondary year/degree completed: _____

(6) Race/Ethnicity: American Indian/Alaskan Native: _____

Asian/Pacific Islander: _____

Black, Not of Hispanic Origin: _____

Hispanic: _____

White, Not of Hispanic Origin: _____

Other (Please describe yourself): _____

(7) Religious Affiliation (Please respond with your specific affiliation or "None"):

_____

APPENDIX E: VERBAL RECRUITMENT SCRIPT

Verbal Recruitment Script

A friend and member of Alcoholics Anonymous is attempting to complete his dissertation towards a Doctorate in Counseling Psychology, and he is asking for our help. Our friend is a student at Seton Hall University in South Orange, New Jersey in the College of Education and Human Services and the Professional Psychology and Family Therapy Department.

This study has two purposes. First, this study will investigate the reliability and validity of newly designed surveys exploring affiliation with Alcoholics Anonymous. Secondly, this study will investigate the relationship between affiliation with Alcoholics Anonymous and quality of life.

Should you choose to participate in the study, the entire process will take about 45 minutes of your time.

As a volunteer participant, you will be asked to fill out five paper and pencil surveys. The first survey is designed to measure how strongly you are affiliated with Alcoholics Anonymous. This survey consists of only statements and concepts taken directly from the book *Alcoholics Anonymous*. The second survey consists of the four degrees of alcoholism that exist in the book *Alcoholics Anonymous*. In completing this survey, you will be asked to check off the degree that best fits your experience of alcoholism. The third survey is designed to explore how deeply you have experienced the 9th Step Promises that appear in the book *Alcoholics Anonymous.* You will be asked to check off varying degrees of identification or experience with these promises as you complete this survey. The fourth survey is called the Quality of Life Inventory and it is designed to measure your interest in and satisfaction with various aspects of life. Finally, you will be asked to complete a demographic questionnaire which will ask you to identify various personal characteristics such as age, race, and educational history. This instrument will not ask for your name, address, or any other information which may identify you in any way.

Your participation in this research study is entirely voluntary, and you may end your participation at any time without an explanation and without penalty.

As mentioned earlier, your anonymity will be preserved throughout the research study. You will not be asked to supply your name, address, or any other information which may in any way provide the researcher or anyone else with your identity. The research packets you will receive will be numbered; however, these numbers will only serve to help the researcher organize the data and will in no way be associated with you or your meeting.

Only the researcher and his supervisor, Dr. Pamela Foley, also of Seton Hall University, will have access to the research data, which will be stored on compact disc only and locked in the researcher's office at all times.

APPENDIX F: INFORMED CONSENT FORM

Informed Consent to Participate in Research

1. Researchers' Affiliation

You are invited to participate in a research study exploring the reliability of newly developed instruments designed to measure affiliation with Alcoholics Anonymous. This study will also investigate the relationship between affiliation with Alcoholics Anonymous and quality of life. This study is being conducted by August L. Leming, M.A., a doctoral student in the Counseling Psychology program in the Department of Professional Psychology and Family Therapy at Seton Hall University in South Orange, New Jersey.

2. Purpose and Duration of Study

This study has two purposes. First, this study will investigate the reliability of newly designed Questionnaires developed by the researcher to explore affiliation with Alcoholics Anonymous. Secondly, this study will investigate the relationship between affiliation with Alcoholics Anonymous and quality of life. The total time to complete this study, including the enclosed Alcoholics Anonymous Affiliation Questionnaire, Acknowledged Degree of Alcoholism Questionnaire, 9th Step Promises Questionnaire, Quality of Life Inventory and demographic questionnaire is 45 minutes.

3. Procedures

Participation in this study will involve the completion of four paper and pencil instruments in addition to a demographic questionnaire. If you decide to participate in this study, please complete and return the instruments and questionnaire to the author in the self-addressed, pre-paid envelope provided and keep this form for your records.

4. Research Instruments

This study involves the use of four instruments in addition to a demographic questionnaire. The instruments involved are the Alcoholics Anonymous Affiliation Questionnaire, the Acknowledged Degree of Alcoholism Questionnaire, the 9th Step Promises Questionnaire, and the Quality of Life Inventory.

The Alcoholics Anonymous Affiliation Questionnaire consists of 36 various elements of Alcoholics Anonymous' suggested program of recovery as written and recorded in the book *Alcoholics Anonymous*. Should you choose to participate, you will be asked to respond to these various elements by checking off one of the provided descriptive statements that best describes your most common experience with the specific concept. You may choose one of seven descriptive statements provided ranging from "Completely disagree with this concept" to "Completely engage in this concept." The Questionnaire includes concepts such as, "I am powerless over alcohol and my life is unmanageable when drinking;" "I ought to have a working knowledge of the 12 Traditions;" and "Sharing in meetings is vital to my recovery."

The Acknowledged Degree of Alcoholism Questionnaire includes the four degrees of alcoholism recorded in the book *Alcoholics Anonymous* and is completed by checking off the description that best fits your personal experience with alcoholism at its most intense level.

The 9th Step Promises Questionnaire includes the twelve promises recorded in the book *Alcoholics Anonymous* and is completed by checking off one of the provided descriptive statements that best describes your most common experience with the promise. You may choose one of four descriptive statements ranging from "No experience of this promise" to "Complete experience of this promise."

The Quality of Life Inventory is a 32-item instrument designed to measure participants' life satisfaction in 16 areas of life, including but not limited to health, learning, and love. The Quality of Life Inventory is completed by checking off one of the provided degrees of satisfaction ratings, ranging from -3 to 3 as well as one of the provided degree of importance ratings, ranging from 0 to 2. The inventory includes items such as, "Health is being physically fit, not sick, and without pain or disability. How important is health to your happiness, and how satisfied are you with your health?"

Finally, the demographic questionnaire includes seven questions designed to gather possibly important information about participants. The questionnaire is completed by providing written information regarding such characteristics as age, years of involvement in Alcoholics Anonymous, and Race/Ethnicity.

5. Voluntary Nature of Participation

Participation in the study is completely voluntary. If you decide not to participate after reviewing the study materials, you are under no obligation to continue. Further, if you begin the study and at any time you decide to discontinue your participation, you are free to do so. Regardless of your choice, please accept the researcher's gratitude for your interest.

6. Anonymity

At no time will you be required to offer or record any information that might identify you as a study participant and member of Alcoholics Anonymous. Study materials are numbered so that individual packets are not confused with one another during data analysis, but these numbers can in no way be associated with you or your name.

7. Confidentiality of Data

Confidentiality will be assured by assigning code numbers to the completed instruments and questionnaires. Summaries of your responses may be cited in publications related to this research project but in no way will such data be attributed to you or your name. All data will be stored in a locked cabinet maintained at Seton Hall University by Dr. Pamela Foley.

8. Access to Research Records

The researcher, August L. Leming, M.A., and his faculty advisor, Dr. Pamela Foley, will have access to this data. No one else will have access to the demographic information or the completed instruments and questionnaires. There will be no records kept of study participants or their names.

9. Anticipated Risks

It is not expected that participation in this study will involve significant risk or discomfort. However, should this exercise bring up difficult feelings that you wish to discuss further, you may wish to talk to a fellow member of Alcoholics Anonymous, your sponsor, or contact your health insurance provider for referrals to a counselor.

10. Anticipated Benefits

It is expected that participants will benefit directly from participating in this study via exposure to Alcoholics Anonymous literature, traditions, and elements of the program of recovery itself. In addition, by adding to the research on the effects of affiliation with Alcoholics Anonymous on quality of life, it may be possible to increase the quality of care and recovery experienced by recovering or recovered individuals in therapy as well as those members of AA not in formal treatment.

11. Procedures to Follow in Case of Distress

As stated above, it is not expected that this study will involve significant risk or discomfort. However, if you do experience significant distress, you are encouraged to discuss these feelings with a counselor or other health professional. If you experience distress, you should contact your insurance provider to find a referral for a counselor near you. You can also contact the New Jersey Psychological Association Referral Service at 1-800-281-6572.

12. *Alternative Procedures*

This study does not involve any clinical treatment; therefore, there are no relevant alternative procedures.

13. Whom to Contact for Additional Information

If you have any questions regarding the research process or would like to have a copy of the results, please contact August Leming at 609-651-4338 or by email at lemingau@shu.edu or Dr. Pamela Foley at 973-275-2742. If you have questions regarding your rights as a research participant, you may contact the Institutional Review Board of Seton Hall University at 973-313-6314.

14. Video- or Audiotaping

There will be no video- or audiotaping associated with this study.

15. Your Right to a Copy of This Form

You are entitled to a copy of this Informed Consent Form. If you choose to participate in this study, please maintain this form for your records.

16. Participant's Informed Consent

Due to the nature of the subject matter and your membership in Alcoholics Anonymous, no signature will be required as proof of informed consent. Instead, by returning the study materials in the self-addressed and pre-paid envelope provided you are in fact stating that you have read the material above and have had all questions answered to your satisfaction. By returning the study materials, you are also agreeing to

participate in this exercise and realize that you may withdraw at any time, without prejudice or penalty.