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AN EVALUATIVE STUDY OF THE USE OF THE 12 STEP RECOVERY
PROGRAM IN ALCOHOLICS ANONYMOUS:
AN INTROSPECTION INTO BEHAVIOR EXHIBITED
BY MEMBERS OF ALCOHOLICS ANONYMOUS WITH
OVER ONE YEAR OF ABSTINENCE FOLLOWING
A 28-DAY TREATMENT PROGRAM

by

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A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
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Abstract

Has Alcoholics Anonymous abandoned its world-famous 12 Step recovery program?

A review of the literature revealed that scholars have not determined if the members of Alcoholics Anonymous (AA) actually use the treatment regime it created and publicly endorses.

Chapter one discusses this research question and those prompted by it, as well as discussing the background of the problem, its significance (both for alcoholics and for professionals in the field), and the social impact of past and present research.

Chapter two discusses the mass of literature on the treatment of alcoholics, the philosophy of AA, and the paucity of data concerning use of the AA program in treatment programs and in AA itself. Various treatment models are discussed, both in themselves and in their relation to AA, and the organization and effectiveness of AA are explored.

Chapter three details the descriptive survey method utilized in the study. Data were gathered in California by telephone interviews, using a questionnaire. Subjects were fifty men and women reporting alcohol-free membership in AA for more than one year following graduation from a 28-day alcohol treatment center. The researcher determined to what degree steps 6 through 12 of the AA 12 Step program are being used. The researcher also employed a Spearman test to determine if there is a significant relationship between the extent of utilization of each of the steps six through twelve and the subjects gender, age, marital status and educational level. In addition, the researcher used multiple means to analyze the data in this study. The frequency-of-use on steps 6, 7, 8, and 9 was measured as a dichotomous variable. A chi-square test was used to discern if there are

differences in the step completion rates depending on gender, age, marital status, and education level. On steps 10, 11, and 12, the researcher used a continuous variable for frequency-of-use, and a one way analysis of variance to determine if there are differences in frequency-of-use depending on gender, age, marital status, and level of education.

Chapter four discusses the results, which indicate that under 6 percent of the membership of AA are actively working and completing the AA 12 Step treatment regime as prescribed.

Chapter five discusses the implications of these results, and draws the conclusion that AA has effectively lost the treatment program it pioneered and has abandoned many of the original activities that made it a viable treatment force.

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by

M. Edward Wignall

Dedication

To my father, Edgar Loran Wignall

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I wish to express my sincere gratitude to the members of my committee: Dr. Marilyn Simon, Dr. Brian Austin, and Dr. Martin Gerstein, for their sincere interest in my future during the course of my study. Dr. Simon has been a constant source of encouragement and wisdom.

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
CHAPTER	
I. INTRODUCTION	1
Research Questions	4
Problem Statement	5
Purpose	5
Significance	6
Background	7
Nature of the Study	13
Social Impact of the Study.....	14
II. LITERATURE REVIEW	16
Overview.....	16
Alcoholism – A Philosophical Controversy	18
Alcoholics Anonymous – Organization	28
Treatment Centers and Alcoholics Anonymous	38
Alcoholics Anonymous Today	41
Conclusion	44
III. METHODOLOGY	46
Overview.....	46
Treatment Program.....	49
Sample Selection	52
Project Design	53
Instrument Design and Validation Panel.....	55
Validation Questions.....	58
Telephone Interviews.....	70
Research Questions	71

IV. RESULTS.....	76
Characteristics of the Sample.....	76
Research Questions	77
Research Question One.....	77
Research Question Two.....	81
Research Question Three.....	83
Additional Findings.....	86
V. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.....	89
Introduction.....	89
Summary	89
Conclusions	95
Recommendations	96
References.....	99
APPENDICES	109
Appendix A	110
Appendix B	113
Appendix C	118
Appendix D	130
Appendix E	136
Appendix F	140
Appendix G	142

LIST OF TABLES

Table One.	Number and percent of subjects who said they had been given specific instructions on how to complete steps 6 through 12.....	78
Table Two.	Number and percent of subjects who said they had completed steps 6 through 9 of the Alcoholics Anonymous program compared to the number and percent who said they knew the steps well enough to teach to others.....	79
Table Three.	Mean number of times that subjects practiced steps 10 and 11 each month, and the number and percent who said they knew the steps well enough to teach other Alcoholic Anonymous Members.....	80
Table Four.	Contingency tables to examine the relationship between the completion of steps 6 through 9 and selected demographic variables.....	82
Table Five.	Chi-square analysis examining the relationship between the completion of steps 6 through 9 and selected demographic variables.....	83
Table Six.	Regression statistics for the frequency of use for the Step 11 model	85
Table Seven.	Regression statistics for the frequency of use for the Step 12 activities	
Table Eight.	Regression statistics for the frequency of use for the Step 12 activities model.....	85

CHAPTER I

INTRODUCTION

We thought 'conditions' drove us to drink, and when we tried to correct these conditions and found that we couldn't do so to our entire satisfaction, our drinking went out of hand and we became alcoholics. It never occurred to us that we needed to change ourselves to meet conditions, whatever they were. (As Bill Sees It, 1967, p. 1)

Most authors are extremely careful when they approach the subject of AA and its 12 Step treatment program, but, if researchers are to talk about consistent effective treatment for alcoholism, there is an issue that must be seriously addressed, especially now when our society is considering universal public health care. Treatment centers for alcoholism that report they use the AA 12 Step model in their treatment programs and send their graduates to AA, have not enjoyed the success that was hoped for, and many treatment centers have closed their doors and gone out of business. Ross, Miller, Emmerson, and Todt (1989) found relapse rates as high as 80 percent six months after treatment. Insurance companies, because of such unacceptable treatment results, have eliminated alcoholism from their policies whenever possible. As we look at massive public financing for universal health care and decide if alcoholism is to be part of that coverage, we must ask some serious questions about AA and the 12 Step model of treatment. If we do not, the general public will be asked to finance treatment activities that this society's insurance industry has found to be far below reasonable levels of success. We must ask, first, if AA is what the public and public policy makers perceive it to be, and second, whether the 12

Step model of recovery is being used consistently by its members. Is there another model of treatment being used? Are the expectations that treatment centers have for the activities of AA founded in reality or on practices that have long since disappeared?

For over four decades, private and public treatment centers that specialize in the treatment of alcoholism have been sending graduates of their programs to AA (Chanco, 1990). When this process began, AA a semi-secret society with a well-defined treatment regime that enjoyed a level of success that had never before been seen. This treatment regime, the 12 Steps of AA, was the heart and soul of the humanitarian movement that spread around the world. Its membership was increased through the activity of its sober members answering the call for help from other alcoholics in distress (AA, 1957). The 12 Step treatment program was designed by AA to do two things: return the alcoholic to a useful place in society; and to train the alcoholic to help other alcoholics who wanted to quit drinking (Wilson, 1939). Though professionals in psychology, medicine, and religion have had serious reservations about its treatment regime, none could argue with AA's success or devise a treatment program that could come close to its effectiveness. But with the institutionalization and commercialization of AA's two functions by treatment centers, intervention specialists, the courts and private therapists, the 12 Step program of AA may exist today in name only.

In her critique of the endless list of self-help recovery programs, often using the suffix "anonymous" and calling themselves 12 Step programs, Wendy Kaminer in her book, *I'm Dysfunctional, Your Dysfunctional* (1993), points out that on close inspection these

programs follow a 'new age' psychological model that is driven by the multi-billion dollar self-help industry. Halliday (1991) provides an excellent overview of this industry, but views its impact as merely harmless. Kaminer, on the other hand, describes the general philosophy of this 'new age' model as a combination of psychology and mysticism. She points out that the model in its many forms can always be identified by its vague and undefinable language. She offers the following to give the reader an inkling of the ideas 'new age' psychology advocates champion:

They share the transformative experiences, predict paradigmatic consciousness shifts and new sense modalities, describe processes of spiritual synchronicity, prescribe personal empowerment affirmations, and devise road maps for readers on their own personal odysseys toward the light, the harmonious inner space of self-actualized energy. (Kaminer, 1993)

It is clear that Kaminer takes special care not to look at the practices of AA, and the casual reader can be left with the impression that it has somehow stayed out of this new self-help recovery phenomenon and has remained unchanged in the face of this massive movement. Because of the international reputation that Alcoholics Anonymous enjoys, the author appears not to have been willing to risk any meaningful observations of this organization. She is not alone, for most serious observers seem reluctant to put it in the same category as its many spin-off self-help programs. Could it be possible that AA no longer uses the 12 Step model of recovery that it designed and found so successful, but has moved to a model that is a hybrid with the self-help industries popular "new age" psychological products and practices. In public and professional discussions of the

treatment of alcoholism, the first question cannot be whether the 12 Step treatment regime is effective, but whether it is being used at all. If it is not being used we must look elsewhere for answers to the success or failure of individuals who are referred to AA for continued treatment.

Research Questions

It is this researcher's hypothesis that the complete 12 Step treatment regime for alcoholism is no longer in general use by the members of AA. This study will consider three primary questions: 1. To what degree does the sample understand and practice the AA 12 Step treatment program; 2. Are there significant relationships between selected demographics (gender, marital status, age, and education) and whether or not a subject had completed Steps 6 through 9 of the AA 12 Step treatment program; and 3. Are there significant relationships between selected demographic variables (gender, marital status, age, and education) and the frequency that subjects participate in steps 10, 11 and 12 of the AA 12 Step treatment program.

The researcher will also address any ancillary issues during the analysis of the data that are seen to be relevant to the general subject. With the issue of massive public financing of these treatment activities it is imperative that we separate fact from perception.

Problem Statement

Alcoholism remains one of the most critical and perplexing problems facing society today. The AA 12 Step program has historically been purported to be the primary model for treatment of alcoholism as reported by Chanco (1990) in his discussion of the thousands of treatment centers that use it and refer their clients to AA. Yet there has been little, if any, formal evaluation of the actual use and application of this program for those who claim membership in AA and are able to maintain abstinence. In order to provide the most effective and expeditious treatment for alcoholics, it is imperative that a study be done to determine to what extent the 12 Step program has been utilized by those who have been successful in aftercare following a 28-day treatment program using participation in AA.

Purpose

Most modern, 28-day treatment programs for alcoholism require the completion of the first five steps of AA by the patient before discharge. The typical after-care treatment plan will include a directive to complete the remaining seven steps in Alcoholics Anonymous (Englemann, 1989).

The purpose of this study was to evaluate a group of successful members of AA to determine their degree of use of the last seven steps of the AA treatment program. As pointed out by O'Brien and Chafetz (1991), the 12 Step program is hailed as the paramount means of successfully treating those suffering from alcoholism. It is desirable,

therefore, that a study be conducted to ascertain actual use of the program by those who have been successful in maintaining sobriety following a standard 28-day treatment program.

Significance

This study will be able to reach people who have not been reached before because the researcher possesses very special qualifications and expertise on the subject of alcoholism and AA. The inquirer has had a personal relationship with Alcoholics Anonymous since 1980, and possesses an intimate knowledge of its customs, language, and practices (see Appendix E).

In the past decade the subject of chemical dependency, alcoholism and AA has received a great deal of publicity, but, in most respects, AA has remained a closed subculture to which the public and most investigators have limited admission. Because of the researcher's unique personal background, training and experience, he has access to information that can be very illustrative and that the outside researcher can only speculate on. Alcoholics are specifically known to be secretive, deceptive, and distrustful, and, if the investigator is not intimately familiar with specialized interviewing techniques and trusted by respondents, the information gleaned can be of little value. This study can provide an opportunity to look not only at what is actually taking place in this very unique subculture, but a rare chance to look at its very soul.

One of the basic ideas of research is to separate fact from illusion; this study provides that opportunity. If this study reveals that successful patients only practice part of the 12 Step program, then this information could aid counselors into seeking a more concentrated and abridged-treatment regime, thus saving the patient, their family, and society, precious time and money. Our society is facing critical decisions on universal health care and alcoholism is a major issue in that discussion. For men and women of good will to make sound decisions about the care of a large segment of our population, it is important that they operate from the best facts that are available. The 12 Steps of Alcoholics Anonymous could be our best answer for the treatment of alcoholism, but if this treatment regime has been abandoned in practice by its founding organization, it is imperative that public policy makers and those that are responsible for designing effective treatment models be aware of that fact when making decisions that will profoundly affect our society.

Background

AA and its 12 Step recovery program remain controversial. O'Brien and Chafetz (1991) go to great lengths in their *Encyclopedia of Alcoholism* to make this historical point. Even the casual reader on the subject will quickly become aware of this situation. Though an apparent combination of psychology, western medicine, and religion, each step of the program expresses serious reservations as to the general well-being of the individual who chooses this recovery regime.

In December 1939, Bill Wilson set down the 12 Steps of AA, approximately four years after he and Dr. Bob Smith founded what is now the international organization dedicated to arresting the disease of alcoholism. These steps were designed to assist the alcoholic to remain abstinent and bring him or her back to a useful place in society. According to Wilson (AA, 1957), the therapy regime did not spring from a specific philosophy, but from what was successful and gave consistent results. No one has disputed the unprecedented success of AA, for before AA there was literally no reliable, successful solution for the alcoholic in our society.

No other system, whether religious, psychological, or medical, can claim the success enjoyed by AA. But to the serious student of the AA 12 Step program, it appears to be a combination of religion, psychology, and modern medicine. This eclectic combination may be the reason that the some helping professionals are uneasy with it.

As pointed out by Kaminer (1993), AA is often looked at as a religious exercise because of the generic use of the term "God" or "Him" in five of the steps and the term "spiritual" in one of the steps. Kurtz (1979), in his detailed history and description of AA, actually calls the organization a religion similar to the first century Christian church. In fact, there has been from the early days of AA what might be called a loose relationship with religions of all denominations. AA groups have generally been welcome to use church facilities throughout our society, but no church has ever adopted either AA methods or philosophy because they contain far too much psychology and modern medicine. This is also due to the fact that the American Medical Association classified

alcoholism as a disease in 1956 (O'Brien and Chafetz, 1991), which AA endorses, while religion generally classifies alcoholism as a spiritual malady. This creates a great philosophical separation that cannot be closed.

Though the 12 Steps of AA contain practices used in modern psychology, such as introspection, shared confidences and new behavior regimes, psychology has serious reservations when it comes to the applicability of theories of genetics and biology to alcoholism and generally discounts research findings in these areas, thus effectively separating itself from AA (Wilson, 1939). As in the case of religion with perceived spiritual maladies, modern psychology by definition is limited to seeing only mental processes.

Modern medicine, though, has declared alcoholism a disease; its standard remedies of surgery and drug therapy have not proven effective. Within the specialty of psychiatry, when drug intervention is not used, therapists generally fall into the same philosophical position as the psychologists. There appears to be a reluctance to venture into areas that are perceived to fall under the purview of religion. This has served as a natural barrier between AA and the medical community. An example of this observation is the following: Dr. Herbert Benson, Associate Professor of Medicine at the Harvard Medical School and the Director of the Hypertension Section of Boston's Beth Israel Hospital, pointed out in his book, *The Relaxation Response* (1975), that the use of meditation techniques to influence the hypothalamus dramatically reduced alcohol use in individuals with dysfunctional alcohol consumption habits. Of the individuals who were considered to be

heavy users of alcohol, only 0.1 percent were still considered heavy users and most of the subjects were abstinent after twenty-one months using these meditation techniques to control hypertension. Benson (1975) points out that the intention of these individuals was not to reach a condition of abstinence from alcohol, but to control hypertension; abstinence from alcohol was an unexpected side effect. Benson's findings were generated at one of our nation's most prestigious medical institutions over three decades ago and continues to be ignored by his profession. Meditation carries with it a religious stigma that the medical community separates from biological mental function. This is an indication of how deep the professional controversy runs in our society. The 12 Steps of AA set down by Bill Smith contains the methods tested by Benson.

According to Wilson and Smith (AA, 1957), these controversies were as detrimental to the alcoholic as no care at all. They observed that when treated by any one of these three professions separately, the condition of the alcoholic usually became worse, not better. It was out of this frustration that alcoholics designed their own treatment regime (Wilson, 1939).

When we look at the history of AA and the history of treatment centers for alcoholism, we notice that they have had a close relationship for over fifty years. It was on Dr. William Silkworth's unit for alcoholics at Towns Hospital in New York City in 1934 that Bill Wilson, one of the founders of AA, experienced a revelation and discovered that he could stay sober by talking to other alcoholics about their mutual problem (AA, 1957). Dr. Silkworth, though always empathetic to alcoholics, could not discover the method that

would help his chronic patients. Bill Wilson worked closely with Dr. Silkworth over the following years and the doctor established a treatment unit for alcoholics at the Knickerbocker Hospital in New York in 1945 using the methods discovered by AA (AA, 1957). Dr. Silkworth treated over 10,000 alcoholics in the following ten years (Kurtz, 1979). At about the same time the other founder of AA, Dr. Bob Smith, had begun treating alcoholics at St. Thomas Hospital in Akron, Ohio. This work began in 1939, and, during the next ten years he treated over five thousand alcoholics using the methods he, Bill Wilson, and the early members of AA discovered were effective (O'Brien & Chafetz, 1991). Both of the treatment centers were hospital-based programs, but were separate units in the institution.

Chanco (1990) reports that in the early 1950s there began the evolution of a new treatment method and setting at the Wilmer State Hospital at Wilmer, Minnesota. The term "free standing" is used to denote a treatment center that is not attached to a medical hospital. Out of this early experimental program emerged the model for the free standing residential treatment center that is in wide use today. One of the professional participants of that program was Dr. Dan Anderson. Dr. Anderson was asked by a group of professional men if he would consider taking charge of a small treatment center for alcoholics. Dr. Anderson consented and began his work at a then small free-standing treatment center at Center City, Minnesota in 1961 (Chanco, 1990). Dr. Anderson and his staff developed a treatment regime that included the steps of AA, group therapy methods, standard psychological techniques and an extensive education about alcoholism, expanding

on the Wilmer Model of treatment. This model has become known as the Minnesota Model and is the standard in the treatment industry today (Englemann, 1989).

Through the 1960s and 1970s the Hazelden model for treating alcoholics, quite similar to the Minnesota Model, became more popular and units were established around the country. While up to the mid-1960s most new members found their way to AA by way of personal outreach of recovered alcoholics, treatment centers, because of new insurance policies with alcoholism treatment included, grew in number after that time, and, consequently, more members were coming to AA by way of treatment center referrals than from the activities of its members (Kurtz, 1979). These new members brought with them methods of treatment that were not the same as the methods used by AA members who were treated within Alcoholics Anonymous itself. Today, most new AA members come directly from treatment centers (Chanco, 1990). To get an idea of this movement, we can look at the figures compiled by the National Institute on Alcohol Abuse and Alcoholism for 1987. The report points out that more than 1.43 million Americans were treated for alcoholism in the United States in that year (NIDA/NIAAA, February, 1989). Most of the people treated for alcoholism in our society are sent to AA to complete their treatment (O'Brien & Chafetz 1991). To believe that AA could go unchanged under this yearly avalanche of new members is questionable at best. As stated above, there has always been a controversy about alcoholism: what it is, and how it should be treated. Alcoholics Anonymous today officially uses the same treatment literature and recommends using its original 12 Step program, but because of the outside influence of the culture and

treatment centers, the practice of using the 12 Steps may not be in general use today. What was so successful may not exist today as a viable free standing treatment program, but in reality may be a "New Age" group support institution where most of its new members from treatment centers are just passing through.

Nature of the Study

This evaluative study is designed to determine if the highly publicized 12 Step treatment regime of AA is actually being used in totality today by its membership for the treatment of alcoholism. This study is designed to provide public policy makers, health professionals and elected officials entrusted with making decisions on universal health care accurate information on this treatment program. It is presented as an evaluative study because of the heightened interest of the general public and the fact that such information is not readily accessible to scientific investigation because of the secretive character of the studied population.

Social Impact of the Study

As AA came into existence, many saw in it the solution to a problem that has plagued mankind for thousands of years. For the first time people in great numbers were able to escape the personal ravages of this deadly disease. With their escape came the hope that society would also find relief from the personal, physical, and financial destruction that this group of people create as they live among us. With the advent of formal treatment centers, men and women of good will believed that the process of ridding our society of this devastating affliction could be greatly accelerated. There were early signs of success, but it has not been the answer to our society's growing alcohol problem. Though treatment is in many cases effective, it has fallen far short of our society's expectations. Treatment centers, for decades, have been sending their patients by the hundreds of thousands to AA to complete the treatment process. If this researcher's observations are correct, this massive influx of new members from treatment centers has changed AA to a point that it no longer uses the treatment regime that made it so effective in the past. Because this has been a process, not an event, it has possibly escaped detection.

The social implications of this study, if the researcher's hypothesis is correct, could be profound. First, it may show that the present treatment model that is in standard use today is based on an assumption that is incorrect, that the treatment of alcoholism must be redesigned in light of the fact that alcoholism is no longer treated through the 12 Step program. Secondly, the treatment expectations for alcoholism may be unrealistic and far below what is actually possible. If there were adjustments made that would assist the

patient to complete a prescribed treatment regime (including a return to the AA program) we could expect higher recovery rates. Finally, it would reopen the discussion on the treatment of alcoholism, a discussion that has been effectively closed for over fifty years.

CHAPTER II

LITERATURE REVIEW

Overview

Articles, studies, and books on the subject of alcoholism can be found in abundance, and when combined with the subheading of chemical dependency, there is an almost endless supply of recent material. This researcher identified over a thousand citations produced in the last six years on the subjects of aftercare and Aa; the only limiting factor appears to be time when looking at this subject. (The term "aftercare" is applied to any treatment regime used following the completion of the usual 28-day treatment program for alcoholism.) The diversity of subject matter from the different schools of psychology, and their special beliefs about cause and treatment, is extensive. The only requirement for studying this subject appears to be an opinion on alcoholism.

The material being reviewed here was generally contradictory and lacking in continuity. As Lull (1988) points out in his dissertation, Alcoholics Anonymous Attendance, Aftercare, and Outcome: A Secondary Analysis of Two Years Post Hospitalization Data,

A review of the literature provides insight regarding the conceptual and methodological issues with which researchers have had to struggle. Clinical intuition, treatment ideology and methodological requirements tend to mix rather uncomfortably. Consensus is achieved in a negative sense in terms of agreement regarding methodological and conceptual limitations. (p. 15)

Lull's observation, not unlike those of most who review the literature, is that the only consensus is no consensus.

This researcher discovered several interesting phenomena in the reviewed literature on the subject of alcoholism in general and the steps of AA specifically. As Lull (1988) points out, even though the most minute aspect of this subject has been looked at by psychologists, the general subject remains fragmented with no apparent unifying theory or cooperation among professionals. Voris (1992), in analyzing two literature reviews published in 1942 and 1967, reached the same conclusion: that it was "impossible to form any sort of opinion about the value of treatment from an examination of the literature alone" (p. 550). A literature review updating these findings by Gordis, Dorph, Sepe, and Smith (1981) concluded that "global conclusions about outcome, based on the literature are impossible" (p. 521). Frohman (1987) also discovered this circumstance, and pointed it out in his dissertation, A Follow-up Study of the Clients from a Privately Operated Substance Abuse Treatment Program: Predictors of Treatment Completion and Outcome.

To thoughtlessly lead even the most capable reader into this murky water can sometimes lead to confusion. Though the subject of alcoholism and aftercare are fraught with endless detailed reports and analysis, this researcher will make a sincere effort to give the reader usable information that can be applied to further study.

This researcher noted, as did Lull (1988), that the ideologies surrounding alcoholism are conflicting and rigidly drawn and that there is little discussion and exchange of information across ideological lines. The realization that there are profound conflicts in

perception on the subject of alcoholism is inescapable. It becomes apparent that there is an overriding proclivity to ignore the work of others. In this researcher's experience, this activity is not unlike the alcoholic who, during periods of unrestrained drinking, makes no connection between his or her individual perception and a greater reality, which has been labeled denial (AA, 1957). This same mental activity seems to be in play among professionals who look at the subject from a preconceived position or belief, thus keeping studies of alcoholism in a state of general confusion as evidenced in the literature.

Alcoholism – A Philosophical Controversy

This researcher felt compelled to find some explanation for the general confusion in the literature. De Bono (1990) offers the simple observation that the nature of a system determines what happens. He states, "The brain system is well suited to developing ideas but not good at generating them" (p. 18). This observation, when applied to individuals whether alcoholic or nonalcoholic, renders humans incapable of constructively using information that falls outside our perception or belief. According to De Bono (1990), the human brain will, by design, ignore this inconsistent information, and under such circumstances the individual, or group of like-minded individuals, will attempt to create a logic to support a belief. When De Bono's (1990) observations are applied to groups, one is left with the hardly encouraging thought that crisis or disaster are the only dependable tools for change. Because most researchers and thinkers operate from outside of a personal involvement, even the opportunity for useful crisis is not available.

When AA experienced, in the lives of its early members, that the alcoholic must reach his or her bottom, a position of complete disaster, before the recovery process could begin (AA, 1957), they may have discovered this limiting brain function that De Bono notes. Johnson (1980) pointed out that an alcoholic's bottoming out, the level that permits a shift in perception and a break in denial, can be engineered by creating a crisis to start the recovery process. Intervention using Johnson's methods are standard in the recovery industry today. As Milan (1978) observed, without denial, alcohol addiction could not exist. Could it be that the alcoholic's destructive system of denial is not unique to the alcoholic, but the standard way the human brain functions, with a more visible negative consequence?

According to Kurtz (1979) and Smith (AA, 1980), the early members of AA moved forward by using a system of incorporating activities that actually worked on themselves, rather than by using preconceived beliefs, thus freeing themselves to incorporate activities from a wide range of available sources and, for the first time, get consistent positive results in achieving and maintaining sobriety.

To the casual reader there might appear to be some general continuity of thought among psychologists surrounding the idea that alcoholism is caused by an abnormal mental process deficiency which is in turn caused by the individual's environment. But on closer inspection one can see a struggle, if not a form of competition, among differing interpretations. Jellinek (1979) was able to identify over 200 definitions, theories of etiology, and conceptualizations of alcoholism noted in the literature. Engs (1990)

presents no less than twenty-four major differences of opinion among psychologists, seven just on the nature of alcoholism. Hester and Sheehy (Engs, 1990) presented no less than eleven separate theoretical models. The following is a brief description of the models that were identified. It should be noted that this is in no way a complete list, but an overview of the more prominent models.

1. Moral Model. The moral model is championed by two segments of our society, law enforcement agents and the clergy. The clergy will give examples of abuse as sin, causal factors will be spiritual, and the implied intervention will be moral and spiritual direction. Law enforcement agents present examples as crime, the causal factor as personal responsibility, and the implied interventions various forms of social sanctions.
2. Temperance Model. The temperance model can be generally identified because its examples will center on prohibition. Adherents of this model emphasize alcohol and drugs as causal factors. The abstainers in this group will use exhortation as an implied intervention, while their legislators favor abstinence and probation by law.
3. Educational Model. Proponents of this model adhere to lectures and effective education, with lack of motivation and knowledge as implied causal factors. They believe that education is the most appropriate intervention method.
4. Characterological Model. Individuals who support this model are often psychotherapists. Their examples will typically utilize psychoanalysis, with the emphasized causal factors being personality traits and dispositions and defense

mechanisms. The implied interventions will generally be psychotherapy, risk identification, and self-image modification.

5. Conditioning Model. Within this group tend to cluster the behaviorists. Their examples will be classical and operant conditioning. Their causal factors will be conditioned response and reinforcement and their implied interventions will be counterconditioning, altered contingencies, and relearning, which is often called "disenabling."

6. Biomedical Model. The proponents of this model are physicians and diagnosticians, and their examples hinge on heredity and brain chemistry. The emphasized causal factors will be physiological and genetic, with implied interventions being risk identification and medical treatment.

7. Social Learning Model. When this group, made up of cognitive-behavior therapists, gives examples they will note cognitive therapy and relapse prevention. The emphasized causal factors will include modeling, expectancies, and skill deficits. Their implied interventions will generally be cognitive restructuring, skill training and self-control training.

8. General Systems Model. Family therapists and support groups generally favor this model. In this group as well will be found the transactional therapists and groups such as "Adult Children of Alcoholics." This model emphasizes causal factors which center around family dysfunction, and its implied interventions are family therapy, recognition, and peer support.

9. Sociocultural Model. The proponents of this model are generally made up of lobbyists/legislators, social policy makers, and retailers. Their examples will be dominated by the control of consumption and their emphasized causal factors will be environmental and cultural norms. They can be identified by supply-side intervention, social policy, and server intervention.

10. Public Health Model. This group, generally considered interdisciplinary, can be identified by their discussions of the World Health Organization and the National Academy of Science. Their emphasized causal factors will include interactions of host, agent, and environment, and their implied intervention will be comprehensive and multifaceted.

11. American Disease Model. This model's proponents are recovering alcoholics and peer support groups. Their example will include AA and Narcotics Anonymous and their emphasized causal factors will include the irreversible constitutional abnormality of the individual. Their implied interventions will be identification/confrontation and lifelong abstinence (Engs, 1990).

The serious student, consulting the literature on these major models, can identify many apparent mutations and interdisciplinary combinations. Paradoxically, it becomes apparent that there has been a reluctance by psychologists to approach AA and its 12 Step treatment regime directly, generally staying clear of scientific and intellectual confrontation. This researcher did not discover any citations that addressed the actual use of the AA 12 Step treatment program. But ironically there appears to be a willingness by

some psychologists to use AA and its 12 step treatment regime as a backup procedure with their own treatment philosophies

Muhleman (1987) reports that there are historical differences and conflicts between 12 Step programs and psychotherapists, and, even though psychotherapists refer their patients to these programs, such referrals create problems and concerns that can be noted in the literature.

The medical community openly incorporates AA as part of its therapeutic activities. Kaufman and Reoux (1987), in their "Guidelines for the Successful Psychotherapy of Substance Abusers," presented to the American Psychiatric Association meeting in 1987 the following outline with instructions on how to incorporate the AA 12 Step treatment regime into a therapeutic relationship:

Achieving Sobriety:

1. Assess the consequences and extent of the substance abuse.
2. Develop methods for detoxification and abstinence
3. Insist method for abstinence a condition of psychotherapy.
4. Diagnose and treat the underlying psychiatric disorder.
5. Family participation.

Early Recovery (first 1/2 to 2 years):

1. Goal is abstinence.
2. Supportive, directive psychotherapy.
3. Focus on disease of substance abuse.
4. Redirect defenses.
5. Reinforce principles through psychodynamic therapy.

Advanced Recovery (after 1 to 5 years of abstinence):

1. Goal is insight and personality change.
2. Traditional reconstructive psychotherapy.
3. Patient needs firm identity and available controls.
4. Explore defenses and underlying issues.
5. Re-implement cognitive-behavioral controls as needed. (p. 200)

The authors go on to suggest that

Considering intrapsychic conflicts and forces with dynamic approaches is helpful to reinforce the principles of Alcoholics Anonymous or other 12-Step groups. For example, unresolved, omnipotent, narcissistic entitlement, power or dependency conflicts may prevent a patient from obtaining a sponsor and/or using AA fully. Psychodynamic therapy of such conflicts may help the patient to accept the principles of a program such as AA more readily. (p. 204)

Meacham (1991), while discussing psychiatry and AA's growing respect among psychotherapists, says that "The mistrust between members of AA and psychotherapists is longstanding. But the rift may be healing, as psychiatrists come to appreciate AA, and AA members begin to soften their criticism" (p. 25). Both AA and psychiatry start by labeling alcoholism a disease (Edwards, Arif, & Hodgson, 1981; Jellinek, 1960; Milan & Ketchum, 1981; Vailant, 1983). This general position allows Miller and Mahler (1991) to say, "The principles and philosophy of the abstinence-based Twelve Step Program of Alcoholics Anonymous can be incorporated into the treatment process for alcohol and drug addiction" (p. 39).

But the general position among psychotherapists that this investigator noted was that AA was not the treatment, but an aid to treatment.

The psychologist, the religious community, and even the medical establishment appear to ignore the biomedical, pharmacogenetic, and pathological research that is available. Agarwal and Goedde (1990) present a comprehensive profile of the latest research that is

available to the field of alcoholism, but breakthroughs generated by these specialties are conspicuously absent in the general literature.

The definition of alcoholism in the reviewed literature can change with each philosophical group that approaches the subject. By way of example, let us consider four working definitions: the epidemiological, behavioral, sociological, and the legal. An example of an epidemiological definition is given by Keller (1960): Alcoholism is a chronic disease manifested by repeated implicative drinking so as to cause injury to the drinker's health or to his social or economic functioning. As Clark (1966) points out, this group's definition emphasizes evaluations of others in the drinker's environment. A behavioral definition will include the invocation of a value judgement of deviancy from the norm. Keller (1960) gives this example: A chronic disease, or a disorder of behavior characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or ordinary compliance with the social drinking customs of the community, and that interferes with the drinker's health, interpersonal relations or economic functioning. The sociological definition focuses on excessive drinking in relation to records of the official community. McCord, McCord and Gudeman (1959) give us a good example: Those men whose chronic drinking had caused sufficiently severe problems to bring them to the attention of the official community were defined as alcoholics, that is, those men who had been arrested two or more times for public drunkenness. If our definition is legal it will include loss of control when drinking alcohol results in a danger to others or him or herself. Curran (1966) points out that this loss of

control refers to control over drinking itself, not over other actions while under the influence of liquor. Because psychology, like religion, is generally limited to confused mental processes and outcomes, psychologists operate under a real disadvantage when attempting a definition of alcoholism.

Though many still focus on the negative implications of drinking, definitions are often used that approach drinking behavior itself. What these definitions usually include is the central issue of loss of control, or more specifically, predictability of drinking outcome. By the mid 1950s the World Health Organization placed alcoholism under the classification of "Other Nonpsychotic Mental Disorders" in its International Classification of Diseases (ICD-8) (WHO, 1974). The American Psychiatric Association moved to this position in its Diagnostic and Statistical Manual of Mental Disorders (1987) (DSM III-R) and classifies alcoholism as a disease using loss of control as an operative criteria..

From the early years of AA, members believed that alcoholism was its own primary disease (Wilson, 1939). A primary disease will have its own etiology or cause, signs and symptoms, pathogenesis or course of the illness, outcome, and effective treatment (Jellinek, 1979). Informed scholars tell us that we know more about alcoholism, in reference to these categories, than we do about many other major human afflictions including cancer, heart disease, diabetes, and multiple sclerosis, to name just a few (Jellinek, 1979). As stated above, medical science today considers and classifies alcoholism as its own primary disease, though its main treatment specialty, psychiatry, mirrors the psychologist to a substantial degree when drug intervention is not used.

The controversy among the major philosophical segments in our culture gains a new dimension when the religious community is added. Alcoholics Anonymous made its separation from religion (i.e., from its Oxford Group precursor) because it discovered early that alcoholics were uncomfortable with any religion (Wilson, 1957). Alcoholics Anonymous makes a distinction between religion and spirituality (Kurtz, 1991). A discussion of the perceived differences between spirituality and religion can be extensive, but Kurtz makes this important point: "Spirituality is one of those things that you only have as long as you're trying to get it. As soon as you think you've got it, you've lost it" (pp. 1-2). Kurtz continues, "This has been expressed in two ways throughout the history of AA. One is the emphasis on being teachable; the other is that AA's spirituality doesn't claim to have all the answers" (pp. 1-2). Members of AA identify themselves as part of a spiritual program (Wilson, 1976). This was one of the central issues in their separation from the Oxford Group: alcoholics objected to its claim to have all the answers, and it had not had the answer to their drinking (Kurtz, 1991).

Spiritual issues have been absent from modern health care education. Chappel and Veach (1993) explain that spiritual issues lack scientific evidence that is tangible, thus separating medicine from one of the major tenets of AA. They expand on this philosophical issue by pointing out modern medicine's confusion between religion and spirituality (Chappel & Veach, 1993). But in fact, medicine's roots are found in religion. Chappel and Veach (1993) explain, "In the early universities, medicine was separated from theology and philosophy but continued to be influenced by religious ideas and practices

until the development of scientific medicine in the 19th century" (p. 18). Modern medicine's separation from religion was based on deep philosophical issues that remain today. Modern medicine, though uncomfortable with religion and spirituality (while still failing to draw a distinction between the two) was fascinated by the results that AA was able to produce and has been involved with AA from its very beginnings.

To come full circle, as was mentioned earlier, modern psychology has in many respects been an attempt to scientifically explain religion. As AA borrowed freely from modern medicine, religion, and psychology, it has something in common with them all, but by that very fact has not been truly befriended by any. When Bill Wilson admonished his young fellowship to be friendly with our friends, he may not have fully realized the beliefs and perceptions that are indigenous to our society (Wilson, 1957). One of the great underlying questions that might be posed is: "Has the great experiment of Alcoholics Anonymous quietly disappeared, as these powerful philosophic giants in our culture struggled against one another?"

Alcoholics Anonymous – Organization

When we consider treatment, a closer look at AA can be helpful because of its successful history treating alcoholics. The best definition this researcher has found for AA is the one that this society has used for itself from the early days of its foundation in the late 1930s. This definition is read at the beginning of most AA meetings:

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their

common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self-supporting through our contributions. AA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety. (O'Brien & Chafetz, 1991, p. 19)

As one studies this organization, its profound simplicity becomes evident, if not overwhelming. It governs itself with a set of bylaws that were apparently designed to keep it focused on its one single issue. This set of bylaws is referred to as the Twelve Traditions. In reading the Twelve Traditions, one can recognize the dangers of social organizations and this society's attempt to escape them. One may also detect the presence of a siege mentality that can escape the casual reader. The following are the organizational bylaws or Twelve Traditions of AA:

The Twelve Traditions of Alcoholics Anonymous

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority - a loving God as He expresses Himself in our group conscience our leaders are but trusted servants, they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.

6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. AA as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinions on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of our Traditions, ever reminding us to place principles before personalities. (AA, 1976, p. 564)

At the center of the AA fellowship has been its 12 step program of recovery. This treatment regime was designed out of the early experience and success of its first members (Smith, 1980). The 12 Step model for treatment has been adopted by numerous other organizations in our culture and the name is in common usage (Kaminer, 1993). It is this 12 step treatment regime that is the subject of this inquiry. Does AA actively use its own 12 step program today? It is this researcher's hypothesis that it does not. The following is the official treatment program of AA:

Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to the simple program, usually men and women who are

constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault; they seem to have been born that way. They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty. Their chances are less than average. There are those, too, who suffer from grave emotional and mental disorders, but many of them do recover if they have the capacity to be honest.

Our stories disclose in a general way what we used to be like, what happened, and what we are like now. If you have decided you want what we have and are willing to go to any length to get it - then you are ready to take certain steps.

At some of these we balked. We thought we could find an easier, softer way. But we could not. With all the earnestness at our command, we beg of you to be fearless and thorough from the very start. Some of us have tried to hold on to our old ideas and the result was nil until we let go absolutely.

Remember that we deal with alcohol - cunning, baffling, powerful! Without help it is too much for us. But there is One who has all power - that One is God. May you find Him now! Half measures availed us nothing. We stood at the turning point. We asked His protection and care with complete abandon.

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

1. We admitted we were powerless over alcohol Â 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 whenever 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 a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (AA, pp. 58-60, 1976)

As can be seen, the 12 Steps are in reality a report on what was successful for recovering alcoholics and are suggested as a guide for those who follow. From the beginning, members of AA appear to have focused on actions that produced consistent positive results rather than upon intellectual theory (AA, 1957).

This study is addressed to the use of the last seven steps of this treatment regime. The AA explanation of these steps is given below:

Step Six: Carefully reading the first five proposals we ask if we have omitted anything, for we are building an arch through which we shall walk a free men at last. Is our work solid so far? Are the stones properly in place? Have we skimped on the cement put into foundation? Have we tried to make mortar without sand? If we can answer to our satisfaction, we then look at Step Six. We have emphasized willingness as being indispensable. Are we now ready to let God remove from us all the things which we have admitted are objectionable? Can He now take them all - every one? If we still cling to something we will not let go, we ask God to help us be willing. (AA, 1976, p. 75)

The actual time involved in completing this step is that needed to read over the first five steps and decide if they have been completed to the best of the individual's ability, and to decide to let go of objectionable parts of one's life.

Step Seven: When ready, we say something like this: 'My Creator, I am now willing that you should have all of me, good and bad. I pray that you now remove from me every single defect of character which stands in the way of my usefulness to you and my fellows. Grant me strength, as I go out from here, to do your bidding. Amen.' We have now completed Step Seven. (AA, 1976, p. 76)

As with Step Six the time involved is negligible.

Step Eight: We have a list of all persons we have harmed and to whom we are willing to make amends. We made it when we took our inventory. We subjected ourselves to a drastic self-appraisal. (AA, 1976, p. 76)

Step eight is another decision. There is no time involved.

Step Nine: Now we go out to our fellows and repair the damage done in the past. (AA, 1976, p. 76)

Step Nine is an action step. This will take time. There are extensive instructions on this step to keep the alcoholic from getting into trouble and to keep him or her from harming others.

Step Ten: This thought brings us to Step Ten, which suggests we continue to take personal inventory and continue to set right any new mistakes as we go along. We vigorously commenced this way of living as we clean up the past. (AA, 1976, p. 84)

This step is a daily step that Alcoholics Anonymous calls a maintenance step. Steps Nine and Ten are accomplished at the same time and when Step Nine is completed, Step Ten is used to keep the alcoholic current.

Step Eleven: Here we ask God for inspiration, an intuitive thought or decision. We relax and take it easy. We don't struggle. (AA, 1976, pg. 86)

It is suggested that the alcoholic go to the library and study up on meditation or locate someone who practices it to learn how it is done.

Step Twelve: Carry the message to other alcoholics. (AA, 1976, pg. 89)

All of Chapter Seven in the Big Book of Alcoholics Anonymous is devoted to this step. It is a lay therapist's guide.

As Peterson (1991) points out, the fundamental teaching methods that AA adopted were developed in China for person-to-person evangelism by Christian missionaries at the turn of the century. These methods were incorporated into the Oxford Group religious movement and it was from the Oxford group beliefs and practices that the AA 12 Step treatment regime was developed (Kurtz, 1979).

There were many other beliefs, practices, and organizational methods that the founders of AA found useful and incorporated into their new organization. When we explore this history we can see the seeds of controversy among professionals in the psychological, medical, and religious communities.

Early in this century religious leaders in the United States and Great Britain actively explored a revolutionary idea. Professor Harry Drummond, teaching at Oxford

University, put forward the idea of scientific Christianity (Drummond 1895, 1899). With Drummond, psychology started to investigate religion, and give the religious conversion experience a scientific explanation (James, 1905; Starbuck 1899). This proposed relationship between religion and science, and the idea that religion is scientific with the winning of souls being affected by scientific methods, caught the attention of young Christian college students (Drummond 1905, 1899; Kurtz, 1979).

In the United States the student Young Men's Christian Association (YMCA) championed these new ideas. On the campus of Pennsylvania State University, Frank Buchman was the secretary of the YMCA chapter and enjoyed noticeable success on collegiate and evangelical campaigns (Spoerri, 1976). Mr Buchman acquired such notoriety that he was invited to participate in Christian evangelical projects in India in 1915 and China in 1917 (Walter, 1940). Buchman noted during the India campaign that mass rallies and large well organized projects were ineffectual and formulated a new method, which he tested during the China campaign in 1917. This new method was based on a personal man to man experience (Walter, 1940). His idea was to use the newly converted people to reach out to their neighbors. He discovered this process strengthened the newly converted and was much more appropriate. His system of conversion produced maximum potential, created a growing movement, and could cross cultural and language barriers (Walter, 1940). In correspondence with another American missionary, Sam Shoemaker, Buchman explained another revelation that he incorporated into his method. "I have found a way to draw confessions from others. It is to confess first myself"

(Shoemaker, 1921, p. 80). Sam Shoemaker was to become the leader of the Oxford Group movement in which both co-founders of AA began their successful attempt to gain sobriety. Sam Shoemaker was to become co-founder Bill Wilson's mentor, teacher, and friend, and his books were actively read by early members of AA. Bill Wilson said of Reverend Sam Shoemaker: "It was from him that Doctor Bob [AA co-founder] and I in the beginning had absorbed most of the principles that were afterward embodied in the 12 Steps of Alcoholics Anonymous" (Wilson, 1957, pp. 38-39). The confession of one alcoholic to another alcoholic is AA's basic method of assisting the practicing alcoholic to confront his or her condition is another excellent example of the use of Oxford Group methods taken from Buchman's discoveries in China (Kurtz, 1979).

Kurtz (1979) explains how Buchman created a formula known as the Five "C"s: Confidence, Confession, Conviction, Conversion, and Continuance. This formula was adopted by the Oxford Group. This method or step approach is the major source of the 12 Steps of AA (Kurtz, 1979). In China Buchman discovered that meetings in homes, which he called "house parties" were superior to any other type of setting for conveying his message (Russell, 1932, p. 99). The use of the "house party" was quickly picked up by the Oxford Group movement, and, since the early members of what was to become Alcoholics Anonymous were members, it was natural for them to use this successful practice. Immediately prior to the founding of AA, the Reverend Shoemaker was the pastor of Calvary Episcopal Church in New York City. Reverend Shoemaker conducted meetings at the church's 23rd Street mission and later at the Thursday night Oxford Group

meetings at his home where the co-founder of AA Bill Wilson and other early AA members first experienced living sober (Alcoholics Anonymous, 1957, pp. 59, 64, 74; Shoemaker, 1967, pp. 24-27). Early AA members had been members of the Oxford Group "house party" meetings (Smith, 1980). These small groups of alcoholics actively separated themselves by calling themselves the "Alcoholic Squad" (Kurtz, 1979).

The basic text of the Oxford Group movement was Walter's *Soul-Surgery: Some Thoughts on Incisive Personal Work* (1940), which was developed from articles in *The Indian Witness* (Spoerri, 1976, p. 56). The book was written by Walter but explains Frank Buchman's experience in China with his "Method" (Walter, 1940). With incorporation of medical terms as seen in the above title and the inclusion of Drummond's conception of scientific Christianity, the Oxford Group set itself at odds with what can be called the traditional religious community. If we look at the Oxford Group as an attempt to establish a middle road between organized religion and newly emerging twentieth century science, it is plain that it only accomplished becoming a perceived adversary of both. With AA's incorporation of Oxford Group beliefs, teaching and methods it too has enjoyed the same reception from organized religion, psychology and medical science.

Treatment Centers and Alcoholics Anonymous

Thousands of people in the past five decades have reached the doors of AA by way of specially designed treatment centers for alcoholism (Chanco, 1990). The majority of these treatment centers use what is called the Minnesota Model made famous by the Hazelden Foundation located at Center City, Minnesota. Lull (1988) reports that 94.3 percent of all in-patient treatment center graduates are referred to AA. Today the treatment of alcoholism cannot be considered without some discussion of the Minnesota Model and its relationship to AA and the 12 Step treatment regime.

What is now known as the Minnesota Model was first known as the Hazelden Model of treatment for alcoholism. The modern treatment of alcoholism can be traced to Dr. Nelson Bradley and Dr. Dan Anderson at the Wilmer State Hospital at Wilmer, Minnesota in the 1950s (McElrath, 1989). In the early 1950s a new program was set up to treat alcoholics. This newly developing program treated alcoholics humanely, used alcoholics as therapists, taught patients about alcoholism, and introduced them to AA. In 1961 the Hazelden treatment center at Center City, Minnesota, which had been established in 1949, hired Anderson to establish there the multidisciplinary treatment methods being developed at Wilmer (McElrath, 1989). While at Hazelden, Anderson utilized a set of assumptions about alcoholism that were revolutionary at the time.

1. Alcoholism is an involuntary, primary illness; not a symptom of something else.
2. Alcoholism is a chronic, progressive illness.
3. It is a multiphasic, multi-dimensional illness.

4. The denial system is part of the illness.
5. It is a "no fault" illness; patients and families should be treated with dignity and respect.
6. Initial motivation for treatment is unrelated to outcome.
7. People dependent on other psychoactive substances can be treated in the same program.
8. The phenomenon of addiction is the common factor in chemical dependency. It is characterized by impaired control over use of the substance, and a dependence on the drug that produces harmful consequences. (Englemann, 1989, p. 72)

What has evolved at the Hazelden Center is what has become known worldwide as the Minnesota Model. The following is a list of components that make up this model. One can quickly see the incorporation of the Wilmer Model:

Philosophy of treatment: Includes the assumption that alcoholism/chemical dependency exists; that it is a multiphasic illness; that the focus should be on the phenomenon of addiction as the major presenting problem; that denial is part of the illness.

Goals of treatment: Improved mental and physical health achieved through total abstinence.

Content of treatment: Help people take better care of themselves by understanding chemical dependency as well as the strategies that will help maintain sobriety.

Quality of interdisciplinary staff: Trained people who meet professional standards to address physical, social, family, spiritual and psychological areas; Recovering chemically dependent people are an integral part of the staff.

Duration of treatment: Length-of-stay based on the average time it takes a typical patient to complete primary care; however, treatment duration must remain individualized.

Intensity of treatment: Living in a therapeutic community that includes lectures; group meetings; individual meetings with professionals as needed; and aftercare planning.

Context of treatment: Atmosphere conducive to self-reflection and self-evaluation; environment in which people are treated with dignity and respect by staff who are caring and concerned - a caring community.

Quality assurance measures: Process and quality measurements.
(Englemann, 1989, p. 104)

Chanco (1990) reported that there were approximately 6,800 treatment programs for alcoholism and most used the Minnesota Model, or something very similar to it. At the heart of this model is the completion of the first five steps of AA and an aftercare program that directs the patient to AA to complete the last seven steps (Taft 1993). An alcoholic who experiences formal treatment under the care and guidance of professionals, according to the literature, will be required to complete the first five steps of the AA treatment program to graduate (Kelly, 1991). This situation, according to Rothman (1991), has violated AA's tradition of non-affiliation with outside organizations. Now a massive block of treatment centers and self-help programs use its material and its treatment regime — an outgrowth of Bill Wilson's decision to be friendly to our friends.

As stated earlier, when the alcoholic completes treatment he or she is encouraged to participate in "aftercare." Consulting the psychological literature using alcoholism and alcoholism aftercare as key words, this researcher found many references to Alcoholics Anonymous. While reading approximately two hundred articles this researcher found about half at least mentioning AA. These citations generally were neither positive or negative, but more in the form of acknowledgement that AA was an option in the treatment of alcoholism. What became very clear to this researcher was that the literature, in general, is dominated by an interest, if not a preoccupation, with process. This is what

separated other treatment models from AA from the beginning. Recovering alcoholics were interested in product more than a narrow parochial interest in theory (Wilson, 1957).

Alcoholics Anonymous Today

Is AA a social network rather than a primary treatment program? When Muhleman (1987) stated that AA is a program for desperate people who want to stay alive, is that realistic or has that function disappeared? With intervention specialists, detoxification units, professional therapists, and treatment centers taking over the historic AA functions, has AA been reduced to a mild therapeutic social support network like its many spinoff self-help programs? If this is the case, AA may not be capable of carrying out the treatment regime it designed and made famous.

The researcher did discover one dynamic change that tends to support a social support model rather than a primary care model. The traditional AA speakers' meeting has all but disappeared in the researcher's immediate geographic area. According to the Central AA Office in Palm Springs, California, there are 294 weekly meetings of AA. Of these recognized meetings only eight are the original open speakers type. And of these eight, three are held within formal treatment centers and are not recognized by AA, and one is for gays, leaving only three of the original type (Central AA Office, 1994). The remaining 286 meetings of AA are of the discussion type. The AA discussion meeting, generally closed to the public, closely resembles the group therapy of the treatment center (Kurtz,

1979). Though this survey represents a small area of the country, it serves a graphic example of a fundamental change in the organization.

DeSoto, O'Donnell, and DeSoto (1989) completed a cross-sectional study of varied lengths of sobriety and combined it with a four-year follow-up study of the same subjects. Though the subjects were taken from AA groups, there was no mention of the use of the AA treatment regime. Rather and Sherman (1989) in their study of the relationship between expectancies and length of abstinence among AA members, refers to AA as a social network, not a treatment program. Gordon and Zrull (1991), in their study of social networks and recovery of individuals one year after inpatient treatment, also defines AA as a social network. Mackay and Marlatt (1991), in their study on alcoholic relapse go even farther to eliminate AA as a primary treatment vehicle, placing AA members in the same category as people with more "normal" behavioral problems, rather than in a category of their own: "Frequently rehabilitation of alcohol dependent individuals occurs within an inpatient hospital treatment program; that is not to say that quitting on one's own, peer support groups, AA, etc., are not viable treatment alternatives" (p. 1258).

Leon (1990) places AA in a family of therapeutic communities that act as a social support to be used with formal professional treatment. Fox (1988), in her discussion of supportive therapeutic environments, places AA in the same general category as movies and arts and crafts. She points out that the major benefit of AA is peer group support, but believes that AA should be subdivided to get closer to a particular patient's peer group. She does not see AA as a primary treatment provider.

This idea that AA is a part of other treatment models rather than a primary treatment is common in the literature. In Gorski's (1990) explanation of the Cenaps Model of recovery, AA is presented as a back-up or secondary activity to professional treatment. He does not discuss the AA treatment model. In discussing recovery-oriented psychotherapy, Zweben (1986) suggests the use of multiple 12 Step programs, once again as ancillary to professional therapy, with no mention of AA specifically. She does, however, agree with Gilbert (1991) that introducing 12 step programs has many benefits, as they offer a wealth of survival skills as well as generous support. So great are the potential benefits of involvement with these programs, she says, that it is useful for the therapists to facilitate the client's use of them in whatever way possible (Zweben, 1986).

Weiner, Wallen, and Zankowski (1990) place AA as part of a recovery regime for women, specifically giving it a peer support function rather than a primary treatment function. Their treatment program includes assertiveness training, group therapy, and women's specialty groups of a wide variety. They suggest that women's AA meetings should supplement professional therapy. These authors go so far as to say that AA should only be used as primary treatment if the person cannot afford professional assistance. The idea that AA is the choice of last resort is not uncommon in the psychological literature. But Weiner et al. do not even separate Alcoholics Anonymous from the many other self-help groups in our society: "As noted previously, disadvantaged women should be referred for involvement in various self-help support groups to assist them in forming and maintaining a constructive and adaptive community peer support system" (p. 244).

Zachon (1989), in his discussion on relapse, like most authors places AA in a socializing role rather than in a primary treatment role. He tells us that the socializing that takes place in AA assists the alcoholic to overcome embarrassment and offers people what he calls "shepherds" to help in the process.

Conclusion

This researcher did discover one significant reference to working the 12 Steps of AA, though it was an ancillary issue in a study by Knouse and Schneider (1987), which focused on personality factors of recovering alcoholics. The 262 respondents to a questionnaire sent by mail had successfully completed a 28-day treatment program with a primary diagnosis of alcoholism. The respondents reported an average of 13.5 months (SD = 9.31) of continuous sobriety, with 80 percent claiming membership in AA; three-quarters of those surveyed, 73.7 percent, were working on the 12 Steps of AA. The researchers, in their emphasized causal factors and implied intervention, operate from a social learning model, but suggest AA as a useful back-up to skill training. This research team reports: "Generalizations about the relative importance of the factors are difficult because of methodological difficulties such as response bias, sampling problems, diagnostic homogeneity, and disagreement over the criterion for successful recovery" (p. 595). This ambitious study looked at a number of factors including personality, family cohesiveness, vocational adjustment, aftercare, involvement, status on intake, stress, and social

adjustment. But involvement in the 12 Step recovery regime was not defined and there were no indications of verifying the responses.

Gilbert (1991), in his study of the first three steps of the 12 Step treatment program of AA, reports a substantial correlation between a patient's belief in the efficacy of working the steps and days of sobriety. Gilbert additionally points out that "The results of this study also suggest that it is feasible to address AA's 12 Steps directly in alcoholism treatment programs" (p. 359). While the bulk of this researcher's literature review shows waning support for AA, he believes with Gilbert that it is a useful cognitive treatment model; the present study attempts to make a case for that usefulness.

The value of the literature review, remarkably despite the paucity of information about actual use of the steps of the AA 12 step program, has been the lack of evidence presented that AA is even considered as a viable primary treatment program. At times, in fact, there appears to be an underlying moralistic theme in these studies, no matter what treatment model is explored: If the alcoholic can overcome certain behavioral problems, his or her problem with alcohol would disappear. Thompson (1989) provides a good example of this attitude. As a result of her observations she concluded that many members of AA could work the 12 steps of AA if they would merely overcome their problems with "procrastination." But in not considering the issue of nonuse of the 12 step treatment program by the general membership, she blames the alcoholic. This position can be considered a version of the moralistic pre-Alcoholics Anonymous position that caused alcoholics to band together in the first place in order to save themselves.

CHAPTER III

METHODOLOGY

Overview

This researcher sought to substantiate the extent to which the 12 step treatment program designed and put forward by AA is in general use today by recent members who had previously graduated from treatment centers for alcoholism. The researcher attempted to determine to what extent steps six through twelve of the AA 12 Step program are actually being utilized. The research method chosen was the descriptive survey approach. This method seemed most appropriate to the task at hand because of the clearly delimited survey population, the close scrutiny afforded by the method, and the opportunity the method gives to set useful research parameters. But in addition to the questions addressed in the survey, several ancillary research questions are also addressed during the course of the study, among them, is there a difference in usage of this treatment regime by gender, age, marital status, and educational level?

The population in this study are alcoholics who report that they have maintained sobriety for at least one year. The sample selected were graduates of a 28-day treatment program and include 25 men and 25 women, ages 18 and older. Subjects were selected based on their willingness to participate from the membership of the treatment center alumni association. The researcher obtained lists of alumni of an accredited 28-day treatment center who have maintained abstinence from alcohol and other mind-altering substances for more than one year. There were approximately 7,000 graduates of the

selected treatment center who gave a California address. From that list the 25 men and 25 women were randomly selected.

There were six criteria for the selection:

1. The individual was a graduate of a 28-day treatment center for alcoholism;
2. The individual has completed the first five steps of the 12 step AA program in treatment;
3. The individual has a primary clinical diagnosis of alcoholism;
4. The individual is reporting abstinence from alcohol and other mind altering substances for more than one year;
5. The graduate is a member of Alcoholics Anonymous;
6. The willingness of the alumnus to participate in the study.

The researcher contacted the potential subjects by phone and by mail and explained the purpose of the study. The investigator assured the potential subjects that no harm could result from their participation. A consent form was signed by the subject prior to a telephone interview (See Appendix E).

The researcher prepared and used a validated and reliable questionnaire appropriate to the study requirements (See Appendix A), and conducted personal interviews by telephone to obtain data. During the phone interviews, the researcher probed to determine the extent of the subjects' breadth, depth, and application of knowledge of steps six through twelve of the AA treatment program. The questionnaire provided a multiple means of assessing the utilization of steps six through twelve of the 12 step AA program after the

alumnus had completed inpatient treatment. The person being interviewed was encouraged to ask the interviewer any questions as to the use of the survey, and any personal questions about the interviewer's qualifications educationally or personally. The researcher obtained permission from all the subjects.

The researcher then determined to what degree steps six through twelve of the 12 step program are being used. To check the validity of the information obtained, the investigator consulted with each subject and informed them of the conclusions obtained by the questionnaire. If the subject felt these conclusions were erroneous, then further investigation was done. The research also determined which of the steps six through twelve is most likely to be utilized by all subjects, as well as by gender, age, marital status, and level of education. This was done utilizing a frequency distribution. The researcher employed a Spearman test to determine if there is a significant relationship between the extent of utilization of each of the steps six through twelve and the subjects' gender, age, marital status, and educational level.

In addition, the researcher used multiple means to analyze the data in this study. The frequency-of-use on steps six, seven, eight, and nine, were measured as a dichotomous variable. A chi-square test was used to discern if there were differences in the step completion rates depending on gender, age, marital status, and education level. On steps ten, eleven, and twelve the researcher utilized a continuous variable for frequency-of-use, and a one-way analysis of variance to determine if there were differences in frequency-of-use depending on gender, age, marital status, and level of education.

Treatment Program

The subjects in the present study were graduates of an accredited 28-day residential treatment center for alcoholism and substance abuse in California. This program draws most of its patients from California along with many patients who give addresses in all other states in the U.S., and there is a broad representation from foreign countries. The treatment center is housed in a modern facility on the grounds of a major internationally recognized medical complex. It is organized as a non-profit corporation. While the treatment center does make arrangements for low-income patients, third party payments are received by the treatment center for most patients. In the past year, due to problems with insurance coverage for alcoholism and chemical dependency, there has been a heightened interest in attracting more "self pay" patients. The treatment center does not accept patients who cannot arrange payment for treatment.

The treatment center uses the disease model of addictions and is clinically organized as a "Minnesota Model" for treatment. The fundamental principles of the "Minnesota Model," again, are honesty and the acceptance of responsibility for behaviors, and the avoidance of blaming, comparisons, and over-dependence on individual "will power" in coping with alcoholism or chemical dependency. The treatment center's stated goal for all patients is abstinence from alcohol and other mind-altering substances for life.

The patient upon arrival completes an intake interview and medical assessment and enters the detoxification phase of treatment. This process is considered complete on the

advice of the medical staff. A complete medical physical is given along with a comprehensive psychological examination which includes psychological testing. If the patient is judged appropriate for treatment he is assigned a primary treatment counselor and placed in one of the four residential treatment units. If the patient is deemed inappropriate for the treatment center, a clinical referral is provided by the staff.

Prior to admission the patient is required to agree to the treatment goals of the center, and indicates in writing that he or she will comply with the program rules and take positive direction.

In both the residential and out-patient programs the patients must take an active part in therapy process groups, attend lectures on alcoholism and substance abuse, and take direction from their assigned primary counselor. Attendance is required at all activities including in-house AA-type meetings, exercise and recreational activities. Patients operate out of, and are responsible to, a small therapy group, approximately seven people, and their residence hall, which is made up of twenty-one patients.

In order to "graduate" from the treatment center, the patient must have successfully addressed the major issues in his life, completed the first five steps of the AA 12 Step treatment program, and participated in "family week." Because the Minnesota Model recognizes that alcoholism and chemical dependency profoundly affect families, it requires families, or what this model calls "significant others," to participate in the recovery process to resolve family issues caused by the patient's alcoholism or chemical dependency.

Inpatient residential and outpatient treatment is completed upon graduation. The patients in this study all participated in the inpatient residential type of treatment setting. The patient, upon graduation, continues the recovery process with the advice and referral of the aftercare staff. This referral can be to an extended treatment program or to AA, whichever is judged appropriate by the primary counselor, aftercare counselor, and the patient. If the choice is a return home, arrangements are made for counseling near the patient's neighborhood. At this point, the patient is considered an alumnus of the treatment center, and, if referred home or to another treatment program, the patient is given the name of an alumni contact person at their destination to assist them in their transition to the next phase of treatment. The alumnus is also be contacted and the name of the patient and date of arrival provided.

The treatment center monitors patients after discharge to give assistance where necessary. The treatment attempts to maintain contact for about one year. The alumni association maintains contact with the new alumni. This contact continues for life. As part of the patient's aftercare, he is instructed to attend AA and complete the 12 Step AA treatment program, contact the alumni representative and remain abstinent from alcohol and other mind-altering substances.

Sample Selection

The researcher had at his disposal lists of graduates from the treatment center that were carried on the rolls of alumni chapters in California. The researcher did not know the listed alumni's length of continuous abstinence beyond the requirement of one year's sobriety. Though the treatment center has discharged over 7,000 patients giving a California address, the researcher's available lists contained approximately 1,000 names.

From these alumni lists, 25 men and 25 women were selected for this study that fit the parameters for usable subjects. The process of selection was designed to achieve a random selection from the available names. The alumni names were segregated into two groups, one male and one female. Each alumni (potential study participant) was assigned a number. The researcher randomly drew a number from 1 to approximately 1,000 and matched it to the number on one of the two alumni lists, and that name and phone number was placed on a list of potential study subjects. This process continued until 25 men and 25 women were selected.

From these two lists, one male and one female, the researcher attempted to contact the alumnus by telephone. If the alumnus could not be contacted, could be contacted but did not meet subject parameters, or was not interested in being a subject in the study, the name was discarded. When a name was discarded it was replaced by a new drawing and name selection. This process continued until 25 men and 25 women were identified who met study guidelines and were willing to participate in the study.

Each of the potential research subjects was sent a written explanation of the proposed investigation and a consent form to be signed and returned using a stamped self-addressed envelope that was enclosed. The potential subject was to indicate an appropriate time and day when the researcher could call and complete the survey, allowing approximately one half hour for the interview. Approximately 76 percent of the potential subjects returned their form by this process. The subjects who did not return their forms were contacted by telephone and given a reminder to do so. This activity netted another 18 percent of potential participants. A reasonable amount of time was allowed to elapse and the approximately 6 percent who did not return their forms were replaced using the original method.

Project Design

Issues of validity and reliability were major priorities in the design of this study. Because the population studied can be secretive and dishonest by choice or by organic impairment, care was taken to address this issue in the original design, and certain steps were taken to ensure quality and that the information gained was understandable and usable by non-professional decision makers and professionals alike.

The first consideration was simplicity. As noted earlier, the field of alcoholism can be confusing to the most qualified student. To be useful to the non-professional decision maker, only a single very simple issue was addressed: Are the last seven steps of the AA 12 Step treatment program in general use by graduates of 28-day treatment programs for

alcoholism that consider themselves members of AA? In designing an instrument to obtain insight into this question, simplicity continued to be a priority. Because of the controversial nature of this study's subject, any information generated can be expected to undergo substantial challenges. Therefore, the instrument was kept as simple as possible so that study could be easily repeated.

Secondly, substantial measures were taken in approaching the issue of validity when collecting self-reporting data from the subject population because of its preconceived historic poor performance. The researcher did not find any substantial information as to whether a member of this subculture is more or less successful at discerning dishonesty or honesty when he or she is the investigator.

The issue of self-reported data was pivotal to this study and most research in the field of alcoholism "hinges on the accuracy of these reports" (Watson, Tilleskjor, Hoodecheck-Schow, Pucel, & Jacobs, 1984, p. 344). Lull (1988) identified four problems with self-reported data: conscious dishonesty on the subject's part, the effects of denial, the immediate effects of intoxication, and the long-term effects of organic impairment due to alcohol consumption. Conscious dishonesty and the long-term effects of organic impairment due to alcohol consumption were seen, by this investigator, as the most pressing areas of concern in this study. Lull (1988), however, in his extensive investigation on the subject of conscious dishonesty, stated his opinion flatly: "Alcoholics are unlikely to hide undesirable information" (pg. 345). And Sobell and Sobell, (1978), Maisto, Sobell, and Sobell, (1979), and Sobell and Sobell (1981) substantiate Lull's

observations. This was encouraging to this investigator, but several steps were incorporated into the study to cross-reference the collected data.

The final issue taken into consideration was the accessibility of future research populations for other researchers. Alcoholics Anonymous groups are found in even the most sparsely populated areas of the country, and many of their members have been associated with treatment centers using the Minnesota Model for treatment. This situation presents an opportunity for researchers in different areas of the country to repeat this inquiry.

Instrument Design and Validation Panel

The instrument used was specifically designed for the purpose of the study. The questionnaire used attempted to approach the subject of the inquiry from several different perspectives. The first six questions (out of 22) of the study instrument address general demographic factors that were incorporated into the study. These were simple uncomplicated questions that were easy to answer and served as an introduction into the instrument. This portion of the survey was designed to put the subject at ease and give him or her an opportunity to give correct answers. (A copy of the questionnaire can be found in Appendix A.)

The next thirteen questions addressed the issue of level of personal activity in working with the last seven steps of the 12 Step AA treatment program. The researcher made several assumptions that were seen to be helpful. The investigator divided the work

involved in any one step into three activities. The first activity for successful compliance was a learning phase, the second was an action phase, and the third was a teaching or instructional phase. This last phase is pivotal in the AA 12 Step treatment program, for in this fellowship of lay helpers the knowledge of the step allows the member to "pass it on." Looking at all three phases separately gave the researcher the opportunity to address the validity of a positive compliance answer three times. For any one of the phases to be missing indicated that the subject did not complete the step.

The last three questions in the survey approached the issue of validity from a different perspective. These three questions concern themselves with how the subject perceives the use of the 12 Step treatment program by his or her fellow AA members. If the researcher found that the subject group was indicating that it was successfully completing the treatment regime, while at the same time the culture of AA was perceived as having a low level of activity, this would be an indication that the questionnaire's basic validity should be questioned. If the reverse of this situation were discovered, the same question would arise.

The second stage of the design process was to submit the proposed questionnaire to a validity panel. The panel was made up of eight recovered alcoholics that were or had been employed as counselors in treatment centers for alcoholism and chemical dependency, as well as several professionals familiar with the issue of research instrument validity. They were asked to evaluate the instrument and give suggestions for improvement. The eight members who were or had been involved professionally with the recovery industry

indicated that the questions on the instrument were appropriate and that a subject was capable of answering the questions without difficulty. From the non-alcoholic members several suggestions were proposed, among them that a series of exploratory questions be developed to challenge answers of the subject could directly approach the issue of validity.

These questions would not appear on the questionnaire. The second suggestion was to develop a scale that would numerically express degrees of compliance. Because the researcher made the decision that a subject was in one of two positions with any step, either finished or not finished, however, the degree of compliance with any one step was not seen as necessary for the survey. The first suggestion, to develop ancillary questions to probe compliance when affirmative answers were given or to explore judgement on the part of the subject, was seen as useful and incorporated into the study. A series of questions were developed that were used in the interview process and were found to be valuable. A discussion of this validation process is outlined below.

The final stage of development of the instrument's validity was to test it on a sample population. The population chosen exhibited the same characteristics of the population to be studied. There were ten individuals that agreed to answer the survey questions. These individuals were physically located in the researcher's immediate area. On completion of the questionnaire the test group was asked if they could supply the investigator with the names of specific people who had firsthand knowledge of their activity and could validate their answers. Because the researcher is well-known in this area, eight individuals in the group agreed and supplied names that would give testimony to their specific answers. The

researcher found a general collaboration to the answers given by the test group. Though not a critical scientific survey, it did indicate to the researcher that the answers given represented a high degree of validity.

Validation Questions

The first five questions of the survey were unchallenged. A series of probing questions were developed to explore answers given on the survey when there was a level of activity specifically indicated, an affirmative answer given for an activity and a specific perception of the activities of other members of AA. Probing questions were not used when the subject indicated that there was no specific activity. The following is a representation of the specific instrument questions and the probing validation questions that were used for each. Following each instrument question there is included a short note to clarify the specific issue. A worksheet was developed and used during each interview, providing a check-off for each probing question to assist the interviewer. This worksheet is included in Appendix B.

Question 6: How many months have you been free of alcohol and other mind-altering substances?

This is an issue of personal self honesty at the highest level to a member of Alcoholics Anonymous. It is generally celebrated and considered the one absolute in AA.

Probing questions:

1. Where did you take your last drink?

2. Have you ever experienced a relapse? If so, when?
3. Who gave you your (year) cake?
4. Where did you celebrate your (year number) anniversary?

Question 7: Did your treatment center give you specific instructions to attend Alcoholics Anonymous?

Inpatient treatment using the "Minnesota Model" for treatment supports AA activities post-treatment.

Probing questions:

1. Who at your treatment told you?
2. When in treatment were you told?
3. Were you told how to find your first meeting after you left treatment?
4. Was attending AA part of your aftercare plan?

Question 8: Did you complete the first five steps of Alcoholics Anonymous at your treatment center?

This is a general requirement for graduation for individuals attending treatment centers that use the "Minnesota Model" for treatment.

Probing questions:

1. Who helped you with Steps 1 to 3?
2. What did you do with your 4th Step inventory.
3. Who took it with you?
4. Who did you give your 5th Step to?

Question 9: Do you consider yourself a member of Alcoholics Anonymous?

A person is a member of AA when he or she attends with a desire to stop drinking or maintain sobriety.

Probing questions:

1. When was your last AA meeting?
2. Where do you go?
3. What type of meetings do you usually attend?
4. Why do you consider yourself a member of AA?

Question 10: How many Alcoholics Anonymous meetings do you attend each month?

There is no set number of meetings to be attended. This is left up to the individual.

When a person leaves treatment they are often told to attend 90 meetings in 90 days. This is called "doing 90 in 90."

Probing questions:

1. How many meetings a week are you comfortable with?
2. Do you need to go to more meetings? What does your sponsor say about your attendance?
3. Do you go with anyone?
4. Do you go to the same meeting all the time? Where is your home group?

Question 11: Were you given specific instruction by your treatment center to complete steps 6 through 12 of the Alcoholics Anonymous 12 Step program in AA?

The first five steps are completed at the treatment center that uses the "Minnesota Model" treatment regime.

Probing questions:

1. Who at your treatment center instructed you to do this?
2. What week were you in when you were told?
3. Was the instruction in lecture or individually?
4. Was this directive in your aftercare plan?

Question 12: Which of the steps 6 through 12 have you been given specific instructions on how to complete?

The first five steps are completed at the treatment center that uses the "Minnesota Model" treatment regime.

Step 6 tells the individual to look back over Steps 1 through 5 and determine if he or she is satisfied with what they have completed. A yes answer signifies a completion of Step 6.

Probing questions:

1. Who gave you instruction on this step?
2. Was this after you completed your 5th Step?
3. Where were you when you received instruction?
4. Where in the Big Book do you find the 6th Step?

Step 7 tells the individual to turn over his or her character defects to a power greater than themselves. These problem areas were discovered in steps 4 and 5. The individual can also ask for the faith to turn them over.

Probing questions:

1. Who gave you instruction on this step?
2. How was the instruction given?
3. How much space is given to this step in the Big Book?
4. What is the 7th Step Prayer?

Step 8 tells the individual to identify and make a list of the people that he or she has harmed and be willing to make amends. This list is derived from the 4th and 5th Steps.

Probing questions:

1. Where does the list come from?
2. Who gave you instruction on this step?
3. Where is it found in the Big Book?
4. How much space is given to this topic in the Big Book?

Step 9 instructs the individual to make amends to people that he or she has harmed. There is a lengthy explanation in the Big Book of do's and don'ts because this can be a dangerous undertaking for the individual and to others.

Probing questions:

1. What are the dangers in this step?
2. Who gave you instruction on this step?

3. Can you start Step 10 and 11 before you finish with this step?

4. How much space is given in the Big Book to this step?

Step 10 instructs the individual to take a daily inventory of his or her action and thoughts. It also instructs the individual to make amends immediately when the individual has harmed another person. This step is referred to as one of the two maintenance steps.

Probing questions:

1. Who gave you instruction on this step?

2. Had you finished step 9 before you started this step?

3. How often is this step practiced?

4. What are the 10th and 11th steps called?

Step 11 instructs the individual to pray and meditate each day. The Big Book gives the individual one prayer and suggests meditation in which the individual "turns his mind off."

Probing questions:

1. What is the prayer and how often is it to be used?

2. Who gave you instruction on this step?

3. What is meditation?

4. Who was your instructor?

Step 12 is about helping other alcoholics or what is known as carrying the message of recovery to alcoholics that are still suffering.

1. What is your idea of 12 Step work?

2. Who can do step work?
3. Who explained to you what you were supposed to do?
4. What does the Big Book say about this step?

Question 13: Which steps have you completed in the series of steps 6 through 9?

This series of steps is completed once and not repeated. See question number 12 for a review of each step.

Step 6. See question number 12 (Step 6) for a review of this step.

Probing questions:

1. Did you complete this step alone?
2. How long did it take you to complete it?
3. In reference to step six what does the Big Book say?
4. Where were you when you completed this step?

Step 7. See question number 12 (Step 7) for a review of this step.

Probing questions:

1. Did you complete this step alone?
2. What did you do to complete it?
3. What is the Seventh Step prayer?
4. Where were you when you completed this step?

Step 8. See question number 12 (Step 8) for a review of this step.

Probing questions:

1. How many items did you have on your list?

2. What did you do to complete it?
3. How long did it take to complete it?
4. Where were you when you completed this step?

Step 9. See question number 12 (Step 9) for a review of this step.

Probing questions:

1. Are you finished with all the items on your list?
2. What types of things did you hesitate to do?
3. How long did it take you to complete this step?
4. Did you have any major problems?

Question 14: Which of the steps 6 through 9 do you understand well enough to teach to another AA member?

This activity is to be repeated with members that need assistance. See question number 12 for a review of each step.

Step 6. See question number 12 (Step 6) for a review of this step.

Probing questions:

1. How many people have you taken through Step 6?
2. What were the problems you have discovered teaching this step?
3. Do your students understand this step quickly?
4. Are you with the person when he or she is taking this step?

Step 7. See question number 12 (Step 7) for a review of this step.

Probing questions:

1. How many people have you taken through Step 7?
2. What were the problems you have discovered teaching this step?
3. Do your students understand this step quickly?
4. Are you with the person when he or she is taking this step?

Step 8. See question number 12 (Step 8) for a review of this step.

Probing questions:

1. How many people have you taken through Step 8?
2. What were the problems you have discovered teaching this step?
3. Do your students understand this step quickly?
4. Are you with the person when he or she is taking this step?

Step 9. See question number 12 (Step 9) for a review of this step.

Probing questions:

1. How many people have you taken through Step 9?
2. What were the problems you have discovered teaching this step?
3. Do your students understand this step quickly?
4. Are the people that you have helped afraid of this step? If so, why?

Question 15: How many times a month do you formally use step 10?

Step 10. See question number 12 (Step 10) for a review of this step.

Probing questions:

1. At the end of the day, how much time is spent on this step?
2. Do you make amends the next day if you can?

3. Where do you do it?
4. Do you write your inventory?

Question 16: Do you understand step 10 well enough to teach it to another AA member?

Step 10. See question number 12 (Step 10) for a review of this step.

Probing questions:

1. What is the biggest problem your student has?
2. What questions do you hear most often?
3. Do you check up on your student's progress?
4. Do you have any suggestions for teaching this step?

Question 17: How many times a month do you formally use step 11?

Step 11. See question number 12 (Step 11) for a review of this step.

Probing questions:

1. What method do you use for your meditation?
2. Where do you usually do this step?
3. Do you get any results?
4. What is hard about this step?

Question 18: Do you understand Step 11 well enough to teach it to another AA member?

Step 11. See question number 12 (Step 11) for a review of this step.

Probing questions:

1. What is the biggest problem your students have?
2. What questions do you hear most often?
3. Do you check up on your students progress?
4. Do you have any suggestions for teaching this step?

Question 19: How many times a month do you participate in activities that are specifically designed to give assistance to alcoholics that are still drinking as referenced in Step 12?

Step 12. See question number 12 (Step 12) for a review of this step.

Probing questions:

1. What do you do?
2. Do you go alone?
3. Do you receive assistance from the AA Central Office?
4. Are your efforts institutional or personal?

Question 20: How many people do you personally know that have completed the first nine steps of the 12 Step program and use Steps 10, 11, and 12 as directed?

This is not an intuitive question. The researcher is looking for the actual people the subject knows personally.

Probing questions:

1. Are the people living in your own community?
2. Can you give their first name?
3. How do you know?

4. Are they active in Alcoholics Anonymous?

Question 21: How many people do you personally know that can teach all 12 steps of Alcoholics Anonymous to a new member?

This is not an intuitive question. The researcher is looking for the actual people the subject knows personally.

Probing questions:

1. Are these people living in your own community?
2. Can you give their first name?
3. How do you know?
4. Are they active in Alcoholics Anonymous?

Question 22: Rated on a scale from 0 (no one) to 100 (every one), what percentage of the members of AA, would you estimate, are actively working on and completing the 12 Step program of AA?

This is an intuitive question taken from the experience of the subject.

Probing questions:

1. How did you come to your conclusion?
2. What qualifies you to make your estimate?
3. Do you believe that others think the same as you?
4. Have you ever talked about this subject to any one else?

Telephone Interviews

All interviews in this study were conducted by telephone because the study subjects were located throughout California. Interviews averaged thirty minutes in length. An example of a typical interview can be found in Appendix C. This transcribed interview was randomly selected by a coin flip to determine whether the presented transcription was to be with a male or a female. Using this method the subject selected was a male. The interview was predetermined by putting the numbers 1 to 25 in a container and drawing out one number. The number 17 was drawn. Therefore, Appendix C is the interview of the seventeenth male interviewed for the study. The specific answers given here are in no way to represent anything other than an example of interview style and format. Due to limited space there was some editing to remove material that was not directly linked to the research questions. Examples of the type of material that was part of each interview were the following: 1. Common AA experience; 2. Common treatment center experience; 3. Common acquaintances; 4. Anonymity; 5. What the study was for and how the information will be used; 6. An invitation to ask the interviewer questions at any time; and 7. That the interview would be immediately stopped if the person being interviewed became uncomfortable. In the case of this interview, permission was given to tape the conversation.

Research Questions

The mean age and the median age, and the mean and the median education level of the subjects were determined. The Kolmogorov-Smirnov statistic for normality was used.

One of the criteria used for sample selection in this study was that the subjects are free from alcohol and other mind altering substances for at least one year. The mean average and the median length of sobriety was determined. The Kolmogorov-Smirnov statistic was used to show the distribution around the mean. The mean length of sobriety for men and for women was determined. A comparison between married subjects and single subject was drawn.

Research Question One

The first research question was: To what degree does the sample understand and practice the AA 12 Step program?

The researcher determined what percentage of the subjects consider themselves members of Alcoholics Anonymous. The distribution was addressed, and the Kolmogorov-Smirnov statistic was applied.

This study selected subjects that have been drug-free for at least one year, and provided the range with respect to how long the population has been sober and subjects ability to teach it to others was addressed as an indication of basic knowledge.

Subjects were asked how many times a month they formally used Steps 10 and 11, and whether they knew the steps well enough to teach them to other AA members.

The question concerning subject participation in activities designed to give assistance to alcoholics was addressed (as referenced in Step 12). The median was addressed along with an indication of skewness, and kurtosis. The Kolmogorov-Smirnov statistic was applied for an indication of normality.

Subjects were asked to indicate what percentage of the members of AA they estimated were actively working on and completing the 12 step program and how many people they knew that could teach all 12 steps to a new member. The mean average estimate and the median was determined. Subjects were also asked how many people they knew who had completed the first nine steps and were currently using steps 10, 11, and 12 as directed; from this the mean and the median were determined.

Research Question Two

To determine whether there are significant relationships between selected demographic variables (gender, marital status, age, and education) and whether or not a subject had completed steps 6 though 9 of the AA program, four contingency tables were constructed for each demographic variable (one for each of the four steps) and the chi-square statistic was used to test for a relationship. Two of the demographic variables were ratio scaled (age and education) and were recoded into categories for the contingency table analyses. The age variable was dichotomized into two groups based on the median, and the education variable was trichotomized (high school, some college, and college graduate). The desired critical alpha level for this study initially will be .05. Since four tests will be

performed for each demographic variable, the critical alpha level may be adjusted in accordance with Bonferroni's theorem. Yate's correction for continuity was used for the tables involving gender, marital status, and age. The chi-square statistic was computed for each of the 16 contingency tables.

Research Question Three

To address the relationships among selected demographic variables (gender, marital status, age, and education) and the frequency that subjects participated in steps 10, 11, and 12 of the AA program, a stepwise multiple regression was used. Three regression models were examined, one for each step. The dependent variable was the frequency (number of times per month) that a subject formally used the step. The independent variables were the demographic variables. Since there were three regression models, the critical alpha level for the F-ratio will be adjusted to .0167 (.053) in accordance with Bonferonni's theorem. The stepwise method was used to include only those variables that significantly impacted the dependent variable and eliminate those variables that were not making a contribution to the model. The result of the stepwise procedure is to improve the overall stability of the model.

The dependent variable for the first model was the frequency of use for step 10. No independent variables were stepped into the model. Four demographic variables were forced into the model to determine the overall F-ratio for the regression, and the corrected r-squared statistic was .0000 (corrected for N's less than 100).

The dependent variable for the second model was the frequency of use for step 11. Marital status was the only independent variable stepped into the model. The overall F-ratio for the regression was assessed, and the variability in the frequency of use for step 11 may be explained by knowing a subject's marital status. A corrected r-squared was used.

The dependent variable for the third model was the number of times a month that the subject participated in activities designed to give assistance to alcoholics as referenced in Step 12. Education was the only variable that was stepped into the model, and the F-ratio and the significance at the critical alpha level was addressed. The corrected r-squared should indicate if the model explained the percent of the variability in the dependent variable if one exists.

There is one question that is of interest to this researcher that falls outside the three research questions presented. That is, whether there is any factor that improves the ability to predict frequency of use for steps 10, 11, and 12

The regression analyses of gender, marital status, age, and education were used as predictors of the frequency of use for steps 10, 11, and 12 of the AA program. To determine if there is anything that improves our ability to predict frequency of use, the same three regression analyses were repeated, except that the number of months the subject had been chemical free was also included as an independent variable. The results of the stepwise regression were identical for steps 10, 11, and 12. The number of months that the subject had been chemical free was not stepped into any of the models.

In a final attempt to improve the three regression models, three additional independent variables were added. The first was the number of people whom subjects knew who had completed the first nine steps and who were currently practicing steps 10, 11, and 12 as directed. The second was the number of people that subjects knew who could teach all 12 steps to a new Alcoholics Anonymous member. The third was the number of AA meetings attended per month.

None of the new independent variables was stepped into the regression models for steps 10 or 11. However, one of these variables was stepped into the model for Step 12 and may explain the variability in the dependent variable. This was the number of people whom subjects knew who could teach all 12 steps. The number of AA meetings that study subjects attend was compared to the frequency of participation in steps 10, 11, or 12.

CHAPTER IV

RESULTS

Characteristics of the Sample

The sample for this study consisted of 25 men and 25 women who met the six criteria for inclusion in this research. All 50 subjects considered themselves alcoholics. The mean age of the subjects was 49.1 years ($SD=11.9$), and the median was 47 years. The Kolmogorov-Smirnov statistic for normality indicated that the ages were normally distributed around the mean ($KS=.065$, $p>.05$). There was only a small difference in the mean ages for men and women (50.2 and 48.0, respectively).

A little over half (56.0%) of the subjects were married. This percentage was identical for male and female subjects.

The mean education level of subjects was 14.8 years ($SD=2.5$), and the median was 14 years. The distribution had normal kurtosis ($K=3.1$), although there was considerable positive skewness ($SK=.74$). The Kolmogorov -Smirnov statistic confirmed the non-normality of the distribution ($KS=1.37$, $p<.01$). Men appeared to have somewhat higher education levels than women (15.7 years and 14.0 years, respectively).

One of the criteria used for sample selection in this study was that the subjects were free from alcohol and other mind-altering substances for at least one year. There was a wide range in substance-free duration ranging from 1 to 11 years. The mean average length of sobriety was 57.8 months ($SD=35.0$), and the median was 53.5 months (about five years). The Kolmogorov-Smirnov statistic showed that the distribution was normally

distributed around the mean ($KS=.68$, $p>.05$). The mean length of sobriety for men was 52.6 months ($SD=31.1$), and for women it was 62.9 months ($SD=38.5$). Married subjects were sober for 64.8 months ($SD=37.6$), while single subjects had been sober for only 48.8 months ($SD=29.8$).

Research Questions

Research Question One

The first research question was To what degree does the sample understand and practice the AA 12 step program?

Nearly all subjects (98.0%) considered themselves a member of AA, and nearly all (94.0%) had completed the first five steps at the treatment center. Ninety percent said that the treatment center had given them specific instructions to attend AA. The average number of AA meetings attended each month was 15.6 ($SD=11.0$), and the median was 12. The distribution was positively skewed ($SK=.76$), and the Kolmogorov-Smirnov statistic indicated that the distribution was non-normal as a result of the skewness ($KS=1.08$, $p>.01$).

Nearly two-thirds (62.5%) of the sample said that the treatment center had told them to complete steps 6 through 12 of the AA program. However, a smaller percentage reported actually receiving specific instructions on how to complete the steps. Table One shows the percent of subjects who said they had been given specific instructions on how to complete steps 6 through 12.

Table One

Number and percent of subjects who said they had been given specific instructions on how to complete steps 6 through 12

<u>Step</u>	<u>Number</u>	<u>Percent</u>
6	18	36%
7	18	36%
8	19	38%
9	19	38%
10	12	24%
11	10	20%
12	10	20%

This study selected subjects who had been drug-free for at least one year, but there was a wide range with respect to how long they had been sober. Therefore, as expected, there was a declining completion rate for steps 6 though 9 (some subjects had not been in the program long enough to complete the higher steps). Even when a subject had completed a step, it was no guarantee that she would be able to teach it to others. A smaller percentage of subjects stated that they would be able to teach the steps to others. Table Two shows the completion rates for steps 6 though 9 compared to the percentage that said they understood the steps well enough to teach to others.

Table Two

Number and percent of subjects who said they had completed steps 6 though 9 of the Alcoholics Anonymous program compared to the number and percent who said they knew the steps well enough to teach to others

<u>Completed step</u>		<u>Know step well enough to teach others</u>		
<u>Step</u>	<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>
6	40	80%	27	54%
7	37	74%	24	48%
8	32	64%	27	54%
9	27	4%	25	50%

Subjects were asked how many times a month they formally used steps 10 and 11, and whether they knew the steps well enough to teach them to other Alcoholics Anonymous members. Table Three shows the number and percent who practiced steps 10 and 11 at least once per month, and the mean average times per month and the standard deviation for both steps. It also shows the number and percent reporting that they knew the step well enough to teach it to others. As expected, the means and percents were smaller for step 11.

Table Three

Mean number of times that subjects practiced steps 10 and 11 each month, and the number and percent who said they knew the steps well enough to teach other Alcoholic Anonymous Members

<u>Practiced at least once per month</u>		<u>Number of times per month</u>			<u>Know step well enough to teach others</u>	
<u>Step</u>	<u>Number</u>	<u>Percent</u>	<u>Mean</u>	<u>SD</u>	<u>Number</u>	<u>Percent</u>
10	27	54%	8.1	11.3	28	56%
11	11	22%	4.1	9.9	10	20%

On the average, subjects participated in activities designed to give assistance to alcoholics (as referenced in step 12) 3.1 times per month ($SD=7.4$). The median was zero. The distribution had high positive skewness ($SK=2.69$) and high kurtosis ($K=9.08$). The Kolmogorov-Smirnov statistic indicated a high degree of non-normality ($KS=2.6$, $p<.01$). The majority of subjects did not participate in any step 12 assistance activities, and a few subjects participated in many (range=0 to 30).

Subjects were asked to indicate what percentage of the members of AA they estimated were actively working on and completing the 12 step program. The mean estimate was 19.3% ($SD=20.1$), and the median was 10. They were also asked how many people they knew who had completed the first nine steps and were currently using steps 10, 11, and 12 as directed. The mean was 12.2 people ($SD=37.3$), and the median was 3. The large disparity between the mean and median indicates that most subjects only knew a few people (3 or less), while a few subjects knew substantially more. Subjects were also

asked how many people they knew that could teach all 12 steps to a new member. The mean number of people was 17.1 ($SD=39.5$), and the median was 7.5. Again, the large disparity between the mean and median indicates that most subjects knew relatively few people that could teach all 12 steps, and a few subjects knew substantially more.

Research Question Two

The second research question was Are there significant relationships between selected demographic variables (gender, marital status, age, and education) and whether or not a subject had completed steps 6 though 9 of the AA program?

In order to test this question, four contingency tables were constructed for each demographic variable (one for each of the four steps) and the chi-square statistic was used to test for a relationship. Two of the demographic variables were ratio scaled (age and education), and were recoded into categories for the contingency table analyses. The age variable was dichotomized into two groups based on the median (less than 47 years and 47 or more years), and the education variable was trichotomized (high school, some college, and college graduate). The desired critical alpha level for this study was .05. However, since four tests were performed for each demographic variable, the critical alpha level was adjusted to .0125 (.054) in accordance with Bonferroni's theorem. Yate's correction for continuity was used for the tables involving gender, marital status, and age. Table Four shows the frequency distributions for all 16 contingency tables.

Table Four

Contingency tables to examine the relationship between the completion of steps 6 through 9 and selected demographic variables									
	<u>Gender</u>		<u>Marital Status</u>		<u>Age</u>		<u>Level of Formal Education in Years</u>		
	<u>Male</u>	<u>Female</u>	<u>Single</u>	<u>Married</u>	<u><47 yrs.</u>	<u>47+ yrs</u>	<u>High School</u>	<u>Some College</u>	<u>College Graduate</u>
Have you completed step 6?									
Yes	21	19	17	23	20	20	10	16	14
No	4	6	5	5	3	7	1	5	4
Have you completed step 7?									
Yes	20	17	17	20	19	18	8	16	13
No	5	8	5	8	4	9	3	5	5
Have you completed step 8?									
Yes	17	15	14	18	15	17	6	15	11
No	8	10	8	10	8	10	5	6	7
Have you completed step 9?									
Yes	15	12	12	15	13	14	6	12	9
No	0	13	10	13	10	13	5	9	9

The chi-square statistic was computed for each of the 16 contingency tables. None of the chi-square statistics was significant (or close to significant) at the .0125 alpha level.

Therefore, we conclude that completion of steps 6, 7, 8, and 9 was not related to gender, marital status, age, or education level. Table Five shows the chi-square statistic and probability for each of the tables.

Table Five

Chi-square analysis examining the relationship between the completion of steps 6 though 9 and selected demographic variables

<u>Variable Pair</u>	<u>Chi-Square</u>	<u>DF</u>	<u>Prob.</u>
Completed Step 6 BY Gender	0.1250	1	.7237
Completed Step 7 BY Gender	0.4158	1	.5190
Completed Step 8 BY Gender	0.0868	1	.7683
Completed Step 9 BY Gender	0.3221	1	.5704
Completed Step 6 BY Marital Status	0.0051	1	.9432
Completed Step 7 BY Marital Status	0.0204	1	.8864
Completed Step 8 BY Marital Status	0.0621	1	.8031
Completed Step 9 BY Marital Status	0.0472	1	.8280
Completed Step 6 BY Age	0.6089	1	.4352
Completed Step 7 BY Age	0.9166	1	.3384
Completed Step 8 BY Age	0.0169	1	.8965
Completed Step 9 BY Age	0.0021	1	.9637
Completed Step 6 BY Education	1.0642	2	.5874
Completed Step 7 BY Education	0.0912	2	.9554
Completed Step 8 BY Education	0.9949	2	.6081
Completed Step 9 BY Education	0.2008	2	.9045

Research Question Three

The third research question was Are there significant relationships between selected demographic variables (gender, marital status, age, and education) and the frequency that subjects participated in steps 10, 11, and 12 of the AA program?

Stepwise multiple regression was used to explore this research question. Three regression models were examined, one for each step. The dependent variable was the frequency (number of times per month) that the subject formally used the step. The independent variables were the demographic variables. Since there were three regression models, the critical alpha level for the F-ratio was adjusted to .0167 (.053) in accordance with Bonferonni's theorem. The stepwise method was used to include only those variables that significantly impacted the dependent variable and eliminate those variables that were not making a contribution to the model. The result of the stepwise procedure is to improve the overall stability of the model.

None of the models achieved significance at the .0167 alpha level. Thus, the conclusion is that gender, marital status, age, and education are not significantly related to the frequency of use for steps 10, 11, and 12 of the AA program. There were, however, a couple of interesting near-significant relationships.

The dependent variable for the first model was the frequency of use for step 10. No independent variables were stepped into the model. When all four demographic variables were forced into the model, the overall F-ratio for the regression was not significant, $F(4,44)=.8678$, $p=.4908$, and the corrected r-squared statistic was .0000 (corrected for N's less than 100), we can conclude that the frequency of use for step 10 is not significantly related to any of the demographic variables.

The dependent variable for the second model was the frequency of use for step 11. Marital status was the only independent variable stepped into the model. The overall

F-ratio for the regression was near-significant, although it did not meet the adjusted critical alpha level of .0167, $F(1.47)=4.9318$, $p=.0312$. The corrected r-squared indicated that 7.57% of the variability in the frequency of use for step 11 could be explained by knowing a subject's marital status. Subjects who were single tended to practice step 11 more often than those who were married, although caution should be observed since the probability of the F-ratio was higher than the critical alpha level. Table Six shows the regression statistics for the model.

Table Six

Regression statistics for the frequency of use for the Step 11 model

<u>Variable</u>	<u>Coeff.</u>	<u>Beta</u>	<u>F-ratio</u>	<u>Prob.</u>	<u>Std. Error</u>
Marital Status	-6.1190	-0.3082	4.9318	0.0312	2.7554
Constant	7.6190		0.6016	0.4419	9.8231

NOTE: Marital status was coded 1=Married and 0=Single.

The dependent variable for the third model was the number of times a month that the subject participated in activities designed to give assistance to alcoholics as referenced in step 12. Education was the only variable that was stepped into the model, although the overall F-ratio was not significant at the critical alpha level, $F(1,48)=4.0232$, $p=.0505$. The corrected r-squared indicated that the model explained 5.81 percent of the variability in the dependent variable. Subjects with higher education tended to practice step 12 more frequently than those with lower education, although caution should be observed because the F-ratio was not significant. Table Seven shows the regression statistics for the model.

Table Seven

Regression statistics for the frequency of use for the Step 12 activities model

<u>Variable</u>	<u>Coeff.</u>	<u>Beta</u>	<u>F-ratio</u>	<u>Prob.</u>	<u>Std. Error</u>
Education	0.8292	0.2781	4.0232	0.0515	0.4134
Constant	-9.1494		1.5502	0.2192	7,3486

NOTE: Education was the number of years of formal schooling completed.

Additional Findings

It is clear from the previous regression analyses that gender, marital status, age, and education were not predictors of the frequency of use for steps 10, 11, and 12 of the AA program. The question then becomes, is there anything that improves our ability to predict frequency of use?

The same three regression analyses were repeated, except the number of months that the subject had been chemical free was also included as an independent variable. The results of the stepwise regression were identical for steps 10, 11, and 12. The number of months that the subject had been chemical free was not stepped into any of the models.

In a final attempt to improve the three regression models, three additional independent variables were added. The first was the number of people that subjects knew who had completed the first nine steps and who were currently practicing steps 10, 11, and 12 as directed. The second was the number of people that subjects knew who could teach all 12 steps to a new AA member. The third was the number of AA meetings attended per month.

None of the new independent variables was stepped into the regression models for steps 10 or 11. However, the model for step 12 improved dramatically, and the F-ratio was highly significant, $F(1,48)=26.3263$, $p<.0001$. Only one variable was stepped into the model, although it explained 34.1% of the variability in the dependent variable. This was the number of people that subjects knew who could teach all 12 steps. Education, which had been significant in the previous model, was not entered because its effects were very small compared to the other variable (the number of people whom subjects knew who could teach all 12 steps). Apparently, the best predictor of how often a subject practices step 12 is the number of people she knows who could teach all 12 steps. The number of AA meetings that subjects attended was not significantly related to the frequency of

participation in steps 10, 11, or 12. Table Eight shows the regression statistics for the step 12 model.

Table Eight

Regression statistics for the frequency of use for the Step 12 activities model

<u>Variable</u>	<u>Coeff.</u>	<u>Beta</u>	<u>F-ratio</u>	<u>Prob.</u>	<u>Std. Error</u>
# of people	0.1110	0.5951	26.3263	0.0000	0.0216
Constant	1.2406		0.0376	0.8470	6.3966

NOTE: Number of people was the number of people the subject knew who could teach all 12 steps.

CHAPTER V

SUMMARY, CONCLUSIONS, AND

RECOMMENDATIONS

Introduction

This study was an inquiry into the use of the last seven steps of the AA 12 Step treatment program by graduates of a 28-day treatment center for alcoholism. Because traditionally most 28-day treatment centers instruct their graduates before discharge to complete the last seven steps in AA, this study sought some insight into the patients ability to accomplish this directive. Subjects were limited to individuals located in the state of California.

Summary

Three research questions were selected to accomplish this objective. The first question was To what degree does the sample population understand and practice the AA 12 Step program? The second question was Are there significant relationships between gender, marital status, age and education and whether or not a subject had completed steps 6 through 9 of the AA program? Finally, the third research question selected was Are there significant relationships between the selected demographic variables (gender,

marital status, age and education) and the frequency that subjects participated in steps 10, 11 and 12 of the AA program?

For this study, 25 men and 25 women, graduates of a 28-day treatment center in California which uses the Minnesota Model of treatment, were chosen using a random method. The subjects were reporting one year or more of continuous abstinence from alcohol and all other mind-altering substances. This researcher made a decision that each subject be abstinent for at least one year to provide ample time for the subject to initiate the AA 12 Step treatment program as directed by the treatment center.

The subjects were randomly chosen from alumni lists of the 28-day treatment center. Approximately one thousand names of individuals with California addresses were available. Prospective study participants were contacted by telephone to identify individuals willing to participate in the research project. Personal characteristics parameters were addressed during this initial interview. When 25 men and 25 women were identified with the proper characteristics for the study and gave verbal consent to participate, each was sent a formal consent form containing all pertinent information about the study, confidential guarantees and consent to be used as a subject (see Appendix E).

On receipt of the signed consent forms, the researcher contacted each subject and completed the research questionnaire. An example of a typical interview was taped and is found in Appendix C. The data were noted on the research form during each telephone interview. When all fifty interviews were completed, the data were subjected to standard statistical methods that were deemed appropriate for this research project.

Each met the six criteria for inclusion for this research project. All 50 subjects considered themselves alcoholics. There was a small difference in the mean ages for men and women; men were approximately fifty years old, and women were approximately forty-eight years old. A little over half of the subjects were married. This level was identical for male and female subjects. Men appeared to have somewhat higher education levels than women, with women at fourteen years of formal education and men at approximately fifteen and one half years.

One of the criteria used for sample selection in this study was that the subjects were free from alcohol and other mind-altering substances for at least one year. Though all subjects reported at least one year of continuous abstinence, there was a wide range in substance free time, the duration ranging from 1 to 11 years. The mean length of sobriety was approximately five years. Married subjects were sober for about six and one half years while single subjects reported about four years..

All of the subjects considered themselves members of AA, and all had completed the first five steps at the treatment center. The one individual who said he was not a member stated he went occasionally, which qualified him as a member of AA. He had experienced four years of very active participation. There were three individuals who stated they had not completed the first five steps of AA at their treatment center. On closer questioning, each stated that they had formally completed the first five steps at the treatment center, but were of the opinion that they had to do them over on a regular basis. The researcher found it interesting that there was confusion on this issue, which represented six percent of

the sample. The first nine steps of the 12 Step program are taken once to the best of the alcoholic's ability; all other work is accomplished in Steps 10, 11 and 12. These subjects, too, were considered to fulfill the individual requirements for the study. Ninety percent of the surveyed population said that the treatment center had given them specific instructions to attend AA. Since all of the subjects graduated from the same treatment center, the ten percent giving a "no" response had some difficulty with the word specifically, but understood that the treatment center wanted them to attend AA. The studied population attends AA about three times a week.

There was some confusion as to whether the subjects' treatment center had discussed completing the rest of the steps in AA, though nearly two-thirds of the sample said that the treatment center had told them to complete steps 6 through 12 of the AA program. Though many subjects were given instructions to complete the 12 Step treatment program, only a small percentage reported actually receiving specific instructions on how to complete the steps on their arrival at AA.

This study selected subjects who had been alcohol-free for at least one year, and there was a wide range with respect to how long they had been sober. The range was from one to eleven years. There was a declining completion rate for steps 6 though 9. Even when a subject had completed a step, it was no guarantee that she would be able to teach it to others.

The subjects were asked how many times a month they formally used steps 10 and 11, and whether they knew the steps well enough to teach them to other AA members. Fifty-

four percent stated that they practiced Step 10, and all of those who practiced this step thought they could teach it. Step 10 is to be practiced on a daily basis, but the subject group only practiced the step a mean of eight times per month. The numbers for Step 11 were discouraging, with approximately one in five indicating any involvement with this step, but those who reported they used it stated that they could teach it. Step 11 is supposed to be practiced daily, but those indicating use of the step were only at a level of four times a month.

On the average, subjects participated in activities designed to give assistance to alcoholics about three times per month. Most of subjects did not participate in any step 12 assistance activities, and several subjects participated in many.

When asked to indicate what percentage of the members of AA they estimated were actively working on and completing the 12 Step program, the mean estimate was 19.3 percent, and the median was ten percent. Subjects were also asked how many people they knew who had completed the first nine steps and were currently using steps 10, 11, and 12 as directed. The mean was 12.2 people, and the median was 3 people. The large disparity between the mean and median indicates that most subjects only knew a few people (3 or less) while a few subjects knew substantially more. When asked how many people they knew that could teach all 12 steps to a new member of Alcoholics, the mean number of people was 17.1, and the median was 7.5 individuals. Again, the large disparity between the mean and median indicates that most subjects knew relatively few people that could teach all 12 Steps, and a few subjects knew substantially more.

When this researcher explored if there were significant relationships between selected demographic variables (gender, marital status, age, and education) and whether or not subjects had completed steps 6 though 9 of the AA program, none were found.

When the third research question was addressed in reference to significant relationships between selected demographic variables (gender, marital status, age, and education) and the frequency that subjects participated in steps 10, 11, and 12 of the AA program, several interesting points came to light. As with the preceding steps, Step 10 was not significantly related to any of the demographic variables. But in the case of Step 11, subjects who were single tended to practice Step 11 more often than those who were married. In the of Step 12, subjects with higher education tended to practice Step 12 more frequently than those with lower education.

It was clear that gender, marital status, age, and education were not very good predictors of the frequency of use for steps 10, 11, and 12 of the AA program. The question then became, is there anything that improves our ability to predict frequency of use? Apparently, the best predictor of how often a subject practices step 12 is the number of people he or she knows that could teach all 12 steps. The number of AA meetings that subjects attended was not significantly related to the frequency of participation in steps 10, 11, or 12.

Conclusions

This investigator found only three individuals, one man and two women, in the studied population who are using the 12 Step treatment regime of AA as directed. This observation represents approximately 6 percent of the study group. It was interesting to note that the study participants as a whole estimated that their fellow members of AA were performing at almost this same level. This investigator found that step activity was carried on primarily on an individual basis with little assistance from experienced AA members. Because the first five steps are completed in about four weeks at the treatment center, insufficient time to complete the remaining seven steps did not appear a viable issue in the study. The participants in the study were allowed a minimum of one year before this examination following the treatment center directive to complete the 12 Step treatment process in Alcoholics Anonymous.

In a time when there have been ongoing discussions on gender, marital status, age, and education, in reference to success, this study indicated that these separate and/or collective issues were not of any great importance. This investigator realizes that the population studied may have some unique characteristics in and of itself, and that another researcher may find correlations with a different population, but this study found these issues almost neutral.

This researcher concluded that the AA culture in California neither supports nor actively teaches its own official treatment program. Furthermore new members' opportunities to engage themselves in the 12 Step treatment regime appear limited at best.

Most disturbingly, according to the subjects in this survey, AA lacks recovered alcoholic instructors to teach its new members its historic and famous treatment program.

Recommendations

For decades treatment centers and other segments of our society have been using AA to fulfil the short-term goal of what to do with the alcoholic when his parochial activity is compete. Bill Wilson's thought that AA must be friendly to its friends assumed that everybody interested in the alcoholic was friends of AA. Over the past several decades many institutions in the culture have used AA as what AA members of two decades ago referred to as a dumping ground, with apparently little interest in the long-term effects on AA. With this in mind, two possible research questions that suggest themselves are, where have the millions of people gone that have been sent to AA; and why don't they stay. The millions of people sent to AA should represent a major dynamic segment of the culture. This is obviously not the case. McBride (1981) raised this question a decade ago and no one has answered it. Glaser and Ogborne (1982) estimated that even at a conservative growth rate of 8 percent, AA's membership should be in the tens of millions.

Another area that might be worthy of investigation are new practices that treatment centers could demonstrate that would assist their patients in making the transition to AA and completing the last seven steps of the AA treatment regime. There are strong indications that the therapy model now used in AA a modified group therapy model that many of its members were exposed to in 28-day treatment centers during the past three

decades. What might be very effective in the controlled environment of the treatment center may not be of much help in the very uncertain environment that the alcoholic must learn to live in. The new graduate is indoctrinated with group therapy, but may understand little about the teacher-student method that can be very useful.

When treatment centers started sending their graduates to AA, men of good will could not foresee the success in drawing patients of the treatment centers that were to follow. What has happened to AA could be analogous to a small one-room school that produced successful graduates and overnight received one hundred thousand new students that spoke another language. The new language that AA was required to learn was group therapy with all of its psychological systems. Most of these psychological approaches had been abandoned by early members of AA because they found them ineffective. The once successful 12 Step treatment program is not the same as group therapy. The 12 Step treatment model is a student-teacher model, the teacher being called a sponsor. Because the flood of new people sent to AA with this new model the culture has apparently changed and the 12 Step model has been effectively replaced. To refer today to AA as a 12 Step program, as Kaminer (1993) points out in her observations of all the AA spinoffs programs, is at best intellectually dishonest.

Whether AA or the treatment centers in our society wish to admit it, the treatment center is the gate keeper of new membership in AA and has been so for several decades. The treatment center, using a model that has gone unchanged for over a half a century, has effectively ignored the dynamic effect that it has had on AA where it has historically sent

its graduates. This investigator believes research in this area could yield a wealth of usable information that is essential to the national discussion.

Throughout the course of this researcher's study at Walden University the issue of change has been a constant consideration. Because of this I feel compelled to address the subject of change as a general topic and in my area of interest specifically. Furthermore, I appreciate the opportunity to share some of what I have gleaned during the course of this investigation and my course work at Walden in this discussion which is found in Appendix G.

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APPENDICES

Appendix A
The Wignall 12 Steps Questionnaire

1. Do you consider yourself an alcoholic?

Yes _____ No _____

2. Male or Female

M _____ F _____

3. What is your age?

_____ Years

4. What is your marital status?

Single _____ Married _____

5. What is your level of formal education in years?

_____ Years

6. How many months have you been free of alcohol and other mind altering substances?

_____ Months

7. Did your treatment center give you specific instructions to attend Alcoholic Anonymous?

Yes _____ No _____

8. Did you complete the first five steps of Alcoholics Anonymous at your treatment center?

Yes _____ No _____

9. Do you consider yourself a member of Alcoholics Anonymous?

Yes _____ No _____

10. How many Alcoholics Anonymous meetings do you attend each month?

_____ Per Month

11. Were you given specific instructions by your treatment center to complete steps 6 through 12 of the Alcoholics Anonymous 12 step program in AA?

Yes No

12. Which of the steps 6 through 12 have you been given specific instructions on how to complete.

6 7 8 9 10 11 12

13. Which steps have you completed in the series of steps 6 through 9?

6 7 8 9

14. Which of the steps 6 through 9 do you understand well enough to teach to another AA member?

6 7 8 9

15. How many times a month do you formally use step 10?

Times

16. Do you understand step 10 well enough to teach it to another AA member.

Yes No

17. How many times a month do you formally use step 11?

Times

18. Do you understand step 11 well enough to teach it to another AA member?

Yes No

19. How many times a months do you participate in activities that are specifically designed to give assistance to alcoholics that are still drinking as referenced in step 12?

Times

20. How many people do you personally know that have completed the first nine steps of the 12 step program and use steps 10, 11, and 12 as directed?

People

21. How many people do you personally know that can teach all 12 steps of Alcoholics Anonymous to a new member of AA?

 People

22. Rated on a scale from 0 (no one) to 100 (every one), what percentage of the members of Alcoholics Anonymous, would you estimate, are actively working on and completing the 12 step program of Alcoholic Anonymous?

 Percent

Appendix B**Validation Form**

To be used with 12 Step Questionnaire

Question 6 (Ask to verify)

- 1. Where did you take your last drink?
- 2. Have you ever experienced a relapse? If so when?
- 3. Who gave you your (year) cake?
- 4. Where did you celebrate your (year number) anniversary?

Question 7 (Ask if answer is yes)

- 1. Who at your treatment told you?
- 2. When in treatment were you told?
- 3. Were you told how to find you first meeting after you left treatment?
- 4. Was attending AA part of your aftercare plan?

Question 8 (Ask if answer is yes)

- 1. Who helped you with Steps 1 to 3?
- 2. What did you do with your 4th Step inventory.
- 3. Who took it with you?
- 4. Who did you give you 5th Step to?

Question 9 (Ask if answer is yes)

- 1. When was you last AA meeting?
- 2. Where do you go?
- 3. What type of meetings do you usually attend?
- 4. Why do you consider yourself a member of AA?

Question 10 (Ask to verify)

- 1. How many meeting a week are you comfortable with?
- 2. Do you need to go to more meeting? What does your sponsor say about you attendance?
- 3. Do you go with anyone?
- 4. Do you go to the same meeting all the time? Where is you home group?

Question 11 (Ask if answer is yes)

- ____ 1. Who at your treatment center instructed you to do this?
- ____ 2. What week were you in when you were told?
- ____ 3. Was the instruction in lecture or individually?
- ____ 4. Was this directive in your aftercare plan?

Question 12

Step 6 (Ask if answer is yes)

- ____ 1. Who gave you instruction on this step?
- ____ 2. Was this after you completed you 5th Step?
- ____ 3. Where were you when you received instruction?
- ____ 4. Where in the Big Book do you find the 6th Step?

Step 7 (Ask if answer is yes)

- ____ 1. Who gave you instruction on this step?
- ____ 2. How was the instruction given?
- ____ 3. How much space is given to this step in the Big Book?
- ____ 4. What is the 7th Step Prayer?

Step 8 (Ask if answer is yes)

- ____ 1. Where does the list come from?
- ____ 2. Who gave you instruction on this step?
- ____ 3. Where is it found in the Big Book?
- ____ 4. How much space is given to this topic in the Big Book?

Step 9 (Ask if answer is yes)

- ____ 1. What are the dangers in this step?
- ____ 2. Who gave you instruction on this step?
- ____ 3. Can you start Step 10 and 11 before you finish with this step?
- ____ 4. How much space is given in the Big Book to this step?

Step 10 (Ask if answer is yes)

- ____ 1. Who gave you instruction on this step?
- ____ 2. Had you finished step 9 before you started this step?
- ____ 3. How often is this step practiced?
- ____ 4. What are the 10th and 11th steps called?

Step 11 (Ask if answer is yes)

- ____ 1. What is the prayer and how often is it to be used?
- ____ 2. Who gave you instruction on this step?
- ____ 3. What is meditation?
- ____ 4. Who was your instructor?

Step 12 (Ask if answer is yes)

- ____ 1. What is your idea of 12 Step work?
- ____ 2. Who can do step work?

- ___ 3. Who explained to you what you were supposed to do?
- ___ 4. What does the Big Book say about this step?

Question 13

- Step 6 (Ask if answer is yes)
 - ___ 1. Did you complete this step alone?
 - ___ 2. How long did it take you to complete it?
 - ___ 3. In reference to step five what does the Big Book say?
 - ___ 4. Where were you when you completed this step?
- Step 7 (Ask if answer is yes)
 - ___ 1. Did you complete this step alone?
 - ___ 2. What did you do to complete it?
 - ___ 3. What is the Seventh Step prayer?
 - ___ 4. Where were you when you completed this step?
- Step 8 (Ask if answer is yes)
 - ___ 1. How many items did you have on your list?
 - ___ 2. What did you do to complete it?
 - ___ 3. How long did it take to complete it?
 - ___ 4. Where were you when you completed this step?
- Step 9 (Ask if answer is yes)
 - ___ 1. Are you finished with all the items on your list?
 - ___ 2. What types of things did you hesitate to do?
 - ___ 3. How long did it take you to complete this step?
 - ___ 4. Did you have any major problems?

Question 14

- Step 6 (Ask if answer is yes)
 - ___ 1. How many people have you taken through Step 6?
 - ___ 2. What were the problems you have discovered teaching this step?
 - ___ 3. Do your students understand this step quickly?
 - ___ 4. Are you with the person when he or she is taking this step?
- Step 7 (Ask if answer is yes)
 - ___ 1. How many people have you taken through Step 7?
 - ___ 2. What were the problems you have discovered teaching this step?
 - ___ 3. Do your students understand this step quickly?
 - ___ 4. Are you with the person when he or she is taking this step?
- Step 8 (Ask if answer is yes)
 - ___ 1. How many people have you taken through Step 8?
 - ___ 2. What were the problems you have discovered teaching this step?
 - ___ 3. Do your students understand this step quickly?

- 4. Are you with the person when he or she is taking this step?
- Step 9 (Ask if answer is yes)
 - 1. How many people have you taken through Step 6
 - 2. What were the problems you have discovered teaching this step?
 - 3. Do your students understand this step quickly?
 - 4. Are the people that you have helped afraid of this step? If so, why?

Question 15

- Step 10 (Ask to verify)
 - 1. At the end of the day, how much time is spent on this step?
 - 2. Do you make amends the next day if you can?
 - 3. Where do you do it?
 - 4. Do you write you inventory?

Question 16

- Step 10 (Ask if answer is yes)
 - 1. What is the biggest problem your students have?
 - 2. What questions do you hear most often?
 - 3. Do you check up on your student's progress?
 - 4. Do you have any suggestions for teaching this step?

Question 17

- Step 11 (Ask to verify)
 - 1. What method do you use for your meditation?
 - 2. Where do you usually do this step?
 - 3. Do you get any results?
 - 4. What is hard about this step?

Question 18

- Step 11 (Ask if answer is yes)
 - 1. What is the biggest problem your student have?
 - 2. What questions do you hear most often?
 - 3. Do you check up on your students progress?
 - 4. Do you have any suggestions for teaching this step?

Question 19 (Ask to verify)

- 1. What do you do?
- 2. Do you go alone
- 3. Do you receive assistance from the AA Central Office?
- 4. Is your efforts institutional or personal?

Question 20 (Ask to verify)

- 1. Are these people living in your same community?

- 2. Can you give their first name.
- 3. How do you know?
- 4. Are they active in Alcoholics Anonymous?

Question 21 (Ask to verify)

- : — 1. Are these people living in your same community?
- 2. Can you give their first name.
- 3. How do you know?
- 4. Are they active in Alcoholics Anonymous?

Question 22 (Ask to verify)

- 1. How did you come to your conclusion?
- 2. What qualifies you to make your estimate?
- 3. Do you believe that others think the same as you?
- 4. Have you ever talked about this subject to any one else?

Appendix C

Sample interview conversation (transcript)

The following is a transcript of a taped telephone interview to give the reader insight into how the questions were asked and how the typical response were given. Though each of the fifty interviews had their particular individual characteristics, they were not substantially different from the one presented here. Because the interviewer has a unique relationship not only because of Alcoholics Anonymous, but because the interviewer and the interviewed enjoy a common experience with the same treatment center, the reader may note a degree of casualness and candor that was unique to this study. One of the goals this researcher was seeking was a high degree of openness and honesty.

Subject will be given the designation "S" and the interviewer will be given the designation "I" in the following transcript.

Partial Transcript:

I Do you consider yourself an alcoholic?

S Yes of course - ah I was the last one to know. (laughter)

I Ok - and you are a male? - I have to ask.

S Yes.

I What is your age?

S Thirty-nine.

I What is your marital status - married or not married?

S Married.

I What is your level of formal education in years? - High school is twelve - add or subtract from there.

S Well I started to college - I guess you could say I did just over a year - I started my second year - I really should have stayed - dumb kid - you know - one year.

I I know - I dropped out during Vietnam - I was at Fort Leonard Wood in two weeks - drafted.

S I had a chance to go to work for a plumber - pretty good money - but you know - I think I should've stayed - couldn't keep my mind on it oh-well.

I Next question.

S Ok - I'm ready.

I This is number six. How many months have you been free of alcohol and other mind altering substances?

S Well let's see - my fourth birthday was in November and this is June so-

I Well - four is forty-eight.

S Yeah - December, January - uhh - that would be seven - so fifty five

I Fifty-five months?

S Yeah - Hard to believe - time flies.

(Sample of validation questioning)

I Where did you take your last drink?

S Well - Long Beach.

I Relapsed?

S Oh-no.

I The same person has given you all your cakes?

S No - First three in Long Beach was my first sponsor - down
here - a friend and the secretary of my home group.

I Where did you celebrate the last one - number five?

S My home group --- I did take another cake at the club.

I Where is your home group?

S AM meeting at Candelwood.

I In Cathedral City?

S Yeah.

I OK - Next Question - Did your treatment center give
you specific instructions to attend Alcoholics Anonymous?

S Well my counselor did.

I What did he tell you?

S Told me to do ninety in ninety - I thought he was nuts.

I You know I really did not hear that till I got out here - I came out here
from Florida - Did yea do it?

S No - but I went to a lot of em.

(Validation questions used)

I This is not one of the questions - but what did you think of them?

S Oh - I thought they were Ok - I found a couple I really liked - I tell yea - I
really liked getting out of the house - my wife was driving me nuts then.

I Did she go through the family program?

S Yeah - kind of - she thought it was (expletive deleted) - but uhh (pause).

I We had better get on with this next question - number eight. Did you
complete the first five steps of Alcoholics Anonymous at your treatment
center?

S Yeah Â but I really think I should do another fourth step.

I The way I was taught was that is what the tenth is about.

S I don't know.

I What does your sponsor say?

S Nothing much - I don't use him much - guess I should get a new one.

(Validation questions used)

I Ready for the next question?

S Uh huh.

I Do you consider yourself a member of Alcoholic Anonymous?

S Yes.

I How many Alcoholics Anonymous meetings do you attend each month?

Most people figure how many a week and multiply it by four.

S Oh I guess three a week - some times four - but I guess you could say -

times four - uh well fourteen - I miss 4 or 5 days once in awhile - but I'd

say fourteen for the record.

(Validation questions used)

I Ok - Number eleven. Were you given specific instructions by your

treatment center to complete steps 6 through 12 of the Alcoholics

Anonymous 12 Step program in AA?

S My counselor said I should get a sponsor and work the steps.

I Would you consider that specific instructions or just a suggestion?

S Oh - I don't know - He told me to do it. Yea instructions.

(Validation questions used)

I Ok - Next question - Now think about this - think about your answer - I'm going to use the word specific again - Which of the steps 6 through 12 have you been given specific instructions on how to complete?

S At (treatment center name deleted)?

I Yeah - or when you got to AA - In the fellowship.

S If you mean taught me how - uhh no - I've went to step meeting.

I Did you get specific instruction there?

S We read out of the book.

I Did anyone tell you how to do it? - What book?

S The 12 by 12 - uhh - No - we had discussions - kind of -

I The ones I have gone to we go around the room and read and comment on the paragraph or two. Some ones opinion or what's going on in their life.

S Yeah - that's it The same - but not instructions.

I No specific instruction on any one in the series 6 through 12 by any person - your sponsor - friend - anybody?

S Nope - not like some one going 1 - 2 - 3 - No.

I Ok, next. Which steps have you completed in the series of Steps
6 through 9?

S Uhh - I know 6 and 7 for sure - and I guess 8 and 9.

I How do you know?

S I think I did them OK - I got all the amends done I could do.

I So you believe that you have all - uh 6-7-8 and 9 - Did you do them with
a sponsor?

S Yeah - I guess - most of it - Well this guy I had wasn't too good - but I
think I did it.

I I know I had trouble with 8 and 9 - it took me years.

S I still have a couple of amends to do - but I don't know where they are.

Nothing big.

(Validation questions used)

I Your doing great. Number fourteen - ready?

S Uh huh - yeah - ok.

I Which of the steps 6 through 9 do you understand well enough to teach to
another AA member?

S I'm not much of a teacher.

I Well - if some one really needed to know.

S I guess 6 and 7 - yea 6 and 7.

I Not 8 and 9?

S No I don't think so.

(Validation questions used)

I This is not one of the questions, but has any one asked you about where
you did 6 and 7.

S Well - I've told a couple of guys - Really nobody asks me
much.

(Validation questions used)

I Ok -- Ok - Number fifteen - we're close to the end - How many times a
month do you formally use Step 10? What I mean by formally is that
you set aside some time at the end of the day and inventory your day,
yourself, people you have harmed - you know - that kind of stuff

S I guess I don't do it formally - sometimes I think about it - but not regular
To be honest I guess I don't.

I You are saying none?

S Sorry to say - but yea.

(Validation questions used)

I Do you understand step 10 well enough to teach it to another AA member?

S No.

I (name) I sincerely appreciate your honesty.

S No - I should think about this stuff more - maybe it will help me get
busy.

I Did you say no one ever ask you?

S I guess not. (nervous laugh)

I How many times a month do you formally use step 11. I'm looking for
how it is explained in the 12 and 12. Do you do it like it says in the
book?

S What does it say?

I You know - the one prayer - just for guidance and the power to carry it
out - You know and Wilson says go to the library and read up on it or
find some one who can teach you - teach you how to meditate - you
know real meditation..

S No I don't do that.

I Ok - I have to ask the next question - Do you understand step 11 well
enough to teach it to another AA member?

S No.

I Still with me - the end is near.

S Yea - no problem.

I How many times a month do you participate in activities that are specifically designed to give assistance to alcoholics that are still drinking as referenced in step 12?

S I don't know - I go to meeting and talk to new comers.

I Well as I read it in the 12 and 12, this is more and outreach thing - you know - talking to wet ones.

S You mean 12 Step calls?

I Yea it could be that - or answering the phone at the central office - some guys are on institutional - my first sponsor had me down to a mission - that type of thing. Carrying the message to people that are still suffering - Ok - and teach it.

S I've never done that.

I Ok - Now we are to the easy part - The following questions are about other people?

S That's good (laughter) that's good - inventory time (laughter) - I'm ready.

I Ok - How many people do you personally know that have completed the first 9 steps of the 12 step program and use steps 10, 11 and 12 as directed?

S Oh boy that's a hard one.

I Take your time - you personally know - their name - who they are - just
the number. People you know.

S Three I think - yea three.

I That's it?

S Yea - I'd say three.

(Validation questions used)

I Ok - Now how many people do you personally know that can teach all 12
steps of Alcoholics Anonymous to a new member of AA?

S Same three

(Validation questions used)

I Ok - We are down to the last question - I know this question will be a
guess - this question is kind of what your gut tells you - so think about it
for a minute - Ok.

S Ok.

I Rated on a scale from 0 (no one) to 100 (every one), what percentage of
the members of Alcoholics Anonymous, would you estimate, are actively
working on and completing the 12 step program of Alcoholics? You
know actively doing - not talking about it. Just your gut feeling. What
you really believe.

S Oh -uh - I'd say between 5 and 10 percent.

I I only have one space - would it be closer to 5 or 10?

S I'd say 10 - but that's probably high - Oh I don't know.

I I know it is a difficult question - but it's more of a feeling - you belief

You've listened to and watched a lots of AA members - a single number.

S 10 percent to on the safe side.

I 10 percent?

S Yea - that's Ok.

(Validation questions used)

I Well that's the end (name), I want to thank you again for your help.

S Glad to do it - I hope it helps some body.

(There was some small talk which has been deleted)

Appendix D**Statistical Codebook**

Number of variables = 34

Data Record Length = 50

Variable 1 Q1

Format: A1 Do you consider yourself an alcoholic?

Offset: 1

Y=Yes N=No

Variable 2 Gender

Format: A1 Gender

Offset: 2

M=Male F=Female

Variable 3 Age

Format: N2 Age

Offset: 3

Variable: 4 Marital Status

Format: A1 Marital Status

Offset: 5

S=Single M=Married

Variable: 5 Education

Format: N2 What is your level of formal education in years?

Offset: 6

Variable: 6 Months free

Format: N3 How many months have you been free of alcohol and other mind altering substances?

Offset: 8

Variable: 7 AA Instructions

Format: A1 Did your treatment center give you specific instructions to attend Alcoholics Anonymous?

Offset: 11

Y=Yes N=No

Variable: 8 Complete steps 1-5

Format: A1 Did you complete the first five steps of Alcoholics Anonymous at your treatment center?

Offset: 12

Y=Yes N=No

Variable: 9 Consider AA member

Format: A1 Do you consider yourself a member of Alcoholics Anonymous?

Offset: 13

Y=Yes N=No

Variable: 10 AA meetings attended

Format: N2 How many Alcoholics Anonymous meetings do you attend each month?

Offset: 14

Variable: 11 Instructions 6-12

Format: A1 Were you given specific instructions by your treatment center to complete steps 6 through 12 of the AA program?

Y=Yes N=No

Variable: 12 Q12-6

Format: N1 Were you given specific instructions on how to complete step 6?

Offset: 17

6=Yes =No

Variable: 13 Q12-7

Format: N1 Were you given specific instructions on how to complete step 7?
Offset: 18
7=Yes =No

Variable: 14 Q12-8
Format: N1 Were you given specific instructions on how to complete step 8?
Offset: 19
8=Yes =No

Variable: 15 Q12-9
Format: N1 Were you given specific instructions on how to complete step 9?
Offset: 18
9=Yes =No

Variable: 16 Q12-10
Format: N2 Were you given specific instructions on how to complete step 10?
Offset: 21
10=Yes =No

Variable: 17 Q12-12
Format: N2 Were you given specific instructions on how to complete step 11?
Offset: 23
11=Yes =No

Variable: 18 Q12-12
Format: N2 Were you given specific instructions on how to complete step 12?
Offset: 25
7=Yes =No

Variable: 19 Completed step 6
Format: N1 Have you completed step 6?
Offset: 27
6=Yes =No

Variable: 20 Completed step 7
Format: N1 Have you completed step 7?

Offset: 28

7=Yes =No

Variable: 21 Completed step 8

Format: N1 Have you completed step 8?

Offset: 29

8=Yes =No

Variable: 22 Completed step 9

Format: N1 Have you completed step 9?

Offset: 30

9=Yes =No

Variable: 23 Q14-6

Format: N1 Do you understand step 6 well enough to teach it to another AA member?

Offset: 31

6=Yes =No

Variable: 24 Q14-7

Format: N1 Do you understand step 7 well enough to teach it to another AA member?

Offset: 32

7=Yes =No

Variable: 25 Q14-8

Format: N1 Do you understand step 8 well enough to teach it to another AA member?

Offset: 33

8=Yes =No

Variable: 26 Q14-9

Format: N1 Do you understand step 9 well enough to teach it to another AA member?

Offset: 34

9=Yes =No

Variable: 27 Q15
Format: N2 How many times a month do you formally use step 10?
Offset: 35

Variable: 28 Q16
Format: A1 Do you understand step 10 well enough to teach it to another AA member?
Offset: 37
Y=Yes N=No

Variable: 29 Q17
Format: N2 How many times a month do you formally use step 11?
Offset: 38
Y=Yes N=No

Variable: 30 Q18
Format: A1 Do you understand step 11 well enough to teach it to another AA member?
Offset: 40
Y=Yes N=No

Variable: 31 Q19
Format: N2 How many times a month do you participate in activities designed to give assistance to alcoholics as referenced in step 12?
Offset: 41

Variable: 32 Q20
Format: N2 What percentage of the members of AA would you estimate are actively working on and completing the 12 step program?
Offset: 43

Variable: 33 Q21
Format: N3 How many people do you know that have completed the first nine steps and use steps 10, 11, and 12 as directed?
Offset: 45

Variable: 34 Q22
Format: N3 How many people do you know that can teach all 12 steps of AA to a new member?

Offset: 48

Appendix E**Consent Form for use in doctoral research titled:**

"AN EVALUATIVE STUDY OF THE USE OF THE 12 STEP RECOVERY
PROGRAM IN ALCOHOLICS ANONYMOUS: AN INTROSPECTION INTO
BEHAVIOR EXHIBITED BY MEMBERS OF ALCOHOLICS ANONYMOUS WITH
OVER ONE YEAR OF ABSTINENCE FOLLOWING A 28-DAY TREATMENT
PROGRAM"

Dear potential participant:

You are invited to be in a research study of the use of the 12 step AA program. You were selected as a participant because the researcher, Ed Wignall is an alumni of the 28 day treatment center you attended. Ed Wignall, whom you have met during your recovery program, has invited you. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: M. Edward Wignall,M.A, a Ph.D candidate at Walden University.

Background Information:

The purpose of this study is to explore use of the 12 step AA recovery regime by active members of AA, with over one year of abstinence from alcohol and other mind altering substances, who have attended a 28 day treatment program.

Procedures:

If you agree to be in this study we ask you do the following: Answer approximately 22 questions by telephone, taking approximately 10 minutes from beginning to end.

Risks and Benefits of Being in the Study:

The study has no significant risks, especially since you anonymity will be assured, and since you are free to skip any question you feel uncomfortable answering.

The benefits to participation are: 1. You will be adding to the knowledge which can be of assistance to individuals beginning the recovery process. 2. You will receive a summary of the researcher's dissertation when it is completed as a way of thanking you for participating.

Compensation:

You will receive no compensation for participating in this research, except the knowledge that you have added to the body of knowledge in this area of interest.

Confidentiality:

The records of this study will be kept private and your identity will not even be known to the researcher once you have completed the questionnaire as each questionnaire will have no identifiers other than the requested demographic data which would not divulge your person's individual identity. In any sort of report that we might publish, we will not include any information that will make it possible to identify a subject. Research records will be kept in a locked file: only the researcher will have access to the records.

Voluntary Nature of The Study:

Your decision to participate or not will not affect your current or future relation with the University or the researchers. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions:

The researchers conducting this research are M. Edward Wignall and Dr. Marilyn Simon. You may ask any question you have now or at any time. If you have questions later, you may contact them at: M. Edward Wignall: (619) 329-5558 or Dr. Simon: (619) 259-0345.

You will be given a copy of this form to keep for your records.

I have read the above information. I have asked questions and have received answers.

I consent to participate in the study.

Signature _____ Date _____

Signature of investigator

(M. Edward Wignall, M.A.) _____ Date _____

Appendix F**Researcher's Subject Background**

The researcher has been a primary counselor in a large treatment center for alcoholism, and held the position of director of outpatient services for Pinellas County, Florida. In that capacity he was responsible for five clinics and supervised and trained a counseling staff of fifteen primary therapists. When the state of Florida was initiating a system of licensure, the investigator was chosen to be on the Governor's Commission for Standards, Practices, and Testing of chemical dependency counselors and therapists. The analyst owned and operated a private clinic in Clearwater, Florida and was considered an authority on alcoholism. This clinic, though providing a wide range of services, specialized in employee assistance programming. Through this clinic, the researcher instituted alcoholism intervention programs for the city of St. Petersburg, Pinellas County, Florida and many major national and international companies with offices in the state of Florida. It was in this capacity that the investigator placed the first patient in the newly opened, Betty Ford Center in Rancho Mirage, California and established a close relationship with its staff, that has continued to the present day.

The inquirer has published aftercare books for alcoholism that have been used by treatment centers across the United States. and is considered an authority on this phase of treatment. The researcher is an alumni of the Hazelden Treatment Center, one of the oldest and most respected treatment centers for alcoholism in the world and was chosen by the Betty Ford Center to be a Professional In Residence. The Professional in Residence experience is an international program open to respected physicians, psychologists and educators. The investigator is a technical consultant in programming and aftercare for two treatment centers in his immediate neighborhood, and personally knows and is trusted by hundreds of recovered alcoholics.

Appendix G

Discussion

I would like to begin this discussion with a short story to be used as a point of reference.

As the old drunk made his way slowly down the beach on his early morning quest for spiders, his stooped back, withered body and his ragged ill fitting clothes, none of which had seen washing water for months, caused the early morning beach runners to give him a wide berth. A spider, for those who by good fortune have not had the opportunity to experience the reality of this pathetic soul, are those few drops in a discarded whisky bottle that do not amount to enough to get a spider drunk and is sacred to those that need it. As the old drunk shuffled along he noticed a bottle rolling over and over in the tide wash a few feet from the water's edge, and without hesitation the old drunk stepped out into the shallow lapping surf. With the singlemindedness and quickness of a gull snatching a fish, he liberated this old purveyor of dreams from its watery home.

As he stumbled up onto the dry beach his ancient, weary, bloodshot eyes scoured the inside of the old bottle for a few drops that would help get him through one more meaningless day. Seeing nothing of value, his old yellowing fingers loosening, he hesitated. What did he see, what was it that filtered through his alcohol addled brain? As he peered through the foggy glass, it was something, not what he wanted, but something, and something animal in him wanted to see. With some great effort, for his fingers had long lost their nimbleness, he dug at the buried piece of cork that blocked the narrow neck. To the watchful eye he gave the appearance of a starved and beaten animal digging into a garbage pail for anything that would sustain life for the moment. Out of frustration I guess, or maybe some primitive anger, he smashed the old bottle on an abandoned piling. What happened next, even by eyewitness accounts, seems unbelievable.

From the remains of the shattered bottle arose, in the twinkling of an eye, a magnificent creature, a man; though not fashionable now, in another age he might have been called beautiful. The old drunk, though startled, or as startled as his dulled senses allowed, stood his ground. Who are you? he stammered. I guess I am me, came the

answer. You might mean what are you. If you are of a childish persuasion, you might call me a genie. But as you do not look too well and may not be with us much longer, I wish to sincerely thank you for releasing me from my captivity. I have been imprisoned in that old bottle for eons, for reasons that do not mean much now. But I am grateful that you and I have crossed paths. The word grateful seeped into the old drunk's dulled reality. And as he was struggling for the words to say, how grateful? the being standing before him spoke the sweetest words the old drunk could imagine. I can grant you two wishes. Anything you want.

Well the old drunk thought - did I hear wish. This guy doesn't know it but he is talking to a man that knows how to wish. I can put my wishing up against anyone's. This foolish guy does not know how good I am. I may be a failure in most things, and I may look and smell a little ripe, but wishing, I know my wishing.

Well, said the strange handsome man, I've been cooped up a long time and have many things that need my attention. Give me a wish and I will show you, don't be shy. Hardly had the words stopped and the old drunk stammered, a bottle of the finest whisky that ever has been made, and showing a fine bit of natural wisdom, on which he prided himself, that is always full. And between heartbeats there was cradled in the old drunk's hand a bottle of the finest whisky that was ever produced. The look of sheer amazement spread across his face like a clap of thunder and he appeared dumbstruck. After a moment he could hear through his wonderment a voice - the voice of his benefactor. Well - come on, I've got to go. Well thought the old drunk I've been fooled before. Maybe this is my imagination or - as his mind swam with confusing thoughts he lifted the bottle to his lips and drank deep. This is wonderful - this is wonderful and as he dropped the bottle from his face the question that was still forming was answered. It was still full. A thought came exploding out of his very being - it is undeniable - there really is a god.

Through the wonderful inner celebration came a voice. The voice was not angry, but impatient. Your other wish, give me your other wish. Though finding some difficulty looking at the new demand through his present joy, the old drunk paused and experienced what he knew was pure genius. Give me another bottle just like this one.

This story has long been dear to this investigator, because within it is found most of the important issues in the treatment of alcoholism, and the human experience. It is

through this simple little story that this research project had to and must continue to journey.

What does the comedian know that the researcher in alcoholism, human thought or human systems does not appear to understand? The study of the common joke, that gives us so much pleasure, may hold within itself the new frontier of human thought and with it the ability to change.

What the comedian does when he tells us a joke, is to create the beginning of a story that the mind treats logically, the way it was taught too, searching for an answer. As the mind is carrying the story into the future (relative term to indicate away) the comedian gives the listener a conclusion and the listener creates a new logic that moves quickly backwards to the listener. This back traveling logic (for lack of a better term) operates more efficiently than classic logic, and it is very fast. Where classic logic is still wandering around looking for an answer, which we humans find uncomfortable, the second logic has completed its task of making sense of a situation, accompanied by a feeling of great pleasure. The brain seems to loves it.

Traditional philosophers and psychologists have had to ignore humor because traditional logic cannot explore this system using its own system of thinking. The traditional logic, or classical Greek logic that we are taught, works very well in science; thus we can go to the moon and beyond. But this logic appears useless when exploring the human condition, as evidenced by the persistence of age old human problems. Our traditional thinking system is based on 'truth', which is to be discovered or revealed by

logic and argument, accompanied by statistics and methods of science. This system uses the negative position and attack to purify or uncover truth. This system will always say no. It is the nature of the system. The humorist operates on an entirely different system using perception. When the perception is changed the situation is changed. This system has no rules, so it can always say yes. We can take a sad man and by changing his perception, he becomes a happy man.

If we are honest, all of us have experienced in our own lives the frustration of doing the same things again and again when the product is disappointing time after time. Why can't we change? We are trapped trying to think our way into change and no matter how much logical thinking we employ, the results are just the same. The old adage that the problem can not solve the problem is an inescapable reality to us all. When applied to the alcoholic we call it denial. We cannot logically get to a place we have never been. What the humorist gives us is an opportunity to use a mental system that is natural and accessible. We use it every time we are successful. We cast a final situation in our imagination and then work the logic back. By this system we need only deal with issues that present themselves. The language of change does not appear to be logic but perception or creative design. If there is a tragedy within the human experience it is being trapped in a mental cell where we have been taught that the door to the outside can only be used for certain things. This researcher has found no evidence that the denial of the alcoholic about his condition is an abnormal brain function. To the contrary, it appears to be the effect of the logical thinking system that each of us is taught in our culture, that

works well for science, but that is not effective when applied to human change. So we get two astronauts that can fly into deep space and return but may kill one another over who gets to wear the red hat. The mere idea that there can be several systems of thinking and that a system can be matched to the kind of problem exhibited, could be liberating. We all know that horses and Hondas are both transportation, but we use them to solve different problems.

Continuing this line of thinking, it makes sense that if the system is changed, the outcome will change. Again, when we look at classic Greek logic on which our culture is based, it always says no. Remembering that its purpose is to uncover truth and its tools are the negative or the adversarial position. On the other hand the system that the comedian uses is one of perception. This could be defined as being able to see the unseen or creativity and design with no rules. It may make sense to the reader that if we are attempting to reach an object, that we should use a system that says we can rather than a system that says that we can not.

It may be helpful to create three situations and three planned outcomes to explore how the perceptual system works. Our first problem is that you and I are to become proficient medical doctors that can perform successfully, but we have a time limit to achieve this level of competence. The amount of time that we are given is five minutes. Using our logical system of thinking we will naturally say that it is impossible. The logical system will always say no. Our thinking seems to go immediately to process, and knowing what we know of the effort and dedication it takes to become a medical doctor, the task set

before us appears impossible. Now using the other system that has no absolutes, we are not required to look at process and have the liberty to look at product. What does a doctor do, and what thing can I do right now that would allow me to be a successful physician? Or even better still, what do patients do. Well they either get better or they get worse. Now this could be helpful. Now if we keep the patients that are getting better, and refer the patients that are getting worse we would be highly successful. Even we of limited knowledge can tell who is getting better and who is getting worse. But you say we have broken all the rules for becoming a successful doctor. Of course, using the more efficient system that is product oriented there are no rules, just a positive outcome. The medical community has a procedure that is call triage, the separating of patients based on perceived outcome. You simply use the procedure that will make you successful. Doesn't it make sense that if a rule is standing in the way of progress, the rule should not be used.

Let's take another situation. We are told that we must become a university professor of modern and ancient philosophy who is recognized and admired by our colleagues. We must start to work tomorrow. There is only one problem — we have a sixth grade education and have been working all our life as a ditch digger. Using our scientific Greek logic there is no way we have enough time to accumulate enough knowledge to impress our colleagues by tomorrow. The first thing that comes to mind is how can I make my colleagues respect and admire me, for they will know immediately that I know nothing about the subject. Again the presenting problem using logic will be process. But using a different system, as before, we can ignore process and look directly at the required

product and being successful in producing it. What will let me say things that obviously lack knowledge and be a positive action toward my goal. Maybe I could use logic which is based on argument and conflict and use it in a way that would be to my advantage.

What if I were to start arguments but never win them. Well, that doesn't sound logical.

Now if I realize that no one has never won an argument and I give some one an opportunity to win one, this would be a wonderful gift. That person could believe that I am brilliant because we now think alike. Will the teacher condemn his finest student? So all I have to do is lose arguments, thus using my complete lack of knowledge as a wonderful tool. What I have come to enjoy about this system is the wonderful feeling of common sense. It can make us smile.

For the last example let us take something simple. We want a position in state government but there have been hundreds of applicants and they will not take our application, but we have to get an interview. If we bypass logic and just look at the interview it opens unlimited possibilities. Let's check what we know about normal systems. One: rules go from the top down. And it is rules that prevent change or anything new. So the best place to enter the system is where there are less rules. So it would be beneficial to enter the system at the top. Well, maybe traditional logic can get us this far. But how would we get to sending the right letter to the wrong person? Why would we send our application, vita, and letters of recommendation to the wrong person. Now what if the wrong person is the head of another department in the state? This one is too obvious. Big people do not traditionally talk to little people, they talk to their equals.

When our letter arrives at the wrong place it does not go down to the bottom, it goes across the hall to the head of the department where we are seeking a position and our application comes down the chain of command. People only question what goes up in systems, not what comes down.

Though these examples can be seen as containing logic, when the system is in action the logic comes after the solution. This is difficult to represent because our language contains logic. The system as this investigator understands it is in the form of pictures or visualizations.

From this investigator's examination of Alcoholics Anonymous the use of a higher power allowed the early members to enter the system of thinking that the humorist uses and produced success, sober people, where there was none before. It allowed them to realize that even people of good will could not help them and in most cases made their condition worse. This idea of the well intentioned person of good will being able to harm an alcoholic can not be approached with a logical system of thinking. But employing the system that the humorist uses may allow the subject to be approached with ease. There are no rules. As stated above, the use of the perceptual thinking system bestowed upon the founders of AA the liberty to take what they needed from any source they saw appropriate at any time. This is unlike the present situation where the logically grounded psychological community, by the nature of its system, is isolated into narrow interest groups that appear, by their behavior, to be oblivious to the work of others outside their immediate group. When they do meet, in fact, it is confrontational. With the act of

allowing a portion of its 12 Step treatment regime within treatment centers that are psychologically driven, a great shift appears to have happened. As this researcher discovered in his immediate neighborhood, 98 percent of Alcoholics Anonymous meetings are the group therapy type that closely resemble what is used in treatment centers.

Of the three major groups that the early AA members borrowed from, only the religious community, when not affected by dogmatic hierarchies, contains the more natural perceptual system of thinking. It is sometimes hidden by its historical practice of governing with rules. When early members were exposed to the Oxford Group movement, though they used scientific terms, it was operating more out of the perceptual system of thinking than its organized religious brethren.

Is the perceptual system of thinking being taught today in our society? This investigator discovered that it is. Though it is not being taught in our historic institutions of learning, it is easily available to the public. The self-improvement industry, though unorthodox, is the platform where hundreds of teachers present their books and lectures to men and women across the country. This is not to be confused with the "New Age" psychological movement. This group can usually be recognized from the titles of the literature. The names will generally sound mystical: Bristol (1954) — *TNT - The Power Within You*; Schwartz (1959) — *The Magic of Thinking Big*; Bristol (1968) — *The Magic of Believing*; Robins (1986) — *Unlimited Power*; and Robins (1991) — *Awake The Giant Within* are typical titles. These authors and teachers have bypassed the traditional

institutions and gone directly to the public. Most of them are self educated. The way it is taught borders on the religious. The following is a excerpt from Bristol (1954):

Let me determine if I understand you: you form the picture of your desire, consciously, and then, while being very quiet, it is reflected back to you, probably only for the fraction of a second! Is this reflection-seeing it-in your mind's eye? And is this what must happen, before the creative power within can be impelled to bring you effective results? Yes, you have described the process very well. (pg. 222)

David Schwartz (1959) told his readers:

When you believe something is impossible, your mind goes to work for you to prove why. But, when you believe, really believe, something can be done, your mind goes to work for you to find the ways to do it (pg. 85).

Schwartz points out the importance of perceptions or pictures: "We do not think in words and phrases. We think in pictures and/or images" (pg. 67).

These teachers, and many like them, teach and write about the perceptual method of thinking just as the religious community world wide teaches . . . the difference between the two is that religion uses an external source for power and the perceptual teachers use an internal source that is not well defined.

Alcoholics Anonymous finds itself on an ancient family tree. In the beginning it positioned itself between two powerful branches, organized religion and medical science. When medicine broke away from organized religion it adopted a new language. This language was logic, the language of science that was well suited for its interests. They have not spoken to one another since the separation. They cannot, they do not speak the

same language. When modern professional psychology separated from medical science it retained the language of science. Such thinkers as De Bono (1969) have observed that the logical system used in science is less than efficient when applied to the human condition. His point may be valid when we look at impressive successes on the scientific front but little, if any, positive movement in the human condition.

When the literature is consulted the struggle between the two systems can be identified. Abraham J. Twerski's (1990) article indicates the intensity of this conflict by its very title, "Is Divine Intervention Really a Drawback?", Twerski successfully ignores the thinking system and harkens his reader back to fears of an institutional parent. Using language as a metaphor for the thinking system, this researcher concluded that this writer is not bilingual but is only talking to his own group. When Hodgson (1989) informs his readers that resisting temptation is a key to recovery, it shows that this group has not moved in fifty years.

The early members of Alcoholics Anonymous discovered that recovery had nothing to do with will power, because it had never worked for them. When these early members of Alcoholics Anonymous discovered the perceptual method of thinking used by the Oxford Group, they experienced some success where none had been before. In modifying what they learned, they designed their program to meet their one objective.

It is this researcher's observation that modern psychology, though it raises the religious issue, remains distrustful of the system of thinking that religions of all types use. The discussion appears not be to about science and religion, but between two systems of

thinking. What confuses the issue even further is that organized religion has fractured into many individual camps each proclaiming the one true God. This historical limiting situation made it impossible for them to talk to one another or to effectively teach their thinking system to the alcoholic, for the prerequisite to be a student was to accept a particular perception of a god. Neither the logical psychologist or the perceptual religious thinker, by the nature of their solution can incorporate the idea that alcoholism is genetic.

With the advent of treatment centers the modern psychological thinking has made a powerful re-entry into the field of alcoholism and with it has been a reintroduction of the logical system of thinking. This psychologically driven institution incorporated part of Alcoholics Anonymous but appears of have given greater emphasis to it's own agenda. The two systems of thinking do not co exist well in the present atmosphere and one, over time, will become dominant. This study indicates that completing the Alcoholics Anonymous treatment regime is a low priority to treatment center graduates. Is this movement beneficial to the culture? Even though there are many alcoholics maintaining in an abstinent position, have we lost the lion's share of those that have passed through the treatment centers of this nation in the past four decades? Has the good truly been the enemy of the excellent?

This researcher has arrived at the position that the serious professional in the field of alcoholism must be bilingual, knowing several mental language systems and capable of leaving behind the baggage of the institutions from which they sprang. For the professional of the future to say alcoholism is a genetic aberration that is not useful to the

organized human community would be a giant leap forward. Secondly, that individuals possessing this genetic aberration in the present culture require intervention. This intervention must include the society saying no to destructive behavior on every level. The professional of the future must be able to understand and use several systems of thinking that he or she can apply to the presenting situation. As with the early members of Alcoholics Anonymous, the only issue to be considered is positive results not the emotional reaction to the method.

Twelve Steps of Alcoholics Anonymous

Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to the simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault; they seem to have been born that way. They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty. Their chances are less than average. There are those, too, who suffer from grave emotional and mental disorders, but many of them do recover if they have the capacity to be honest.

Our stories disclose in a general way what we used to be like, what happened, and what we are like now. If you have decided you want what we have and are willing to go to any length to get it - then you are ready to take certain steps.

At some of these we balked. We thought we could find an easier, softer way. But we could not. With all the earnestness at our command, we beg of you to be fearless and through from the very start. Some of us have tried to hold on to our old ideas and the result was nil until we let go absolutely.

Remember that we deal with alcohol - cunning, baffling, powerful! Without help it is too much for us. But there is One who has all power - that One is God. May you find Him now! Half measures availed us nothing. We stood at the turning point. We asked His protection and care with complete abandon.

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

(Wilson, W., pp. 58-60, 1976)