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A Study of the Relationship Between Alcoholism and Self-Esteem

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ABSTRACT

The relationship between the length of sobriety in the twelve step program of Alcoholics Anonymous (AA) and self-esteem level was examined for 27 recovering alcoholics. Participants included 13 male and 14 female members of AA who volunteered to complete the Coopersmith Self-Esteem Inventory and a cover/survey letter that contained demographic questions. Where it was predicted that there would be no relationship between length of sobriety and self-esteem level, it was found that there was a positive relationship between the two for the total group and the female group. That is, where length of time sober in AA increased, the alcoholic's self-esteem also increased. However, the prediction of no relationship was found to be true for the male group.

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CHAPTER I

INTRODUCTION

In the world today, the issue of addiction continues to be a major problem and challenge with astonishing costs in dollars and human suffering (Dawkins, 1988; Delaney & Poling, 1990; Harlow, 1991; Vaillant, 1990). According to Peele (1989), "More and more addictions are being discovered and new addicts are being identified" (p. 23). In American society, there are an estimated 20 million or more alcoholics, 20 million compulsive gamblers, 25 million love and sex addicts, and 80 million eating-disordered individuals (Peele, 1989). A study from 1985 concluded that nearly half of the prison inmates had been under the influence of alcohol while committing their crimes (California Task Force, 1990). Estimated annual costs for alcohol and drug abuse alone to residents of the state of California are said to be $17.7 billion total from lost productivity, crime, welfare, treatment and support, deaths, and lost jobs (California Task Force, 1990).

There is a great deal of preventative and remedial work taking place in order to overcome this growing problem (Alexander, 1990; Trebach, 1990). Looking first at the preventative side, Alexander (1990) and Trebach (1990) both state that the "War on Drugs" campaign has failed in its intended goal to prevent the use of drugs and reduce the current addicted population. Trebach (1990) states:

> After eight years of a multi-billion dollar drug war, our prisons are filled to record levels, violent drug traffickers pollute our cities, and drug abuse is rampant. Despite the most aggressive drug war in history, so much

> cocaine has been imported since 1981 that the price has dropped to a fraction of its former level. While some of our children now find it more difficult to buy marijuana, many find it much easier to buy crack and cocaine. (p. 515)

The remedial work that is taking place has to do with treatment and relapse prevention. DeJong (1994) defines relapse as the resumption of substance use after a period of abstinence and reports that there are high relapse rates for alcoholism. Miller & Mahaler (1991) state that the rate of relapse following treatment programs for substance abuse is estimated to be approximately 66%. Vaillant (1990) claims that there has been no progress in the prevention of relapse in alcoholism within the last three decades of prominent research.

Drug substitution or replacement is believed to be a common occurrence among addicts (DeJong, 1994). According to Peele (1988), many addicts have multiple addictions. Loughhead (1991) reports that a study of abstinence revealed that 45% of the pathological gamblers also claimed substance abuse, 79% of the alcoholics believed they were sexually addicted, and 55% of the compulsive overeaters reported alcohol abuse. He also believes that arresting one addiction will only cause another dormant addiction to "pop up" unless the underlying issues are dealt with.

According to Brown, Peterson, & Cunningham (1988), "Relapse rates remain high regardless of the treatment approach used" (p. 51). They also declare that up to 95% of alcoholism treatment centers in the country utilize and recommend the program of Alcoholics Anonymous (AA). Ragge (1991) discusses the acceptance that the United States has for the AA program as the

treatment of choice for alcoholism, with nearly all treatment centers directing their patients to AA meetings. He also points out that media and famous individuals present the AA program in only the best light. McBride (1988) states:

> One organization has continued to dominate the ideology and treatment in the recovery field. Alcoholics Anonymous (AA) has the highest reported number of recovering alcoholics of any organization. The 1983 active membership in the United States and Canada was estimated to be around one half million and growing at a rate of 8%. (p. 115)

Little research has been conducted upon the effectiveness of the AA program (McBride, 1988) despite the impact that AA has had upon the recovery community.

A growing body of evidence within the "recovery movement" supports the idea that treating feelings of worthlessness, toxic shame, or low self-esteem plays a key role in recovering from addictions (Balcome, 1991; Bradshaw, 1988; Brown, 1991; Cook, 1988; Evans, 1988; Forman, 1987; Loughhead, 1991; Ramsey, 1988; Young, 1991). The addicted population must resolve issues pertaining to feelings of worthlessness or low self-esteem in order to bring about a deep and lasting second order change (Young, 1991).

This study focused specifically on addiction to alcohol otherwise known as alcoholism and will look at the treatment modality of AA, which is only one of a number of recovery methods available, in relationship to the alcoholic's self-esteem. The purpose of this research was to investigate the relationship between length of sobriety in the AA program and self-esteem. The following questions

were posed: Does the current self-esteem level of recovering alcoholics in AA relate to the amount of sobriety in the 12 step program? Does the current self-esteem level of recovering male and female alcoholics in AA relate to the amount of sobriety in the 12 step program? In order to address these questions, the following hypotheses were formulated:

1. There is no relationship between self-esteem and length of sobriety in the 12 step program of AA.
2. There is no relationship between self-esteem of females and length of sobriety in the 12 step program of AA.
3. There is no relationship between self-esteem of males and length of sobriety in the 12 step program of AA.

CHAPTER II

REVIEW OF THE LITERATURE

Self-Esteem

According to Satir (1988), self-esteem is the value or worth that each individual places on himself or herself that will be either positive or negative. People with a high sense of worth treat themselves with dignity and love in contrast with those with a lower sense of value who experience a devaluing of themselves. Satir (1983) views positive self-worth as the foundation of mental health that allows individuals to respect all aspects of life.

Self-esteem is an overall judgment which individuals have of themselves; that is, how much they like themselves. This judgment directly influences how they live all aspects of their lives (Briggs, 1970) including how they get along with others, how they make use of their aptitudes and abilities, and the kind of person they marry. According to Briggs (1970), "Self-esteem is the mainspring that slates every child for success or failure as a human being" (p. 3).

Satir (1988) describes self-esteem as a concept, an attitude, a feeling, and an image that is illustrated by behavior. Bradshaw (1988) states that self-esteem is an attitude or belief about one's value as a human being. Self-esteem is a quiet sense of self respect that resides deep inside, how people feel about themselves privately (Briggs, 1970). Another definition is a self evaluation of one's beliefs about his or her capability, significance, success, and worth (Coopersmith, 1993).

People who have a high opinion of themselves feel competent, radiate trust and hope, and accept themselves. Integrity, honesty, responsibility,

compassion, and love all flow more easily from them. They feel that they make the world a better place by who they are and readily see and respect the worth of others (Satir, 1988).

P. S. Potter-Efron (1988) believes that an internal feeling of self-worth has most probably occurred as a result of an individual having been accepted for who he or she was as a child. The quality of the relationships that exist between the children and those who play a significant role in their lives greatly influences the concept that they will develop about themselves (Briggs, 1970).

Every infant is born without a sense of self and must learn to be human (Briggs, 1970) by living with others. An infant coming into the world has no past, no experience, and no scale on which to judge his or her self-worth. The baby must rely solely on his or her experiences with people and the messages that he or she receives about his or her value as a person (Satir, 1988) to determine how he or she will begin to perceive himself or herself. Initially, individuals will gather an ideas of themselves from the thousands and thousands of impressions that emanate from the body language and attitudes of others (Briggs, 1970). Verbal language will be added to this list as one begins to use and understand words. The child will pick up on both the verbal and non-verbal messages that are a part of every communication exchange, so there is no fooling or covering up of what is really felt about him or her (Briggs, 1970). As children grow, life experiences and other people will be sending positive and negative messages about their worth (Satir, 1988). Core messages that they receive as infants will be the basic foundation from which they will determine the validity of this incoming information.

A sense of competence or mastery is another contributing factor to children's growing perceptions of themselves (Briggs, 1970). Subby (1990) describes six of Erik Erikson's eight human developmental stages of psycho-emotional growth and the need for successful completion of the steps in order to evolve into mature individuals who love themselves. Naiditch (1988) states that within each stage of development there is a positive message that encourages growth and nurtures self-esteem and that if the message is negative, the identity of the individual is discounted. The first of Erik Erikson's eight stages of development occurs in infancy and is about trust. Primary caretakers need to possess the ability to be emotionally and physically available and treat the children as valuable. If this does not happen consistently, the children will progress to the next stage lacking a sense of worth and trust of themselves, which causes a feeling of powerlessness.

Evans (1988) believes that the second and third stages of Erikson's developmental process deal with boundaries. Caretakers need to have a sense of self responsibility and to be secure within themselves in order to let the children explore their world and begin the separation process. If this does not occur, children will grow up with a confused identity, not knowing where they end and others begin, and see themselves as objects that can be controlled by others. They will also have difficulty accepting responsibility for their lives because they blame themselves. This self-blame results in a sense of over-responsibility. Otherwise, they may blame others resulting in a sense of under-responsibility (Evans, 1988; Mellody, 1988; Subby, 1990).

According to Subby (1990), the purpose of the fourth stage of Erikson's

developmental theory is to develop a sense of confidence. Parents need to verbally and behaviorally model effective problem solving skills and moral and social conduct. The child needs to learn that he or she is capable of making healthy choices and seeing a project through to completion. Subby (1990) remarks, "If the limits that our parents set for us during this period are rigid and controlling, then instead of industry we learn inferiority" (p. 64).

Stages five and six of Erikson's model involve identity and intimacy and are an ongoing life long process. Subby (1990) states:

> A sense of identity means that we have developed a clear, loving, accepting, and intimate relationship with ourselves. Erikson defines intimacy as the capacity to commit one's self to a concrete affiliation and/or partnership and to develop the ethical strength to abide by such commitments, even though they may call for significant sacrifices and compromises. (p. 66)

In order to achieve the above goals of identity and intimacy, people need to have successfully proceeded through the previous four stages. If this does not occur, the transition into adulthood will most likely be permeated with feelings of shame, confusion, hopelessness, and powerlessness in their search for who they are. They will also be unable to attain true intimacy with others. They have become a "dependent personality" which means that they believe their self-worth comes from sources outside of themselves (Cook, 1991; Subby, 1990; Young, 1991).

When people feel they have little value, they expect and invite the worst. This clears the way to becoming a victim. In defense, they hide behind a wall of

distrust and sink into feeling lonely and isolated. As a result of this separation from others, they become apathetic, indifferent toward themselves and those around them, hindering their ability to form relationships (Satir, 1988).

Constant feelings of low worth lead to an attitude of defeat that can evolve into a perception of oneself as a failure (Satir, 1988). In this state of mind, the individual is at high risk of developing destructive behavior towards himself or herself and/or others. He or she is also vulnerable to drugs, alcohol, or other methods of unhealthy coping (Satir, 1983). Risk taking is difficult and problem-solving skills are limited, thereby hindering his or her ability to overcome these self-defeating behaviors.

Persons with low self-esteem become intermittently subservient and tyrannical, feel a constant threat of rejection, and are unable to view themselves and others realistically. They often use manipulative tactics in attempts to get a sense of value from others and they easily surrender their power to others which often leads to emotional slavery (Satir, 1988). They may develop masks to hide behind. These masks look like confidence, yet often there is a brittleness, an exaggeration or a tension in their behavior that reveals the feeling of inadequacy underneath. Self concepts are learned and can be altered in a positive direction (Briggs, 1970).

Addiction and Alcoholism

By its nature, alcoholism is secretive and difficult to measure, and alcoholics take elaborate measures to hide their abuse, making research difficult (California Task Force, 1990). In addition, there are a myriad of definitions for the term "addiction" being used in our society today (Forman, 1987). Below are

listed some of the beliefs about or definitions of addiction that this researcher has discovered in the literature.

Chelton & Bonney (1987) believe that alcoholics experience a loss of aliveness and continuity of self. The authors hold that the central problem of addictive disorders relates to psychological survival and early psychic development. Addicts have difficulty tolerating the loss of the addiction, because they believe that their survival is dependent on the behaviors of the addiction, which have been attempted substitutions for past inadequate parental relationships.

Ragge (1991) defines addiction as, "The continual repetition of a normally non-problematic behavior to self-destructive excess" (p. 55). Chelton & Bonney (1987) describe the addiction process in the following manner:

> Individuals with an addiction use a certain behavior pattern or activity that has become socially, physically, or psychologically harmful to them, and they use it repeatedly and persistently. They seem unable to cease the behavior no matter what the risk or cost to them or others. They feel desperately in need of the activity and cling to it in an increasingly pathological way. Attempts to interfere with the addiction are frequently met by intense feelings of helplessness, and reactions of withdrawal, denial, and rage. (p. 40)

Cook (1991) describes an addiction as an excessive attachment to an experience that is harmful to the user. The addict feels compelled to repeat the experience over and over again. The most powerful and reinforcing experiences to which an addict could become addicted are those which either increase positive

emotional states, decrease negative emotional states, or both.

Addiction has been thought of in conjunction with handling negative feelings (Loughhead, 1991). Young (1991) states, "Addiction is more about an unwillingness or inability to feel bad than it is about the desire to feel good" (p. 503). Ramsey (1988) says that alcoholism has been called a disease of feelings. Loughhead (1991) believes that alcohol and other psychoactive substances affect neurotransmission in various pathways of the brain. Addicts choose an addiction in order to bring about neurotransmission consistent with a desired feeling state or alteration of consciousness.

Bradshaw (1988) describes addiction as a process used to "take away" intolerable reality. This pain has become the main focus of the addict's life, taking time and energy away from other important aspects of his or her life. The addiction thus has life-damaging consequences.

Hatterer (1982) defines addiction as a process in which there is an overpowering desire or need for a substance that produces a psychophysiological high. The desire or need is compulsive in nature. The high is a pleasurable coping mechanism to any conflict, stress, or pain. Eventually, the high begins to diminish and less relief is experienced. Yet, the addiction persists despite volitional attempts at abstinence or moderate use (Loughhead, 1991).

The "disease" concept of alcoholism is commonly referred to as the "medical model" which suggests that alcoholism is analogous to other physical diseases and falls within the province of clinical medicine (McCamey & Wade, 1986). The "disease theory" that is presented in Peele (1989) states that an addiction operates independently of the addict's life and that treatment consists

basically of arresting the addictive process. That is, addicts are encouraged to believe that they will always be alcoholics because there is no cure. They are taught to concentrate on abstaining from the particular substance that is causing the problems for them.

The idea that alcoholism is a "disease" was born from the results of a 1945 survey created by AA members and compiled by E. M. Jellinek (Ragge,1991). Jellinek's now famous "Jellinek Chart" (see Appendix A) is an upside down bell curve often seen in hospitals, treatment centers, and popular and professional literature (E. M. Jellinek, 1960). Characteristics of the "disease theory" include change in tolerance, loss of control, physiological changes leading to withdrawal syndrome, and progression of symptomatology (McCamey & Wade, 1986).

Alcoholics Anonymous (1955) describes alcoholism as a disease in which there is "an allergy of the body coupled with an obsession of the mind". According to Forman (1987), the twelve step program of AA says the powerlessness and unmanageability are the criteria for addiction. "If a person's relationship with anything repeatedly causes his life to be unmanageable and yet he keeps on going back to it anyway, then he is addicted", says Forman (1987).

The above definitions all share the common element that the addict is trapped within a cycle that consists of seeking a mood altering experience which has ceased to produce the benefits it once did. This high is pursued despite detrimental and self destructive consequences. According to Alcoholics Anonymous (1955), this cycle is a form of "insanity" defined as doing the same behavior over and over, while expecting different results. Addicts experience a loss of control, a feeling that their lives have become unmanageable and that they

are powerless over their addiction.

Alcoholism and Self-Esteem

A connection between addiction and low self-esteem has become a popular and enduring belief (Brown, Peterson, & Cunninghan, 1988; Cook, 1988; Sandahl, Lindberg, & Bergman, 1986; Sayette, 1994; Schroeder, Laflin, & Weis, 1993; Underhill, 1991). Low self-esteem has become an accepted explanation for addiction, and as a result, increasing self-esteem has become an important goal of many drug education programs (Schroeder *et al.*, 1993).

Sandahl *et al.* (1986) report the results of a 3 year follow-up study of 300 alcoholic inpatients. During treatment, the alcoholic sample showed signs of lower self-esteem and diminished locus of control than the general population. The follow-up indicated that as destructive drinking habits improved, so did self-esteem, especially among the female patients.

Underhill (1991) believes that treatment services for alcoholics must be oriented toward increasing self-esteem in order to facilitate long-term recovery. Alcoholic women tend to have lower self-esteem than male alcoholics. There is a greater social stigma attached to women with alcohol problems as compared with male alcoholics and women are likely to internalize this harsh judgement, thus learning to view themselves with hopelessness and hatred. Underhill (1991) reports that this problem of lower self-esteem is not limited to early sobriety, but is a continuing issue for women in recovery.

Forman (1987) states that addiction seems to flourish in an atmosphere of apathy, shame, and self-hate. Alcoholics have consistently been found to manifest a pathologically low self-concept (Brown et al., 1988). Chaplin and

Orlofsky (1991) say that alcoholics tend to show an external bias on measures of locus of control and a negative self-concept relative to control subjects. Cook (1988) reports that the factors labeled "fragile and out of control" and "empty and lonely" appear to be potent contributors to the development and maintenance of problems of addiction. Ramsey (1988) proposes that an addict's behavior serves as a defense against feelings of worthlessness by altering his or her mood.

Peele (1989) contends that the alcoholic becomes addicted to the experience itself, the feeling of power and wholeness, that could come from a number of sources ranging from drugs to food to sex. The author believes that upon the arrest of the disease of alcoholism, the alcoholic will be compelled to reach for another source of escape until the underlying issues have been resolved. Peele (1989) states that all addictions provide a means of coping with feelings. Chelton & Bonney (1987) describe the desperation, nothingness, and lack of a sense of self that the sober alcoholic feels. The prominent issue being addressed here is the opinion that addicts are desperately attempting to escape the pain of being who they are or who they believe they are.

According to Ramsey (1988), alcoholism has been called a disease of feelings. Ramsey (1988) also says, "Another definition of an alcoholic is a person whose drinking costs him more than money as a person pays for his drinking at the expense of self-esteem and self-worth" (p. 88). Ragge (1992) states that learning that essential parts of the self are bad and unlovable is at the heart of addiction. The author also speaks of the attraction that alcohol has to those whose lives are pervaded with learned helplessness and the constant battle they must fight to keep feelings of powerlessness out of awareness.

The California Task Force (1990) states that the "hitting bottom" step the addict must get to before recovery can begin is a state of negative self-worth, a vacuum in which self-denigration replaces self-esteem. So, certainly the addict's beliefs about himself or herself would be on the negative scale. Bradshaw (1988) believes that addicts have a core belief that they are unworthy and unlovable, that lead them to seek some powerful mood altering substance that could distort this belief.

A recent study of the reinforcing effects of alcohol suggests that intoxication may be negatively reinforcing to the extent that alcohol reduces the salience of negative information about the self (Sayette, 1994). Intoxicated subjects disclosed fewer negative items than sober subjects and did so in a way that was isolated from their self-concept which was not true for the sober subjects. Also, there were no such differences during the disclosure of positive attributes.

Addicts commonly share a childhood history of child abuse and dysfunctional parenting. They often have vast problems developing relationships beginning as early as age seven, feel insecure, and have emotional conflicts. Addiction seems to be related to a flaw in the development of the addict's self image and is trying to make up for early life problems and defective parental relationships (Cook, 1988; Loughhead, 1991).

Shame-based issues or feelings and beliefs of worthlessness are being addressed more and more for the purpose of treating addictions (Cook, 1991; Fossum & Mason, 1986). Brown (1991) states, "Shame-based feelings from childhood have been identified as important contributing factors in the chemical dependent's need to compulsively consume addictive chemicals" (p. 78). Potter-

Efron (1989) says that the lower the level of self-esteem, the more likely there will be an attraction to addictive substances that promise relief from internal pain and emptiness.

Bradshaw (1988) believes that, "Neurotic shame is the root and fuel of all compulsive/addictive behaviors" (p. 15). The addict has a core belief that they are unworthy and unlovable (Bradshaw, 1988; Carnes, 1983). That core belief comes from the internalized shame, and the addict is convinced that he or she will become lovable and whole if he or she can get more of the "drug of choice" (Bradshaw, 1988).

According to Ramsey (1988), "Shame is deeply related to the development and perpetuation of alcoholism" (p. 87). Addiction has been called a defense against unhealthy shame or low self-esteem (Bradshaw, 1988; Cook, 1988). Addiction functions to mood alter the addict so they are unable to feel the pain of the core belief that they are worthless (Ramsey, 1988).

Addicts are typically ashamed of their addictive behavior and believe that they should be able to control themselves. They are convinced that they are bad and attempt to hide the addictive behavior from others. Thus, the shame they feel from the powerlessness of their inability to control their addiction adds fuel to the fire and helps lower an already core belief of worthlessness (Ramsey, 1988; Young, 1991). Bradshaw's (1988) view is that another layer of self-degradation is brought on by the downhill cycle of addiction causing the addict's self perception to plummet farther.

The Program of AA

AA is a self-help recovery program that is based on a twelve step philosophy. Cofounded in 1935 by two alcoholics who were attempting to stay sober, membership has grown, according to AA's own estimation, from approximately 100 in 1939 to over 978,900 in 1989 (Room & Greenfield, 1992). The program is spiritually based which means that recovery comes about as a result of faith in a higher being or "higher power" (DeJong, 1994).

AA is believed to provide effective assistance for recovery from alcoholism and is the treatment of choice. Nearly all treatment centers in the United States introduce their patients to the twelve step philosophy. Medical, psychological, and alcoholism journals regularly portray AA as the most successful and qualified method of recovery that reaches the largest number of alcoholics (DeJong, 1994).

The twelve step program of AA has at the foundation of its recovery process the belief that the alcoholic is powerless over his or her addiction and needs to accept this in order to maintain long term sobriety. Addicts are able to acquire this shift in perspective by "working" the twelve steps which involves sharing and listening to fellow recovering addicts (Brown, 1991; Young, 1991). Addictive behavior must be arrested and maintained in order to begin the recovery process (Cook, 1991; Loughhead, 1991).

The twelve steps of AA were written by cofounder Bill Wilson, and many believe that he was "spiritually guided" (Ragge, 1991). Alcoholics Anonymous (1955) states:

Here are the steps we took, which are suggested as a program of recovery:

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

become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs. (p. 59)

According to Ramsey (1988), Step One requires an absolute admission of

powerlessness over one's addiction in order to accept and work the remaining steps. The "unmanageability" is about the alcoholic facing the consequences of his or her drinking. Step Two offers a solution to Step One. The power that alcoholics need can come from a source outside of and greater than themselves and restore their lives to wholeness. The third step allows for choices. The alcoholic may define his or her Higher Power and decide what to do about the problem. The first three steps are described as the foundation of the recovery program in which the power in the alcoholic's life is realigned (Ramsey, 1988).

Step Four shifts to an internal focus in which the individual begins to examine the positive and negative aspects of his or her life. Step Five is a validation and continuation of Step Four and frequently the beginning of a sense of belonging to humanity. Steps Six and Seven are about self-acceptance and humility. Steps Four through Seven help individuals to "get right" with themselves (Ramsey, 1988).

Steps Eight and Nine permit the alcoholic to access the damage he or she has done to others and begin to take action toward restoration of relationships. These steps permit alcoholics to "get right" with others (Ramsey, 1988).

The last three steps have been called the maintenance steps designed to support, reinforce, and maintain recovery. Step Ten is a continuation of Steps Four and Five. Step Eleven aids the individual in developing his or her relationship to a higher power. Step Twelve reminds the alcoholic of what he or she has received and to carry the message of the program to others (Ramsey, 1988).

AA is a "spiritual" program (Machell, 1991). DeJong (1994) defines

spirituality as finding sustenance through belief in a higher power. Another definition is a source of hope (Lacks & Leonard, 1986). Brown & Peterson (1991) state that the following factors are "very relevant" to developing and maintaining spirituality: admitting powerlessness, believing in a "power greater than oneself" and turning one's life over to the care of that power, doing an AA fourth and fifth step, remaining abstinent and in touch with reality, being honest with oneself and others, having a sponsor, self-acceptance, treating others with respect and dignity, recognizing irrational thoughts, promptly admitting it when wrong, making amends to others, engaging in prayer and meditation, accepting pain as part of the growth process. Machell (1991) declares that a "higher power" is an individualized concept of a belief in a power or source that is outside of and greater than oneself.

AA meetings are held in a variety of locations that include rooms rented from churches, schools, and community organizations; free space in treatment centers; clubhouses established by AA members. The size of the meetings can range anywhere from half a dozen to hundreds (Ragge, 1991). The Twelve Traditions are a set of guidelines that every meeting follows and that explain "why it works" (Machell, 1991). According to Montgomery, Miller, & Tonigan (1991), these directives provide for the autonomy of each group allowing for variation in the structure and content of meetings which are shaped by personalities and individual experiences. Anonymity of members is protected by the knowledge and use of first names only (Ragge, 1991).

Ragge (1991) says, "Also part of every meeting is the reading of sacred text" (p. 110). The fond nickname for this text is the "Big Book". The first

portion was written by cofounder Bill Wilson and describes the AA recovery program. The last section of the volume contains a variety of personal stories there to help readers identify with admitted alcoholics (*Alcoholics Anonymous*, 1955). Ragge (1991) declares that a popular reading is an abbreviated version of Chapter Five entitled "How It Works" that contains AA's description of the plight that the alcoholic faces and the solution to the problem. *Alcoholics Anonymous* (1955) states:

> Our description of the alcoholic, the chapter to the agnostic, and our personal adventures before and after make clear three pertinent ideas:
>
> (a) That we were alcoholic and could not manage our own lives.
>
> (b) That probably no human power could have relieved our alcoholism.
>
> (c) That God could and would if He were sought. (p. 60)

"The Seventh Tradition" which states that AA is self supporting through it's own contributions, is read while a collection basket is passed for members to give as they are able (Ragge, 1991).

According to Tournier (1978), the message carried in and out of AA meetings is that alcoholics cannot hope to escape their predicament until they give up any illusions of control and accept the label of "alcoholic". "Sharing personal experience", "twelfth step sharing", and "sharing experience, strength, and hope" are common terms used to describe the method of conveying this message. The general format for this sharing is telling what it was like, what happened, and what it is like now (Ragge, 1991). Members begin by telling their story which includes the misery and despair that their drinking had brought them to, more

commonly called "their bottom". They then describe how they have had a "spiritual awakening" from working the twelve steps of the program. Alcoholics Anonymous (1955) defines "spiritual awakening " as a profound personality change adequate to bring about recovery from alcoholism.

"Drunk-a-log" is the expression alcoholics use to describe their drinking history which begins with the first drink ever taken and ends with the arrival at AA (Ragge, 1991). Tournier (1978) says that one purpose of the "drunk-a-log" is to enable the speaker to "qualify" for the program by declaring that he or she is powerless over alcohol. Ragge (1991) states, "The first-timer at a meeting may be awed by the sincerity, honesty, and telling of intimate secrets. This is a direct result of the 'humility' of the speaker as expressed through his or her admission of the 'unmanageability' of his or her life before AA and his or her 'powerlessness' in the face of alcoholism" (p. 115). The drunk-a-log is frequently the longest part of the talk (Tournier, 1978).

The speaker continues to tell the story of how he or she arrived at AA and his or her gratitude for how the twelve step program has saved his or her life (Ragge, 1991). Serenity is acknowledged as a benefit of working the program. This is a state of "evenness" that comes about as a result of no longer feeling resentments and self-pity as well as extremes of happiness otherwise known by members as "too good" (Ragge, 1991). "One day at a time" is a slogan on which the members base their living in order to maintain sobriety (Machell, 1991). Ragge (1991) says that meetings end with a closing prayer such as the Lord's Prayer or the Serenity Prayer and all members chant, "Keep coming back, it really works!"

The newly recovering person is known as a "newcomer" in AA circles and is told to go to 90 meetings in 90 days, don't drink, and get a sponsor (Ragge, 1992). According to Brown *et al.* (1988), sponsorship provides constant emotional support to the "newcomer" through one on one attention and program talk.

Despite overwhelming confidence in AA's abilities, the effectiveness of the twelve step program remains unproven (DeJong, 1994). Tournier (1978) states that AA has acquired a moral ascendancy which has enabled many members to successfully assert to be the voice of the alcoholic. This claim has never been sufficiently challenged. Tournier (1978) believes that acceptance of AA's perspectives as facts has fettered innovation and tied the field to a treatment strategy that is limited in its applicability to the universe of alcoholics.

Ragge (1992) says that there have been only two controlled studies of AA independent of any other type of treatment. They both involved mandated attendance and results showed that those involved with AA had the least success. An eight year study of the over-all success of AA followed 100 men who had been consecutively admitted for detox at an alcoholism clinic (Ragge, 1992). The results revealed that relapse was more common for those who had attended AA and that 81% of those who had quit on their own had either abstained for ten or more years or drank infrequently.

AA and Self-Esteem

Young (1991) states that AA considers restoration of self-esteem an integral part of the recovery process. According to Brown (1991), the twelve step program is viewed as a powerful rehabilitative process for low self-esteem. Both

the twelve step principles and the caring, supportive nature of the program have been described as helpful in increasing the self-esteem of alcoholics. Low self-esteem can begin to heal as alcoholics expose their painful selves in an open and accepting environment (Young, 1991).

Brown (1991) states that AA helps recovering alcoholics to maintain sobriety and diminish feelings of worthlessness. However, there are many who do not find the AA atmosphere "safe enough" to abandon protective defenses. They are likely to maintain some inner core sense of low self-worth despite their involvement and efforts in AA. This inner sense of worthlessness often propels the alcoholic who is attempting to work a recovery program to "go out" and relapse. Brown (1991) says, "Addicts who continually relapse often have a core belief that they are worthless and need to resolve their self-esteem issues or they will most probably continue to relapse" (p. 78).

A common occurrence with twelve step programs is that upon the arrest of the alcoholism, alcoholics may switch addictions or become addicted to the twelve step program in order to escape the intolerable pain of feeling worthless (Loughhead, 1991; Ramsey, 1988). Ragge (1992) says that abstinent alcoholics in AA often smoke more cigarettes and drink more coffee. Religious and sexual addictions quite frequently come to the forefront. Through the twelve step program, some addicts may confuse powerlessness over their addiction with powerlessness over themselves. If addicts refuse to take responsibility for themselves, which is necessary to overcome a core belief of worthlessness, they may remain stuck, feeling helpless and dependent upon the group to make them feel whole (Fischer, 1988; Peele, 1989).

In conclusion, self-esteem and its regulation are considered to be of etiological importance in the treatment of alcoholism. In addition, there have been only a few studies related to the effectiveness of the most widely accepted form of rehabilitation in the country, AA. Sandahl et al. (1986) found that self-esteem was the only personality factor to have a positive correlation to improved alcohol habits in a three year follow-up study of alcoholic inpatients. Self-esteem is also believed to be sensitive to feelings of guilt and shame associated with relapse.

Three hypotheses were formulated for this study and are as follows:

1. There is no relationship between self-esteem and length of sobriety in the 12 step program of AA.
2. There is no relationship between self-esteem of females and length of sobriety in the 12 step program of AA.
3. There is no relationship between self-esteem of males and length of sobriety in the 12 step program of AA.

CHAPTER III

METHOD

Subjects

The subjects were 27 recovering AA members in the St. Louis, Missouri area who volunteered to participate in the study. The sample represented in this study consisted of 13 males and 14 females and was a sample of convenience. The mean age of the total group was 42.5, the male group was 44, and the female group was 41. The total group consisted of 10 who were married and 17 who were unmarried. Within the male group, 6 were married and 7 were unmarried. The female group consisted of 4 who were married and 10 who were unmarried. The mean or average length of sobriety in AA for the total group was 6.6 years. The mean for the male group was 6.8 years and 6.4 years for the female group (See Table 1). The volunteers were given packets containing the instrument to measure self-esteem and demographic questions to complete.

Materials

AA members that agreed to participate were given a copy of the Coopersmith Self-Esteem Inventory form, an envelope, and a cover/survey letter (See Appendix B). The cover/survey letter included an explanation, demographic questions, and instructions to complete the Coopersmith.

The Short Form of Coopersmith's (1967) Adult Self-Esteem Inventory (See Appendix C) was used to measure self-esteem. This tool is a self-report questionnaire with twenty-five items. The items on the scale can be separated into five categories: social self-esteem, total self-esteem, self-deprecation, self-certainty, and family relationships. All the items were designed to measure self-

esteem. This researcher was interested in an overall measure of self-esteem in relation to length of sobriety in AA, consequently there was not an analysis by category. High scores on the inventory correspond to high self-esteem, and the negative items are considered correct if they have been answered "unlike me", as well as positive items being correct if they have been answered "like me" (Coopersmith, 1993). To arrive at a total score, the sum of self-esteem items answered correctly or the total raw score was multiplied by four. The range of possible scores from the Coopersmith Inventory is a minimum of 0 and a maximum of 100.

Reliability coefficients for internal consistency have ranged from .71 to .92, and test-retest consistency has been reported in one study to be .64 (Coopersmith, 1993). Construct validity of the subscales proposed measuring source of self-esteem has been confirmed in earlier studies (Coopersmith, 1993). There has been reasonable interpretation of the concurrent validity of the instrument (Coopersmith, 1993) from two correlations that yielded coefficients of .33 and .30.

Procedure

This researcher was located at a local AA office which runs various AA meetings throughout the day. Members arriving to attend a meeting were briefed in a standardized manner by this researcher about the nature and purpose of the study and were requested to participate. Anonymity was assured to the members.

Subjects were given a package that contained the Coopersmith Self-Esteem Inventory form, an envelope, and a cover/survey letter. Respondents were advised that the total time could take 15 to 30 minutes, before being sent to a

quiet room within the office in order to complete the forms. They were instructed to seal the completed forms in the envelope and physically return the information to this researcher.

Table 1

Sample Descriptives

Length of Sobriety in AA in years	**Gender** M = male F = female	**Age**	**Marital Status** U = unmarried M = married
8	M	47	U
½	M	33	M
1	M	25	U
½	M	47	M
12	M	55	M
14	M	51	U
5	M	35	U
8	M	33	U
8	M	49	M
3	M	39	M
10	M	65	M
17	M	53	U
2	M	39	U
8	F	35	U
1	F	46	U
6	F	38	M
5	F	42	U
16	F	45	U
11	F	49	M
15	F	48	U
½	F	25	U
½	F	31	M
6	F	40	M
2	F	37	U
9	F	48	U
4	F	36	U
5	F	55	U
$\bar{x}$ = 6.6	N = 27	$\bar{x}$ = 42.5	(M) Total=10 (37%) (U) Total=17 (63%)
Male $\bar{x}$ = 6.8	M = 13 (48%)	Male x = 44	(M) Male=6 (46%) (U) Male=7 (54%)
Female $\bar{x}$ = 6.4	F = 14 (52%)	Female x = 41	(M) Female=4 (29%) (U) Female=10 (71%)

CHAPTER IV

RESULTS

Variables considered included length of sobriety in AA and self-esteem level as measured by the Coopersmith Self-Esteem Inventory scores. Level of Measurement (LOM) for both variables was the interval level. Each variable was also divided into male and female categories for further analysis. The descriptive statistics for this sample are displayed below in Table 2.

Table 2

Descriptive Statistics

Variables	Mean	Std Dev	Max	Min	Range
Coopersmith Self-Esteem Score					
Male	55.4	19.0	84.0	20.0	64.0
Female	56.6	25.0	84.0	4.0	80.0
Total	56.0	22.0	84.0	4.0	80.0
Length of Sobriety in AA					
Male	6.8	5.4	17.0	0.5	16.5
Female	6.4	5.0	16.0	0.5	15.5
Total	6.6	5.1	17.0	0.5	16.5

Pearson product-moment correlations were used to determine the relationship between the independent variable, length of sobriety, and the dependent variable, Coopersmith score (See Table 3). The r statistic describes the magnitude or the degree and direction of the relationship between two variables. The r^2 is the value that can be viewed as a percentage that the two variables share

in variability. The values labeled "sig" describe the probability that the two variables are independent or dependent. The alpha value of .05 was used for all analyses in the discussion of these statistics and hypotheses testing.

Table 3

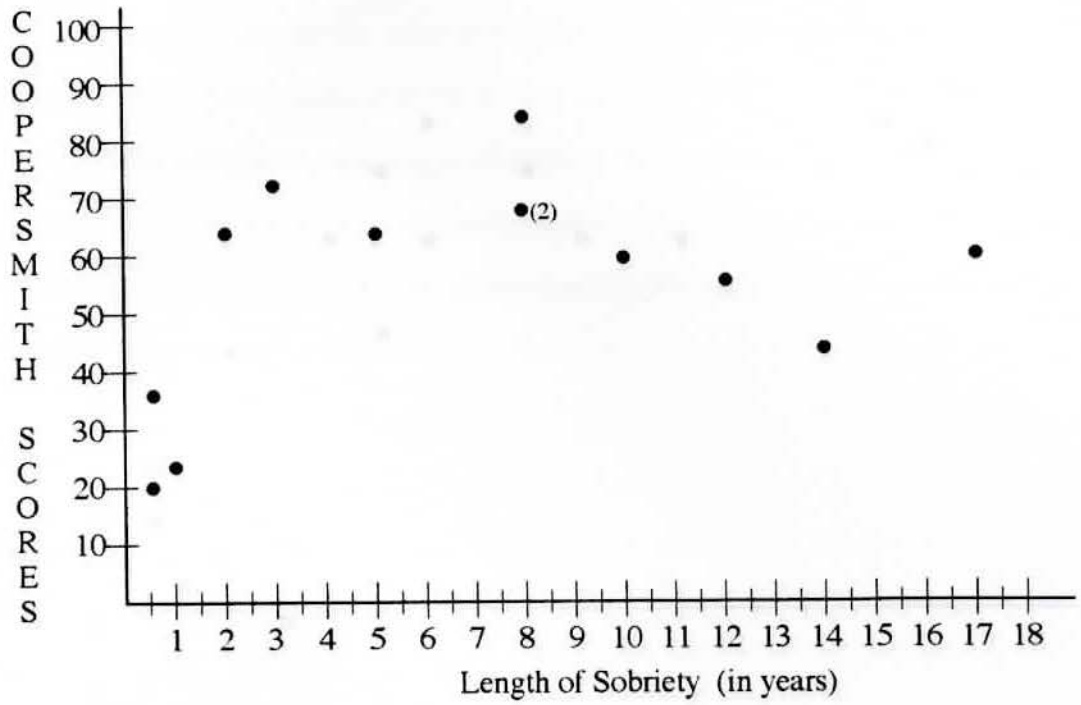
Correlation of Variables

Correlation	Coopersmith Male	Coopersmith Female	Coopersmith Total
Length of Sobriety in AA	$r = .37$ $r^2 = .14$ sig = .19	$r = .75$ $r^2 = .56$ sig = .005	$r = .58$ $r^2 = .34$ sig = .002

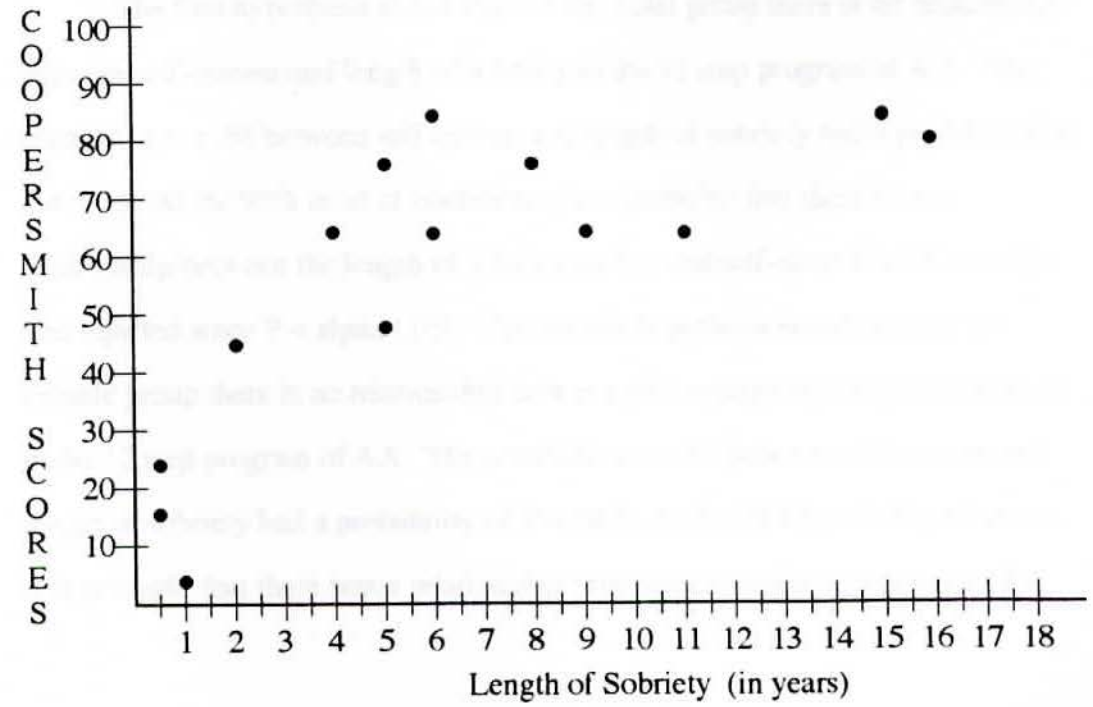
There was a positive correlation for all groups indicating that there was a relationship between the length of sobriety in AA and the self-esteem level. That is, as one variable went up, the other variable tended to go up also. The correlations for the total and the female groups were statistically significant. The female group exhibited a stronger correlation with r=.75 than the Male group with r=.37. The value of shared variability or the predictability of one variable from another was greater for the Female group with r^2=.56 than for the Male group with r^2=.14.

The following scatter plots provide a visual representation of the distribution of data points on the X and Y axis, thus illustrating their probable relationship.

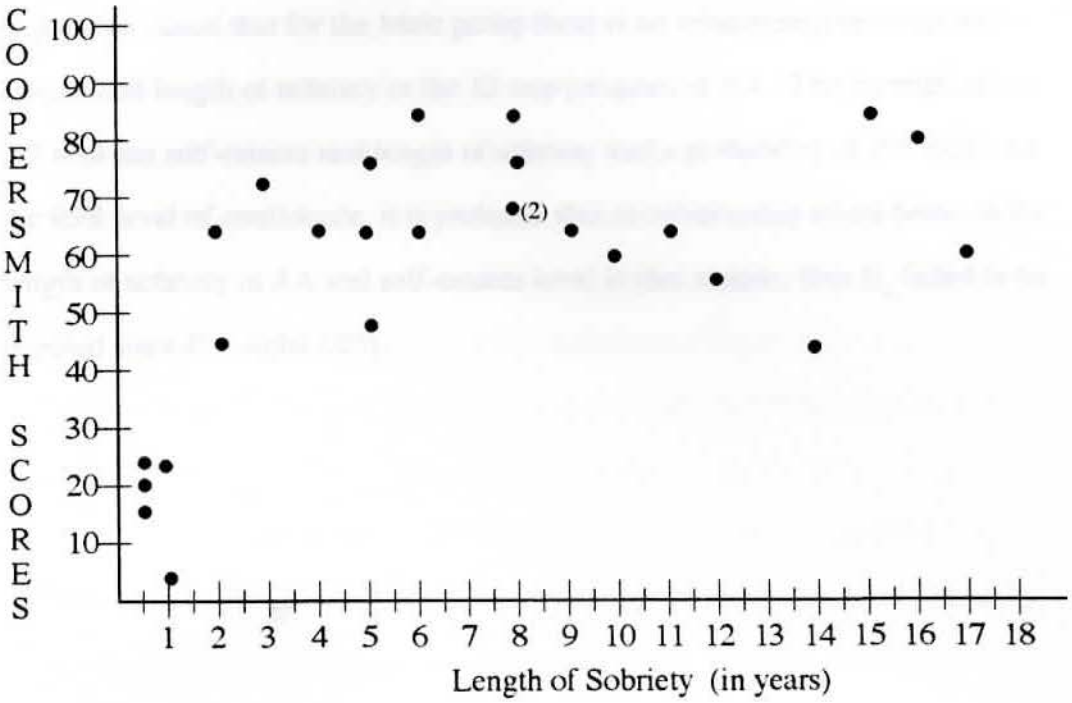
PLOT 1: Plot of Coopersmith Scores with Length of Sobriety for Males



PLOT 2: Plot of Coopersmith Scores with Length of Sobriety for Females



PLOT 3: Plot of Coopersmith Scores with Length of Sobriety (Total)



The first hypothesis stated that for the Total group there is no relationship between self-esteem and length of sobriety in the 12 step program of AA. The correlation $r = .58$ between self-esteem and length of sobriety had a probability of $P = .005$. At the 95% level of confidence, it is probable that there was a relationship between the length of sobriety in AA and self-esteem level, thus Ho was rejected since $P <$ alpha (.05). The second hypothesis stated that for the Female group there is no relationship between self- esteem and length of sobriety in the 12 step program of AA. The correlation $r = .75$ between self-esteem and length of sobriety had a probability of $P = .005$. At the 95% level of confidence, it is probable that there was a relationship between the length of sobriety in AA

and self-esteem level, thus Ho was rejected since P < alpha (.05). The third hypothesis stated that for the Male group there is no relationship between self-esteem and length of sobriety in the 12 step program of AA. The correlation r = .37 between self-esteem and length of sobriety had a probability of P = .005. At the 95% level of confidence, it is probable that no relationship exists between the length of sobriety in AA and self-esteem level in this sample, thus H_o failed to be rejected since P > alpha (.05).

CHAPTER V

DISCUSSION

The null hypotheses being tested stated that there was no relationship between length of sobriety in the AA program and self-esteem level for the total group, as well as the female and male groups. The findings of this study suggested that the self-esteem level of recovering alcoholics in the AA program tended to go up as the amount of sobriety increased. However, for the second and third hypotheses, analysis of the data by gender revealed that this was more true of the female group and not true of the male group.

This study has explored the idea that healing addictions involves increasing the addict's self-worth. The relationships described in Plots 1 and 2, where the self-esteem levels tended to increase as the length of sobriety time increased, closely followed what was described in the literature regarding self-esteem and addictions. In fact, each of the significantly statistical relationships support the belief that active addicts have a low level of self-worth. The California Task Force (1990) described the "hitting bottom" step the addict must experience before recovery can begin as a state of negative self-worth or a vacuum in which self-denigration needs to be replaced with self-esteem.

The findings of this study were in agreement with the results as reported by Sandahl et al. (1986) of a three year follow-up with 300 alcoholic inpatients. That study concluded that increased self-esteem was the only factor connected with decreased drinking, especially among the female population. This study showed significantly positive correlations of the above variables in the total group and the female group. That is, self-esteem levels tended to go up as recovering

alcoholics achieved more and more sobriety.

Another area where the study was consistent with the literature was in the beliefs that alcoholic women tended to have lower self-esteem than male alcoholics (Underhill, 1991). The descriptive statistics displayed in Table 2 showed a lower score of 4 from the Coopersmith Self-Esteem Inventory for the female group compared with a minimum score of 20 for the male group. Both groups had two subjects who had 6 months of sobriety, which was the lowest possible level as shown from the plots.

The literature suggested that the twelve step program of AA was a powerful rehabilitative process for low self-esteem, and that AA provided an open and accepting environment in which alcoholics could heal (Young, 1991). The findings of this study seem to support those suggestions for the total group and the female group. That is, there were significant positive correlations between time spent abstinent working the twelve step program and one's level of self-esteem.

The treatment program of choice in the United States was investigated in this study. Up to this point, according to the literature, the AA program has been readily accepted with very little research having been conducted on the effectiveness of the model. Ragge (1992) stated that there have been few studies related to the effectiveness of the AA program, and they involved programs of mandatory attendance. In addition, the results of those studies showed unfavorable relapse rates. This paper may help to lead the way to further study of the twelve step program.

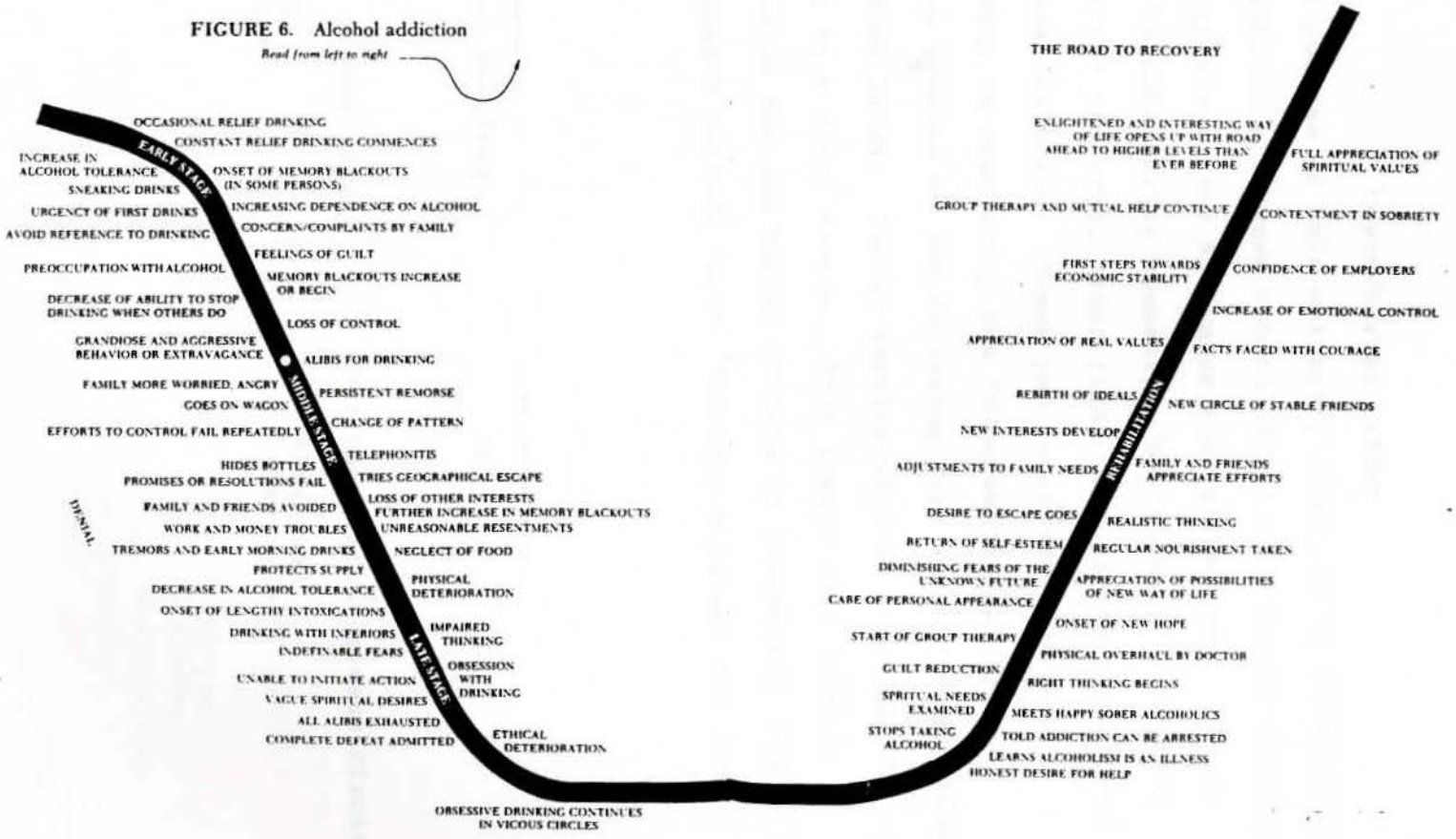
Confounding factors effecting the present study include the difficulties of defining and measuring such abstract variables as self-esteem and abstinence.

Possible fluctuations of the addicts perceptions of themselves and switching to other addictions may have influenced the self-esteem scores. Self-reported alcohol use may be problematic, as well as the severity of alcoholism within the sample. There are to many outside variables at work to presume a cause and effect relationship. Others include the difficulty of measuring the influence of any treatment prior to entering the AA program as well as any treatment in conjunction to AA which may possibly include outpatient follow-up, therapy, or workshops.

This study has brought to light the possibility that the AA program may address the healing of self-worth, which according to the literature is believed by many to be essential in recovery from addiction. Yet, the analysis revealed that this was true for the female group and not for the male group. Does the program work adequately for the female gender but not for the male gender? Does AA differentially effect ethnic or cultural groups the same? Does AA differentially effect persons who are religious vs nonreligious? Are age and socioeconomic background significant factors in the success or failure of working the program?

The greatest weakness of the study was the small and non-random sample size. A larger sample may have produced different results. The non-random sample size may not have been representative of the general population of recovering alcoholics. While this study focused specifically on the area of AA's ability to elevate self-esteem, the potential for future research of the AA program is virtually an open door due to the deficiency of investigation in the field. In addition, the alarming increase and destructiveness of addictions is definitely a valid reason to continue this type of research.

FIGURE 6. Alcohol addiction



Appendix B

Cover/Survey Letter

The purpose of this voluntary survey is to investigate the relationship between length of sobriety in the 12-step program of Alcoholics Anonymous and self-esteem. Please respond to this survey honestly. Don't dwell on any one question for too long. Your first response to a question is the most accurate. Thank you in advance for your cooperation in completing the Coopersmith Self-Esteem Inventory located on the following page and the demographic information below. Survey results will be compiled and reported in a final Thesis. This thesis will fulfill requirements for the Master of Arts in Counseling degree at Lindenwood College in St. Charles, Missouri for Judy Astel.

_____ _____

Length of sobriety in AA

Age

Gender: Please circle

M=male
F=Female

Marital status (please circle)

M=Married
U=Unmarried

Appendix C

COOPERSMITH SELF-ESTEEM INVENTORY

Directions: On the other side of this form, you will find a list of statements about feelings. If a statement describes how you usually feel, put an X in the column "Like Me." If a statement does not describe how you usually feel, put an X in the column "Unlike Me." There are no right or wrong answers. Begin at the top of the page and mark all 25 statements.

_____X 4 =_____

Like Me	Unlike Me	
_____	_____	1. Things usually don't bother me.
_____	_____	2. I find it very hard to talk in front of a group.
_____	_____	3. There are lots of things about myself I'd change if I could.
_____	_____	4. I can make up my mind without too much trouble.
_____	_____	5. I'm a lot of fun to be with.
_____	_____	6. I get upset easily at home.
_____	_____	7. It takes me a long time to get used to anything new.
_____	_____	8. I'm popular with persons my own age.
_____	_____	9. My family usually considers my feelings.
_____	_____	10. I give in very easily.
_____	_____	11. My family expects too much of me.
_____	_____	12. It's pretty tough to be me.
_____	_____	13. Things are all mixed up in my life.
_____	_____	14. People usually follow my ideas.
_____	_____	15. I have a low opinion of myself.
_____	_____	16. There are many times when I would like to leave home.
_____	_____	17. I often feel upset with my work.
_____	_____	18. I am not as nice looking as most people.
_____	_____	19. If I have something to say, I usually say it.
_____	_____	20. My family understands me.
_____	_____	21. Most people are better liked than I am.
_____	_____	22. I usually feel as if my family is pushing me.
_____	_____	23. I often get discouraged with what I'm doing.
_____	_____	24. I often wish I were someone else.
_____	_____	25. I can't be depended on.

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