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An Examination of Gender and AA Status Effects on the Relapse Potential of Alcoholics Anonymous Participants

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AN EXAMINATION OF GENDER AND AA STATUS EFFECTS ON THE RELAPSE POTENTIAL OF ALCOHOLICS ANONYMOUS PARTICIPANTS

Reginald A. Johnson

An Abstract Presented to the Faculty of the Graduate School
of Lindenwood University in Partial Fulfillment of the
Requirements for the Degree of
Master of Art
December, 1999

Abstract

This study explored the differences in short term (two years or less) and long term (three or more years) Alcoholics Anonymous participation and gender differences on the potential for relapse. Previous studies on the relationship between AA participation and treatment outcome have had mixed results. There has been limited research into alcoholism and its impact on women. Sixty AA participants were selected, thirty who had two or less years with AA, and thirty who had three or more years with AA. There were fifteen females and males in both the newcomers and old-timers groups. These participants rated their level of confidence in resisting alcohol using the Situational Confidence Questionnaire (Annis and Graham, 1987). The results revealed a number of significant differences in mean SCQ subscale scores based on differences in gender and status on confidence scores on five of the eight SCQ subscales.

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A Thesis Presented to the Faculty of the Graduate School
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Requirements for the Degree of
Master of Art
December, 1999

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Acknowledgments and Dedication

This paper is dedicated to my mother, Mary Johnson, who was the giver of life to me and nurtured me throughout my life. To my friend, Terri Austin, whose dogged persistence encouraged me to stay the course. To my friend, Kim Travers, who has been a personal guide through a life of arduous challenges, and to the founders and members of the fellowship of Alcoholics Anonymous.

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Chapter 1

Introduction

Alcoholism generally develops slowly over a lifetime and can occur in people of all ages. Heredity, culture, economics and the environment all contribute to its development. The long-term effects of alcoholism may effect the central nervous system altering personality and perception of the past, (Vaillant and Hiller-Sturmhofel, 1999).

According to the Diagnostic and Statistical Manual IV, (APA, 1995) alcohol dependence and abuse are among the most prevalent mental disorders in the general population. Alcohol is the most frequently used brain depressant and a cause of considerable morbidity and mortality. At some point in their lives, as many as 90 percent of adults in the United States have had some experience with alcohol and 60 percent of males and 30 percent of females have had one or more alcohol-related adverse life event.

Symptoms of depression, anxiety, and insomnia frequently accompany alcohol dependence and sometimes precede it. Alcohol-related disorders are associated

with a significant increase in the risk of accidents, violence and suicide. "Alcohol intoxication is associated with the commission of criminal acts and it contributes to absenteeism from work, job-related accidents and a variety of family and economic difficulties," p. 196.

Treatment of alcoholism is a subject that has been studied often. One of the most effective treatment methods has consistently been the use of a 12-step program such as Alcoholics Anonymous. Since its inception in 1935, AA has grown to be the most widely used organization for the treatment of alcoholism and substance abuse. Currently AA consists of an estimated 1,800,00 members in 134 countries, (Ingvarson, Le, & Page, 1995.) At the core of AA are the 12-steps, which were originally adapted from a Christian organization, the Oxford Group. This group emphasized changing one's life and removing sin by passing through five stages known as the five procedures. These five procedures are giving in to God, listening to God's direction, checking for guidance, achieving restitution, and sharing (Ingvarson, et. al., 1995). The initial phase of the program is the achievement of sobriety, which is a temporary state, often the product of

external pressure. The ultimate goal of AA is recovery, a state in which the decision not to drink has been integrated into the alcoholic's sense of self and way of acting, (Brown, 1995). Alcoholics Anonymous has been studied as an effective treatment for alcoholism but many of these studies have led to inconclusive findings due to the voluntary nature of the organization and difficulty in finding control groups for comparison (Miller, Montgomery & Tonigan, 1995).

The prevention of relapse is the primary focus of treatment efforts including those of AA. Relapse may be brought on due to a variety of circumstances. According to Brown, Grant, Patterson, Schuckit & Vik, (1995) psychosocial stress is a primary or secondary consideration in the majority of addiction relapse models. Severe stress is believed to tax coping repertoires and social resources, increase negative affect and increase focus on the stress-reducing effects of alcohol, thus leading to relapse in some cases.

According to Miller, et. al, 1995, the relationship between AA membership and sobriety has been demonstrated and the researchers found that attendance and involvement with AA was negatively correlated consumption of alcohol, (indicating that relapse was lower among these individuals) and positively correlated with scores on a meaning of life scale.

In terms of gender, there have been limited studies into the effectiveness of treatment modalities such as AA in treating alcoholism in women. There are many women-only AA groups and there are also a number of women's treatment and support groups.

Women for sobriety is an organization whose purpose is to help all women recover from problem drinking through positive reinforcement, cognitive strategies, and physical means. This program is a based on a thirteen-point "new life" acceptance program.

Statement of Purpose

The purpose of this study was to examine the effects of gender and length of AA participation on

the potential for relapse, as measured by the Situational Confidence Questionnaire (SCQ). This study compared the risk for relapse of 30 newcomers to AA with 30 old-timers (at least three
years of participation)using the Situational Confidence Questionnaire (SCQ). The study also examined the differences in males and females in terms of confidence scores.

The SCQ measures the client's self-efficacy for being in high-risk drinking relapse situations according to eight confidence subscales.
The design used will be a functional design with SCQ. scores as the dependent variable and gender and AA status as the independent variables, where AA status will be determined by length of participation in AA.

New AA members are defined as those who have been attending AA meetings on a regular basis for two years or less. Established AA members are defined as those who have been attending AA meetings on a regular basis for three years or longer. Relapse is operationally defined as any return to drinking

during the period of treatment/participation in AA.

Hypotheses

This study examines 8 hypotheses:

1. The first hypothesis examines the effects of gender and AA status on confidence scores on the physical discomfort subscale.

2. The second hypothesis examines the effects of gender and AA status on confidence scores on the Pleasant Emotion subscale.

3. The third hypothesis examines the effects of gender and status on confidence scores on the Positive Social Situations subscale.

4. The fourth hypothesis examine the effects of gender and status on confidence scores on the Social Problems at Work subscale.

5. The fifth hypothesis examines the effects of gender and status on confidence scores on the Social Tension subscale according to AA status and gender.

6. The sixth hypothesis examines the effects of gender and status on confidence scores on the Testing Personal Control subscale.

7. The seventh hypothesis examines the effects of gender and status on confidence scores on the

Unpleasant Emotions/Frusrations subscale.

8. The eighth hypothesis examines the effects of gender and status on confidence scores on the Urges and Temptations subscale.

Chapter 2

Literature Review

Addictions

All addictions are based upon the chemicals in the brain. The brain produces opiate-like substances that kill pain. These substances are called enkephalines and endorphines. These substance also alter moods. Individuals can change their brain chemistry by engaging in mood-altering activity. According to Cangemi and Peterson (1993) all psychoactive drugs create some disruption in the chemical messages sent from one neuron to the next within the synapses of the central nervous system. When the attachment receptors are preoccupied by the drug, the chemical message becomes inhibited or enhanced and this may ultimately be expressed by mood alteration.

Cangemi and Peterson (1993) state that the mood induced by smoking crack cocaine is comparable to leaping out of an airplane and free-falling at 140 miles per hour. When an activity or substance meets a psychological need, a person will tend to repeat the behavior that met that need. Whether an

addiction is psychological or physical, certain fundamental needs underlie addictive behavior.

Each individual has levels of enzymes and neurotransmitters that produce a feeling of well-being. When these levels are higher than optimum, anxiety and restlessness may result. If levels are lower than optimum, depression and fatigue may dominate. Any activity that helps an individual achieve or maintain this optimum level will appear desirable. Any may have the potential for becoming addictive. Among the many types of addictive behavior patterns, there are addictions to food, gambling, sex, relationships, spending, theft, violence, pornography, drugs and alcohol, Cangemi and Peterson (1993).

According to Cangemi and Peterson, (1993) women suffer in a variety of ways when faced with addictions. Up to 60% of addicted women are reported to be victims of family violence and sexual abuse and alcohol consumption is often the reason for family violence. Addictions disrupt family life, affect economic security, familiar relationships, parental effectiveness and a host of other daily life

activities.

In addition to the problems that face all people with addictions, women who are addicted or in relationships with those who are addicted may be victims of abuse or sexual violence. They may also be victimized by the males they are in relationships with Cangemi and Peterson (1993).

Alcoholism

Alcoholism is a chronic and progressive addiction. According to Kendler and Prescott (1999) it has been found that genetic factors play a major role in the development of alcoholism. Environmental factors appear to have little influence on the development of alcoholism.

Many twin and adoption studies have found that male twins have a similar propensity for becoming alcohol abusers, alcohol dependent or alcoholic addicted, (Kendler and Prescott, 1999). According to Hiller-Sturmhofel and Vaillant (1996) alcoholism is a disease that differs from most diseases in that it develops slowly over a person's life, it can occur in people of all ages, it has no single known cause, and each alcoholic has their own unique history of

alcohol abuse.

The connection between alcoholism and co-existing psychiatric diagnoses does not clearly define the causality of either condition. Most studies investigating associations of alcoholism with psychiatric disorders have focused on depression because both alcoholism and depression tend to run in families and often occur together in the same person (Hiller-Sturmhofel and Vaillant, 1996). The common comorbidity of alcoholism and depression has led to the hypothesis that people begin to drink to relieve their depression. However, evidence indicates that in most cases depression is a consequence rather than a cause of alcoholism.

Genetic predisposition is demonstrated in many studies that show that the children of alcoholics, particularly sons of alcoholic fathers, are at increased risk for alcoholism (Hiller-Sturmhofel and Vaillant, 1996). Living with an alcoholic parent may increase environmental risk factors associated with alcoholism. Studies of children of alcoholic parents revealed that men with few childhood environmental weaknesses but an alcoholic parent were four times

more likely to develop alcoholism.

The majority of the studies done on alcoholism have focused primarily on males while females have not been studied as extensively. According to Lake (1982) alcoholism among women is quickly rivaling the rates among men. Some issues cited as precipitating women's alcohol abuse include low self-esteem, poor self-concept, abuse and dependency. In terms of the effects of alcoholism, women may be more susceptible to the physical effects of alcohol than men (Hommer, 1999).

Traditionally alcoholism has been thought of as a disease primarily affecting men. As a result, nearly all of the research on the effects of alcoholism on the brain has been conducted on males. Hommer (1999) cited research that indicates that women's brains are more sensitive to the neurotoxic effects of alcohol than men and women develop cirrhosis and cardiomyopathy after fewer years of heavy drinking than men.

Studies by York(1995)indicate that female alcoholics have a higher death rate due to increased risk for suicide, alcohol-related accidents,

cirrhosis and hepatitis. There are also studies that suggest that female alcoholics are at increased risk of death from breast cancer.

York (1995) found that female alcoholics are at increased risk for depression, low self-esteem, alcohol-related physical problems, marital discord, domestic violence and pregnancy-related problems such as miscarriage, fertility difficulties, sexual functioning difficulties. In extreme cases the child may be born with fetal alcohol syndrome, a debilitating life-long disorder in which children may be born with low-birth weight and physical abnormalities. Developmental areas may be affected. The effects of alcoholism and alcohol abuse on the population at large include more than $200 billion in health care costs, premature death, impaired productivity, automobile collisions, crime, social welfare costs and a variety of personal costs that cannot be measured with a dollar figure (York, 1995).

Recovery and Treatment Approaches

Recovery from addictions such as alcoholism is a complex process with uncertain outcomes for future alcohol use. Brown (1995) refers to recovery as a

long-term process. More than just sobriety, recovery is a state in which the decision not to drink alcohol has been integrated into the alcoholic's sense of self and way of acting.

There are various treatment modalities for addictions such as alcoholism. Most are abstinence based and many adopt a 12-step approach such as Alcoholics Anonymous. Other treatment approaches include Rational Recovery (R.R.). Established in 1985 by Jack Trimpey, a recovered alcoholic, R.R. is based on the principles of Rational Emotive Therapy (Galaif and Sussman, 1995).

R.R. is considered to be a non-traditional cognitive program of self-empowerment. Individuals should have the internal motivation and desire to maintain sobriety. R.R. advocates that alcoholics learn to abstain from alcohol use through many means including rational thought. Individuals learn that their alcohol use is an irrational decision, (Galaif and Sussman, 1995).

Another approach to recovery from alcoholism is Save Our Selves (S.O.S.). This organization is a nonspiritual program that was formed in 1986 to address the needs of alcoholics who were uncomfortable

with the spiritual aspects of Alcoholics Anonymous.

There are also a variety of in-patient programs that provide individual, family and group therapy. These programs often employ cognitive-behavioral methods and some employ the use of medications such as Antabuse, (Miller and Verinis, 1995). The major factors in determining the treatment outcome six months after treatment appeared to be attendance at AA and aftercare. There was a more favorable treatment outcome in the higher socioeconomic level population but the use of continuing care after treatment appeared to make a difference, regardless of economic status.

In terms of treatment options for women, an organization called Women for Sobriety was begun in 1976 to address the specific needs of female alcoholics. Kirkpatrick (1998) estimates that there are 7.5 million female alcoholics in the United States.

Women for sobriety is an organization whose purpose is to help all women recover from problem drinking through positive reinforcement, cognitive strategies, and physical means. This program is a based on a thirteen-point "new life" acceptance program.

Alcoholics Anonymous

Begun in 1935 by recovered alcoholics Bill Wilson and Dr. Robert Smith, AA has become the most widely used organization for the treatment of alcoholism. There are estimated to be 1.8 million members in 134 countries (Ingvarson, Le and Page, 1995). The influence of this approach can be seen in the number of similar programs that have been established to treat other addictions including drugs, gambling and eating disorders.

The basis of AA is a 12-step program of recovery (see appendix). These steps were adapted from a Christian organization, the Oxford Group. This group emphasized changing one's life and removing sin by passing through five stages known as the five procedures (Ingvarson, et. al., 1995).

AA membership is open to people from a variety of backgrounds and there are specific meetings designated for women, adolescents, dually-diagnosed, hearing-impaired and a variety of other categories of individuals. The anonymous quality of AA is a central aspect of the program.

The current AA membership is 65% male and 35% female. The average age is 46. There are currently

more than 51,183 AA groups in the U.S. with approximately 1, 166,927 members (Alcoholics Anonymous General Service Office, 1999).

Alcoholics Anonymous and Prevention of Relapse

AA involvement seems to bridge economic, age, gender, ethnic and educational differences with a wide cross-section of people participating in these support groups. It has been found that drinkers who had higher levels of alcohol consumption had a greater likelihood of attending AA (Hiller-Sturmhofel and Tonigan, 1994).

There has been a great deal of anecdotal support for AA but little empirical evidence of the effectiveness of this approach, due in part to the anonymous nature of the groups. According to Galaif and Sussman (1995) some studies have examined the effectiveness of AA using correlational data and several of these studies indicate that those who attend AA after completing an in-patient treatment program are relatively likely to maintain sobriety when compared to those who do not participate in aftercare.

These authors identify several groups of individuals who are not likely to be helped by AA. Those who are uncomfortable in large crowds or intimate meetings, those who are not religiously oriented,

minorities and those of lower socioeconomic status and those who are dually diagnosed are not as likely to benefit from AA participation.

In terms of effectiveness, Miller, Montgomery and Tonigan,(1994), found that while AA involvement was not predictive of the recovery outcome for study participants, the extent of AA involvement was found to predict outcome. Miller, et al. (1994) suggest that in a meta-analysis of 13 studies of the efficacy of AA participation, the larger sample size rendered the correlation between AA attendance and treatment outcome significant. It was also found that mandatory AA attendance was not associated with differentially improved outcomes. AA was designed to operate by a process of attraction and voluntary affiliation, not be coercion.

In terms of gender and the effectiveness of AA, Hiller-Sturmhofel and Tonigan (1994) state that "AA involvement may be less benefical for women because co-occurring disorders that are more prevalent among women, such as depression, often are not addressed explicitly in AA programs," p. 308.

Chapter III

Methodology

Subjects

The population for this study was men and women attending AA meetings at four different sites in the state of Missouri. A total of 69 AA participants were involved in the study. An initial population of 34 long-time participants was reduced to 30 due to incomplete responses to the questionnaires. An initial population of 35 newcomers to AA was reduced to 30, also due to incomplete responses.

Of the 60 usable responses, 50 (83.3%) identified themselves as White and 10 (16.7%) identified themselves as African-American. In terms of gender, 30 (50%) were male, and 30 (50%) were female. The mean age of respondents was 42.85 years (SD=11.6). The mean age of males was 47.3 and the mean age of females was 40.3. The mean age of the old-timers was 46.9 and the mean age of the newcomers was 38.7.

The majority of the study participants were college graduates (46.7%) followed by 25% who had some college. The educational statistics are shown in

Table 1. This represents a generally well-educated sample with at least 2/3 of the sample having at least some college.

Table 1

Education Level

Education Level	Number	Percent
Some High School	1	1.7
High School Grad	3	5
Some College	15	25
College Grad	28	46.7
Advanced Degree	13	21.7

The majority of the study participants (60%) were in the income range from $20,000-$60,000 as shown in Table 2. There were a surprising number in the higher income bracket as well; with 28% reporting annual income > $60,000.

Table 2

Income

Income Range	Number	Percent
$0-19,9999	7	11.7
$20,000-39,999	21	35
$40,000-59,999	15	25
$60,000-79,999	6	10
$80,000+	11	18

The majority of the subjects were married (45%) followed by 21.7% who were single and 20% who were divorced. The marital status statistics are shown in Table 3.

Table 3

Marital Status

Marital Status	Number	Percent
Single	13	21.7
Separated	4	6.7
Divorced	12	20
Widowed	4	6.7
Married	27	45

Instruments

The Situational Confidence Questionnaire

(Annis and Graham, 1987) is used to identify client's self-efficacy for being in high-risk drinking relapse situations. The SCQ is a 39 item scale in which respondents are asked about their confidence in being able to resist the urge to drink heavily in specific situations. The test is designed for use in adult alcoholics.

The SCQ measures eight subscales which are Unpleasant Emotions/Frustration, Physical Discomfort, Social Problems at Work, Social Tension, Pleasant Emotions, Positive Social Situations, Urges and Temptations, and Testing Personal Control. The SCQ is linked to the revised Inventory of Drinking Situations by the same authors. The 100-item IDS was reduced by selecting the 42 items that had the highest item-subscale correlations.

The normative sample for the 42-item SCQ consisted of 424 clients in two Canadian substance abuse treatment facilities. There were 27% females and 73% males. The average age was 41 years with a range from 18-76. Following factor analysis, three items were eliminated, resulting in the 39-item version of the questionnaire.

The test can be administered using paper and pencil or electronically. It can be administered individually or in small groups and takes approximately 10-15 minutes complete. The total score is based on a 0 to 100 percent confidence scale of the ability to resist the urge to drink in a particular situation. A confidence score of 0= 0% confidence , 20= 20% confidence and so on up to 100%.

Individual items are rated by subjects on a six-point likert scale. The authors report evidence of construct and criterion-related validity. Reliability for the overall tests is .98 with subscale correlations ranging from .59 to .91.

Reviewers indicate that the SCQ is reliable and good for use in groups. Limitations include lack of utility for the subscale scores and the possibility that subjects will fake responses in order to appear to be progressing (Annis and Graham, 1987).

Procedure

During the summer of 1999, volunteers who attend Alcoholics Anonymous meetings in a large Midwestern city were solicited to complete the SCQ. A total of four different meetings sites were involved with

participants from 10 different meetings asked to participate. The questionnaires were distributed by the group leaders and returned to the researcher by the leaders in a sealed envelope. Confidentiality was ensured because the researcher was not present when the questionnaires were filled out and names of individuals were not included on the answer sheets.

All respondents were given the Situational Confidence Questionnaire (Annis and Graham, 1987) to assess their self-efficacy in high-risk drinking situations. The questionnaire took approximately 10 minutes for respondents to complete. Once the questionnaires were returned, the subjects scores were computed and tabulated. The data was analyzed using a analysis of variance for factorial design with gender and AA status (newcomer versus old-timer) as the independent variable and the eight SCQ subscale scores as the dependent variable.

Chapter IV

Results

Preliminary Analysis of Data

The respondents reported participation in the AA program for an average of 6.07 years (SD=5.72). About 50% were in AA for two years or less and 50% were in AA for more three years or more. In terms of meetings per week, 38.3 % reported that they attended once per week, 30% reported that they attended two meetings per week, 20% reported that they attended three meetings per week, 6.7% reported that they attended four meetings per week, 1.7% reported that they attended five meetings per week and 3.3% reported that they attended seven meetings per week.

In terms of relapse, 41.7% reported that they had no relapses, 25% reported that they had one relapse, 16.7% reported that they had two relapses, 10% reported that they had three relapses, 1.7 percent reported that they had four relapses, 3.3% reported that they had five relapses, 1.7% reported that they had six or more relapses.

Descriptive Statistics

It would seem that in general, subjects reported

a very high level of confidence on all eight subscales as shown in Table 4.

Table 4

Subscale	M	SD
Physical Discomfort	94.25	10.85
Pleasant Emotions	91.75	13.60
Positive Social Situations	92.93	10.74
Social Problems at Work	92.32	13.64
Social Tension	91.27	12.66
Testing Personal Control	87.5	19.30
Unpleasant Emotions/Frustrations	92.27	11.80
Urges and Temptations	90.67	12.30

Gender Differences

To examine if there were gender differences in relapse, a chi square analysis was conducted. Results suggest that proportionately more women experienced relapse (73%), while proportionately fewer men experienced relapse (43%), ($X=5.55$, $p=0.18$.)

When examining gender differences in number of meetings attended per week, it was found that there

was no significant differences in the number of meetings attended (X= 3.86, p=0.145.) However, it was interesting to note there were twice as many males (n=13) who attended three or more meetings a week compared to the women (n=6).

Examination of Hypotheses

Analysis of the variance between subjects for each of the eight subscales were conducted. The first hypothesis examined the effects of gender and AA status on the confidence scores on the physical discomfort subscale.

Table 5

Subcale PD

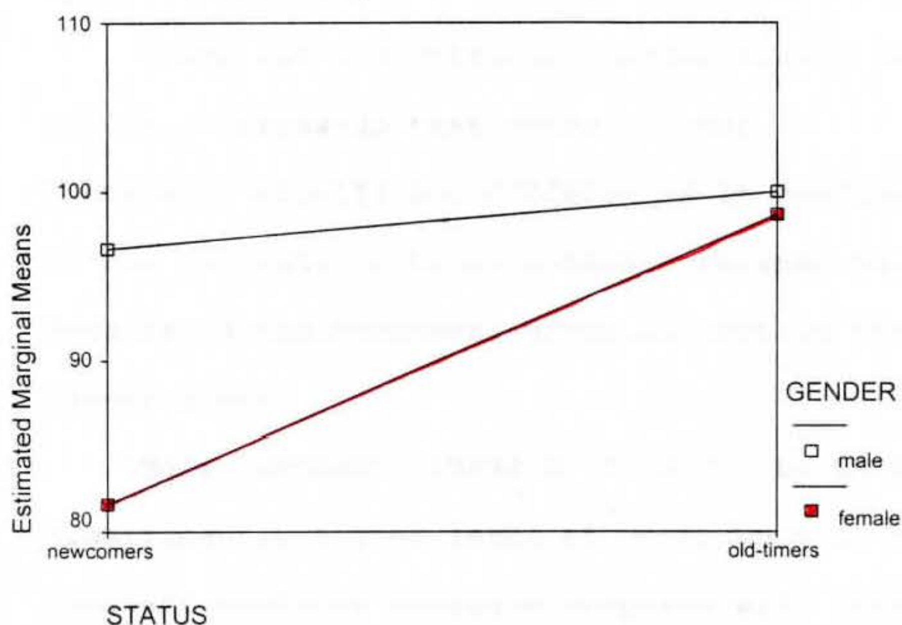
Source	MS	df	F	P
Gender*	1000.417	1	15.18	.000
Status*	1550.417	1	23.53	.000
Gender/Status*	700.417	1	10.63	.002

*p<.05

There was a significant gender-status interaction effect. Follow-up tests revealed that there were significant differences in confidence scores on the physical discomfort subscale between males and females in the newcomers group but not in

the old-timers group. Male newcomers (M=96.66, SD= 7.72) to AA reported a significantly higher level of confidence on the physical discomfort subscale compared with female newcomers (M=81.67, SD=14.1). (T=3.614 , p=.0001).

Table 5a



The second hypothesis examined the effects of gender and AA status on confidence scores on the Pleasant Emotion subscale according to status.

Table 6

Subcale PE

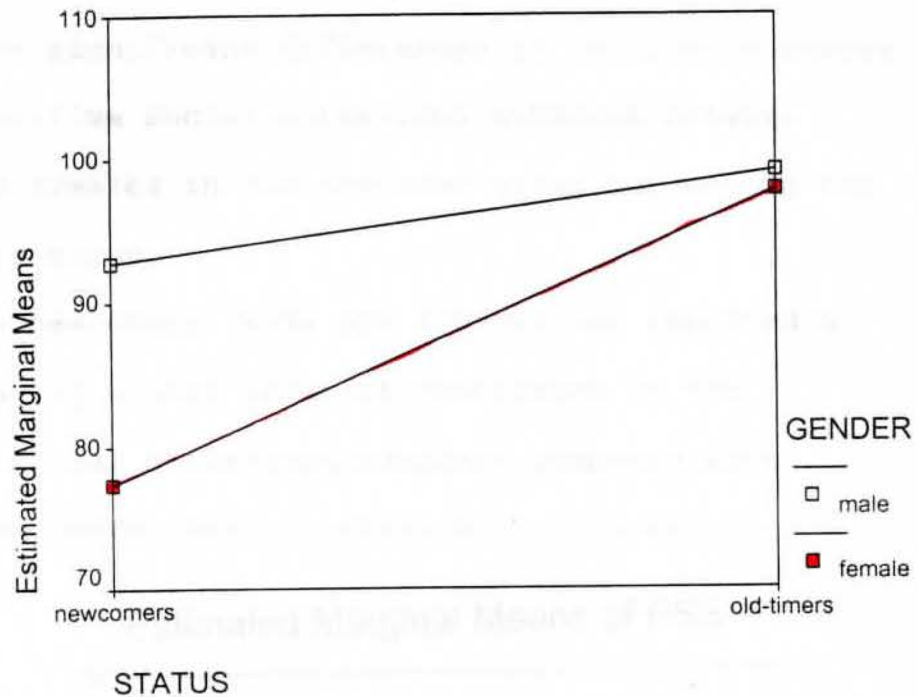
Source	MS	df	F	P
Gender*	1060.921	1	9.25	.004
Status*	2684.028	1	23.39	.000
Gender/Status*	751.188	1	6.55	.013

*p<.05

There was a significant gender-status interaction effect. Follow-up test revealed that there were significant differences in confidence scores on the pleasant emotions subscale between males and females in the newcomers group but not in the old-timers group.

Male newcomers (M=92.8, SD=9.7) to AA reported a significantly higher level of confidence on the pleasant emotions subscale compared with female newcomers (M=77.3, SD=18). (T=2.936 , p=.007).

Table 6a



The third hypothesis examined the effects of gender and AA status on confidence scores on the positive Social Situations subscale.

Table 7

Subcale PSS

Source	MS	df	F	P
Gender*	924.338	1	14.88	.000
Status*	1921.004	1	30.92	.000
Gender/Status*	484.504	1	7.79	.007

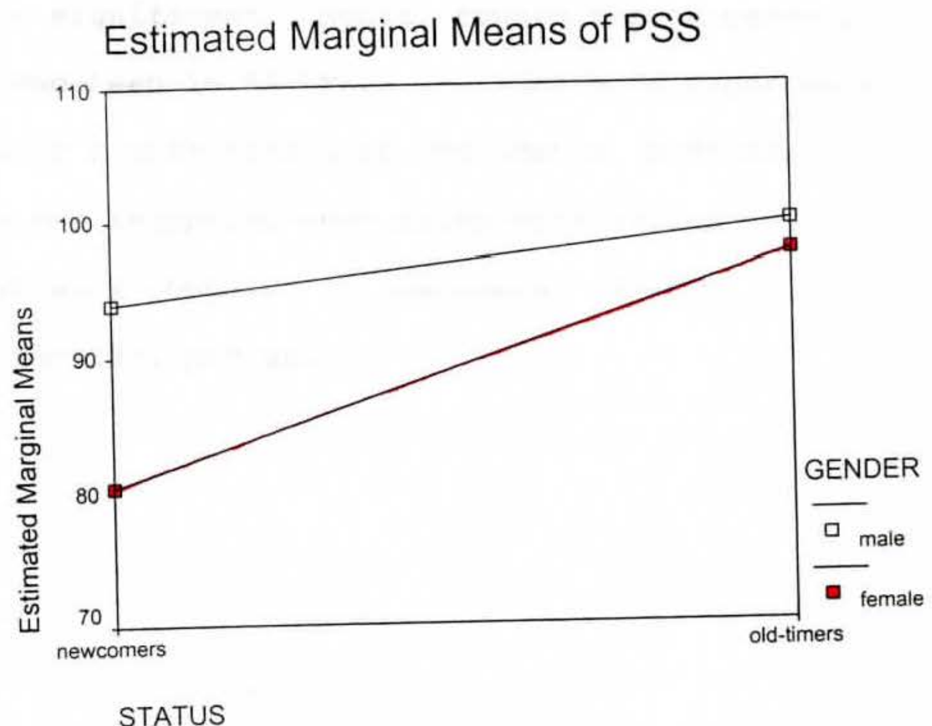
*p<.05

There was a significant gender-status

interaction effect. Follow-up tests revealed that there were significant differences in confidence scores on the positive social situations subscale between males and females in the newcomer group but not in the old-timers group.

Male newcomers (M=94 SD= 7.09) to AA reported a significantly higher level of confidence on the positive social situations subscale compared with female newcomers (M=80.5, SD=12.6). (T=3.622, p=.0001).

Table 7a



The fourth hypothesis examined the effects of gender and status on confidence scores on the Social Problems at Work subscale.

Table 8

Subcale SPW

Source	MS	df	F	P
Gender	534.017	1	3.70	.059
Status*	2249.713	1	15.60	.000
Gender/Status	122.123	1	.85	.36

*p<.05

There was no significant gender-status interaction effect. Examining the variables, only AA status was found to be significant. Hence, regardless of gender, those who had been in AA three years or more reported a significantly higher levels of confidence (M=98.44, SD=5.16)in not relapsing when faced with social problems at work compared to newcomers. (M=86.2, SD=16.6), t=-3.87, p=0.00.

Table 8a

The fifth hypothesis examined the effects of gender and AA status on confidence scores on the Social Tension subscale.

Table 9

Subcale ST

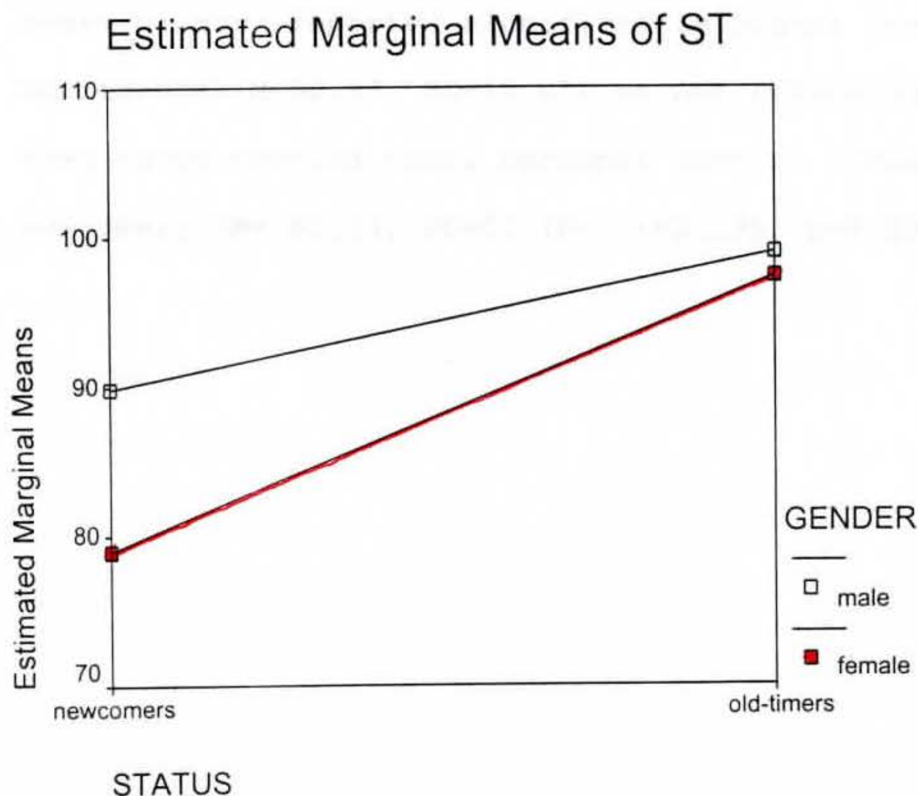
Source	MS	df	F	P
Gender*	589.067	1	5.78	.020
Status*	2829.067	1	27.74	.000
Gender/Status	326.667	1	3.20	.079

*p<.05

There was no significant gender-status interaction effect. Examining the main effects, AA status and gender were found to be significant.

Hence, regardless of gender, those who had been in AA three years or more reported significantly higher levels of confidence (M=98.13, SD=4.03) in not relapsing when faced with social tension compared to newcomers (M=84.4, SD=14.6), t=-4.98, p=0.000. In addition, males reported significantly higher levels of confidence (M=94.4, SD=11.81) in not relapsing when faced with social tensions compared to females (M=88.13, SD=12.89), t-1.96, p=0.054. Male newcomers reported signficantly higher levels of confidence (M=89.87, SD=15.56) in not relapsing when faced with social tensions compared to females (M=79.83, SD=11.56), t=2.185, p=0.037.

Table 9a



The sixth hypothesis examined the effects of gender and AA status on confidence scores on the Testing Personal Control subscale.

Table 10

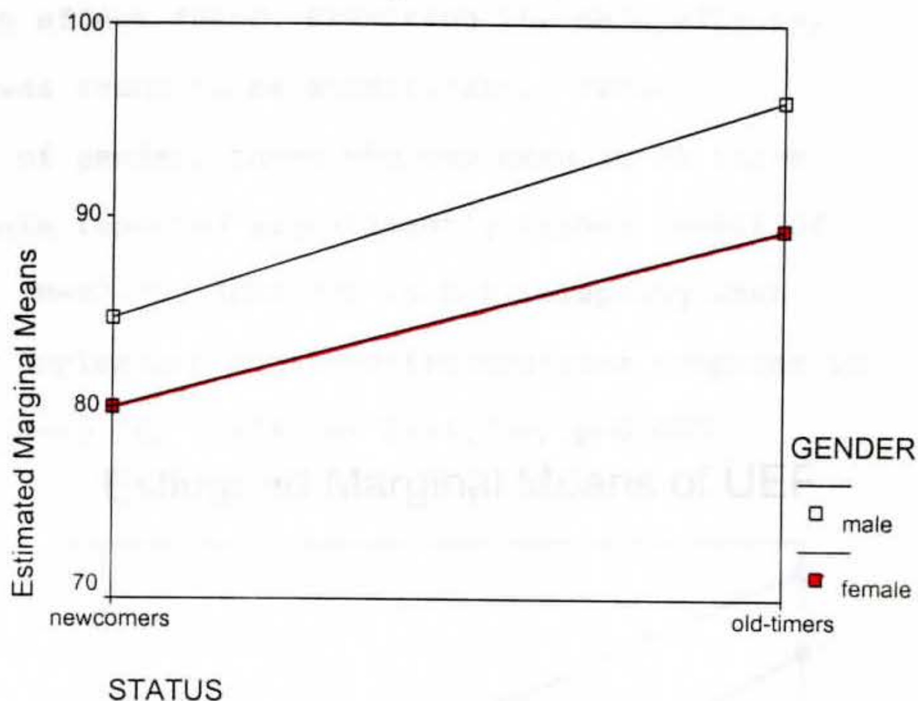
Subcale TPC

Source	MS	df	F	P
Gender	481.667	1	1.36	.249
Status*	1601.667	1	4.51	.038
Gender/Status	15.00	1	.042	.838

*p<.05

There was no significant gender-status interaction effect found. Examining the main effects only AA status was found to be significant. Hence, regardless of gender, those who had been in AA three years or more reported significantly higher levels of confidence (M=92.67, SD=12.85) in not relapsing when they faced testing their personal control compared to newcomers (M= 82.33, SD=23.18), t=2.135, p=0.037.

Table 10a



The seventh hypothesis examined the effects of gender and AA status on confidence scores on the Unpleasant Emotions/Frusrations subscale.

38

Table 11

Subcale UEF

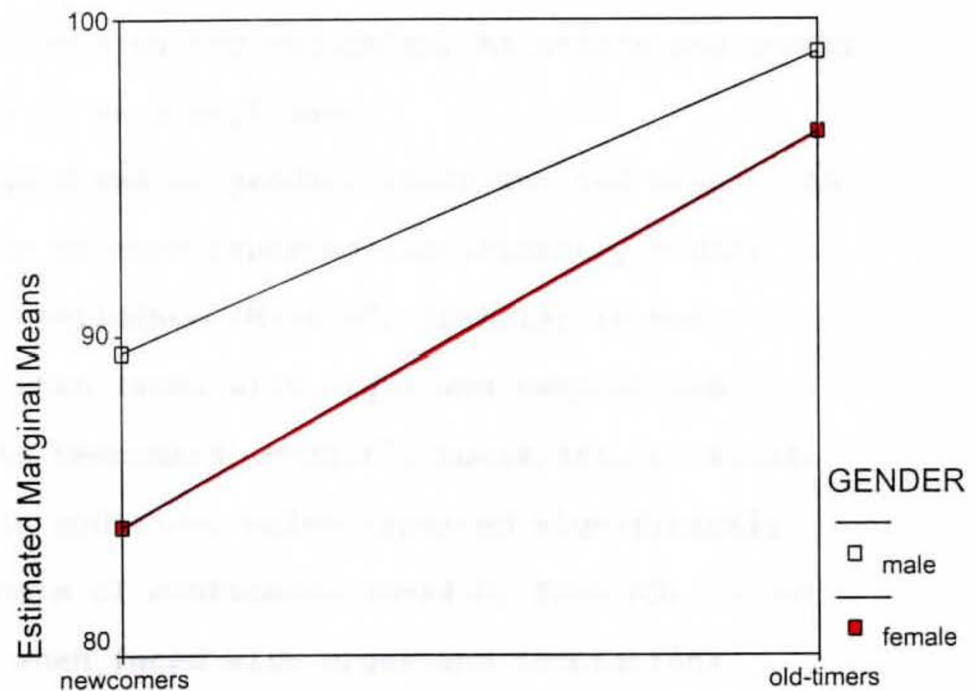
Source	MS	df	F	P
Gender	236.017	1	2.15	.148
Status*	1804.017	1	16.43	.000
Gender/Status	32.267	1	.294	.59

*p<.05

There was no significant gender-status

interaction effect found. Examining the main effects, AA status was found to be significant. Hence, regardless of gender, those who had been in AA three years or more reported significantly higher levels of confidence (M=97.75, SD=4.57) in not relapsing when faced with unpleasant emotions/frustrations compared to newcomers (M=86.78, SD=14.16) t=-4.038, p=0.000.

Table 11a



The eighth hypothesis examines the effects of gender and AA status on confidence scores on the Urges and Temptations subscale

Table 12

Subcale UT

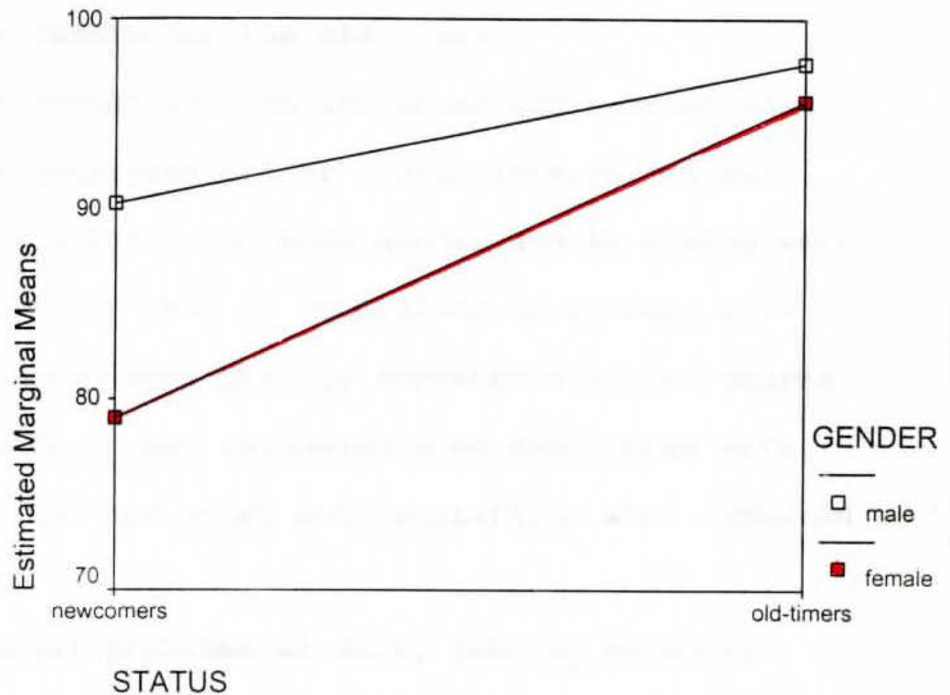
Source	MS	df	F	P
Gender*	666.667	1	6.47	.014
Status*	2160.000	1	20.96	.000
Gender/Status	326.667	1	3.17	.080

*p<.05

There was no significant gender-status interaction effect. Examining the variables, AA status and gender were found to be significant.

Hence, regardless of gender, those who had been in AA three years or more reported significantly higher levels of confidence (M=96.67, SD=5.14) in not relapsing when faced with urges and temptations compared to newcomers (M=84.67, SD=14.38), t=-4.304, p=0.000. In addition, males reported significantly higher levels of confidence (M=94.0, SD=8.03) in not relapsing when faced with urges and temptations compared to females (M=87.33, SD=14.84), t=2.164, p=0.035. Male newcomers reported significantly higher levels of confidence (M=90.33, SD=9.35) in not relapsing when faced with urges and tempations compared to females (M=79, SD=16.5), t=2.315,p=0.028.

Table 12a



Summary of Findings

This study explored the differences in short term and long term Alcoholics Anonymous participation and gender differences on the potential for relapse. Previous studies on the relationship between AA participation and treatment outcome have had mixed results. There has been limited research into alcoholism and its impact on women.

1) The results suggested that for physical discomfort, pleasant emotions and positive social situations, there was a gender-status interaction with male newcomers reporting significantly higher confidence levels but no gender differences in

confidence levels for the old-timers.

2) On social tension and urges and temptations there no significant gender-status interaction was found. Main effects for both gender and AA status were found indicating that 1) regardless of gender, old-timers reported consistently reported a higher degree of confidence in not relapsing when confronted with social tension and urges and temptations when compared to females.

3) Social problems at work, testing personal control and unpleasant emotions/frustrations, there was no significant gender-status interaction. Only the main effect for AA status was found, suggesting that regardless of gender, old-timers reported a consistently higher degree of confidence in not relapsing when confronted with social problems at work, testing personal control and unpleasant emotions/frustrations, when compared with females.

Chapter V

Discussion

In general, there is strong evidence that old-timers consistently reported a higher degree of confidence in not relapsing on all 8 subscales of the SCQ as compared to newcomers. This is consistent with literature that finds a moderate positive relationship between AA participation and maintenance of sobriety (Miller and Verinis, 1995).

In addition, male newcomers seem to report a greater degree of confidence in not relapsing when confronted with physical discomfort, pleasant emotions and positive social situations when compared to female newcomers. But the gender differences seem to be eliminated with longer participation in AA. This would seem to suggest that length of participation in AA, regardless of gender, is more indicative of confidence in potentially relapse-inducing situations.

In terms of treatment, these findings suggest that the needs of women should be studied and addressed more vigorously by AA. They also suggest the need for alternative treatment options, such as

Women For Sobriety, to be expanded to meet the needs of more female alcoholics.

Limitations

The participant's level of involvement was not assessed during this study. There was a conscious decision to select a precise number of newcomers and old timers based on gender and length of time in the program of AA. There was no attempt to identify religious and sexual orientation. There was no attempt to support AA's efficacy over other treatments. This study did not examine pre-existing psychological problems. In addition, this was a cross-sectional study looking at differences between two groups of people. Future studies should take a longitudinal approach and trace improvements made by individuals over time.

Participants of lower socioeconomic standings are not adequately represented in this study. There was not adequate representation of the races. The sample size is also rather small. This study does not intend to suggest that alcoholics must gravitate to AA as the only treatment modality for arresting

the debilitating effects of alcoholism. Any person, male or female, black or white, rich or poor, atheist or believer, dually diagnosed or not, who desires treatment is encouraged to participate regularly, using any form of treatment deemed appropriate and accessible . The results of this study are intended to advance further analysis of the various treatment strategies that are available to those who experience the incapacitating consequences of excessive alcohol usage.

Implications for Practice

Following excruciating withdrawal symptoms and securing a degree of sobriety it is recommended that a sober person attend to issues relating to their alcoholism by way of various approaches. This study provided strong evidence of the efficacy of AA participation in maintenance of sobriety since old-timers consistently reported higher levels of confidence in not relapsing. AA offers an immediate means of support that incorporates the alcoholic into a heterogeneous group. There are specific support groups that meet the desires of alcoholics of every category. There are a number of alternative programs for women, minorities, poly-substance abusers, behaviorally-oriented or cognitive acclimated as well

as controlled drinkers.

In terms of the implications for working with alcoholics, the female participants had consistently lower confidence scores than the males. This indicates a need to address the needs of women more effectively.

It also suggests that alternative programs such as Women For Sobriety may be better equipped to deal with the needs of female alcoholics.

Additionally, the male newcomer participants also report higher confidence scores than the female newcomers. This indicates that there is a difference in the males and females that join AA. This may indicate that women who come to AA are dealing with more intensity in their addictions or it may indicate that males are not accurately reporting their confidence levels. Gender-related differences in alcoholism and recovery need to be examined and the results of that work need to be incorporated into treatment.

Appendix A

Cover Letter

Dear Participant,

I am a graduate student at Lindenwood University, St. Charles, Missouri, and I am conducting a comparative study on Alcoholics Anonymous membership and recovery to complete my thesis. The thesis is partial fulfillment for the requirements of a Master of Arts degree in Professional Counseling. Your participation will be greatly appreciated, and by completing the attached materials, you will be granting your permission for me to use your responses in this study. The questionnaires are completely anonymous and all information will be held in the strictest confidence. Please complete all information and return to me. If you would like a copy of the results, please contact me. I appreciate your support am thanking you in advance for your participation.

Sincerely,

Reginald Johnson

P.O. Box 4924

St. Louis, MO 63108

Appendix B

Demographic Form

AGE:

ETHNICITY:

GENDER

EDUCATIONAL LEVEL: (Please circle highest level)

Some High School

High School Grad

Some College

College Grad

Advanced Degree

ANNUAL FAMILY INCOME: (Please circle appropriate range)

0-$19,999

$20,000-$39,999

$40,000-$59,999

$60,000-$79,999

$80,000+

MARITAL STATUS (Please circle appropriate category)

Single Separated Divorced Widowed Married

HOW LONG HAVE YOU BEEN ATTENDING AA MEETINGS?

HOW OFTEN DO YOU ATTEND AA MEETINGS?

HOW MANY TIMES HAVE YOU RELAPSED SINCE JOINING AA?

Appendix C

The twelve steps of AA , Halzeden, (1986) are:

1) "We admitted we were powerless over alcohol-that our lives had become unmanageable," p. 21. Men and women who are allergic to alcohol and who compulsively persist in drinking will eventually become sick from a unique illness. Step one briefly portrays the pathetic enigma of uncontrolled drinkers who have acquired this illness over which they are entirely powerless. The study of step one is largely devoted to the physical illness of alcoholism.

2) "Came to believe that a Power greater than ourselves could restore us to sanity," p. 25. Step two deals with mental illness. This mental illness is displayed in various ways including taking that first drink with the idea that control can be maintained and the use of alcohol and reliance upon it for physical and mental energy to meet daily responsibilities. Other areas include the inability to be self-critical in judging behavior, excuses for risky behavior such as drinking while driving, resentment, financial difficulties and suicidal ideation or attempts.

3) "Made a decision to turn our will and our lives over to the care of God we understood Him," p. 34. This step identifies the spiritual illness of alcoholism and suggests a remedy. Understanding of this step comes from acts such as admitting alcoholism and faith in God and the A.A. program.

Also involved in this step is the decision to identify character flaws that isolate the alcoholic from others and to submit those flaws to God for removal. Other actions include forgiving others, fair treatment, acting with kindness and sanity in business and home life, being honest and appreciative, helping others, showing tolerance and a belief in one's spiritual potential.

4) "Made a searching and fearless moral inventory of ourselves," p. 42. The purpose of taking a moral inventory is to expose the harmful character traits of the alcoholic's personalities and to eliminate them with help of A.A. Alcoholics need to discover the causes for their addiction to alcohol. Through taking this inventory, AA proposes that alcoholics may transcend their limitations and straighten their unmanageable lives. The addiction to alcohol involves

habits, physical health, emotions, and misconceptions acquired over a period of years.

5) "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs," p. 55. In this step the alcoholic is to review the personal inventories which list and analyze character defects and their effects on others. Step five is a pivotal step. It calls for action that starts a real spiritual awakening as the alcoholic backs up faith with verbal works.

6) "Were entirely ready to have God remove all these defects of character," p. 63. This action brings a new feeling of moral strength. Alcoholics are said to face their real selves and find in the completion of steps six and seven a new peace, a release from tension and anxiety as they lay their misconceptions and defects of character in God's hands.

7) "Humbly asked Him to remove our shortcomings," p. 70. In this step alcoholics are said to be exerting great mental cooperation with God and feeling an intense humility that cries out for recognition and divine help. They are asking God to rid their lives of of misconceptions and defects. Knowledge of the illness, alcoholism, prompts them to turn to God for

help. The alcoholic must pray.

8) Made a list of all persons we had harmed, and became willing to make amends to them all," p.77. The objective of this step is to outline the course of conduct which will directly rectify the harm or injury the alcoholic's drinking may have imposed on others to arrive at a state of mind that concedes the damage they have done and embraces a sincere willingness to amend it.

9) "Made direct amends to such people whenever possible, except when to do so would injure them or others," p. 83. This step puts into practice the outline for step eight. Some restitution is started upon the alcoholic's acceptance of the A.A. program as a way of life. This is usually quite limited as it is not until they have spent several months in A.A., and have fortified their sobriety with good fundamental knowledge of the program.

10) "Continued to take personal inventory and when we were wrong promptly admitted it," p.88. Step ten is one of the maintenance steps. Its purpose is to remind alcoholics that moral defects-selfishness, dishonesty, resentment, and fear- are still problems they will encounter daily. A.A. suggests a daily

inventory to disclose harmful thoughts and actions.
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," p. 96. This step is needed to help alcoholics not to mistake recovery for cure, so after a few months of sobriety they will not consider the practice of the A.A. philosophy unnecessary.
12) "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principals in all our affairs," p. 106. Without the spiritual principles of the Twelve Steps there could be no A.A. Lacking the benefit of spiritual influence, resentful, alcoholic thinking may take over and drive each member back to the insanity of alcoholism.

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Vita Autoris

The author was born in St. Louis, Missouri on August 27, 1950. He is the only child of parents Mary and Sylvester Johnson. Reginald earned a certificate of high school equivalency after leaving high school. Reginald attended Washington University, Saint Louis University and graduated from the Art Institute of Chicago in 1977 with a bachelor of fine arts degree in film-making and photography. Reginald worked in several occupations, including freelance photography, building remodeling, freelance poetry, musical performance, horticulture and emergency medical services. In recent years Reginald has worked in the social services field as a substance abuse casemanager, substance abuse counselor, and an adolescent counselor. He is currently residing in St. Louis County and is employed as a crisis intervention counselor. Reginald is completing his Master's degree in counseling at Lindenwood University.