

*The following submission, written by **Shannon Byrne, Shauna Mahoney, Jamie Morrill, and Katryn Tremer**, was written to fulfill a requirement for Professor Sharyn Potter's *Methods of Social Research* course. Shannon, Shauna, and Jamie are Sociology and Justice Studies majors, entering their senior year. Katryn received her Bachelor of Arts in Sociology in May 2007. Their work on relapse trends among Alcoholics Anonymous attendees was presented at the 2007 Undergraduate Research Conference at the University of New Hampshire.*

Relapse Trends Within Alcoholics Anonymous

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Keywords: Alcoholics Anonymous
Court Mandated Treatment
Intervention Strategies
Rehabilitation
Inpatient/Outpatient
Relapse

Abstract: Alcohol abuse and dependence exist as major social problems throughout the United States. Several different strategies are used to help problem drinkers overcome addiction, including inpatient/outpatient services, rehabilitation and intervention programs, and support groups such as Alcoholics Anonymous (AA). As few comparative studies have been conducted, controversy exists over which programs are the most effective in controlling alcohol abuse and whether or not court mandated treatment in any program can be effective. In order to test the effectiveness of AA in both court mandated and voluntary attendees, surveys were distributed to 81 AA members in New Hampshire and Massachusetts. Questions related to ones involvement with AA and ones experience with relapse. Almost half of the sample indicated having experience relapse since becoming a member. Despite this, the relationship between

attendance to AA and relapse rates was not statistically significant. 100% of those surveyed agreed that AA was either “very helpful” or “somewhat helpful” in controlling addiction. Almost half indicated that fellowship was the most important strength of the program. It was difficult to make any inferences about the effectiveness of court mandated attendance as only two individuals surveyed indicated that they were court mandated to attend. The qualitative results do, however, suggest that court mandated attendance is not effective. This study gives insight into the perceived effectiveness of AA as well as strengths and weaknesses of the program.

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Introduction

Alcohol abuse and dependence exist as major social problems throughout the United States. Approximately 7.6% of those over the age of 12, or 18 million individuals, meet the criteria for alcohol dependence (U.S. Department of Health and Human Services 2006). Several different strategies are used to help problem drinkers overcome addiction. Intervention programs allow friends and family members to be part of the treatment process. Other rehabilitation programs apply intensive therapy to help their patients. Support groups, such as Alcoholics Anonymous (AA), bring problem drinkers together in a comfortable setting in which to discuss their struggle with alcohol abuse. Any of these strategies may be accessed through inpatient or outpatient facilities, and individuals may become involved in one of two ways: by their own free will or by way of legal coercion. Much controversy exists over which of these treatment strategies is most effective in controlling relapse (U.S. Department of Health and Human Services 2006).

Our research question is: What are relapse trends among Alcoholics Anonymous members? We hypothesize that: (1) those who attend Alcoholics Anonymous meetings

multiple times per week (3 or more times) will be more likely to relapse than those who attend Alcoholics Anonymous meetings only one time per week; (2) the younger members (those ages 39 and younger) of Alcoholics Anonymous will have more instances of relapse than the older members (those ages 40 and older) of Alcoholics Anonymous; (3) those who are court-mandated to attend Alcoholics Anonymous are more likely to relapse than those who are attending Alcoholics Anonymous voluntarily; (4) the older the age (ages 40 and above) the longer the membership with Alcoholics Anonymous, and the younger the age (ages 39 and below) the shorter the membership with Alcoholics Anonymous; and (5) that membership and attendance to Alcoholics Anonymous will have a significant effect on relapse rates.

Review of Literature

Alcohol Rehabilitation Services and Facilities

There are numerous types of rehabilitation facilities for individuals seeking to overcome addiction. These include individual and group therapy, family education and counseling, gender specific treatments, psychotherapy, hypnotherapy, spiritual counseling and body work. Though there is an abundance of literature concerning the effectiveness of rehabilitation facilities, few studies have compared the effectiveness of different facilities and programs. It is important to gain a better understanding of the strengths and weaknesses of different programs and highlight which types of programs lead to lower rates of relapse.

For some individuals, accessing rehabilitation services may be difficult. Many factors, specifically demographics, have an effect on a person's accessibility to alcohol abuse treatment services (McLellan 1998; McDaniel 2006). There are two types of

inequalities which exist and create barriers for individuals who are seeking alcohol treatment services: “supply-side causes and demand-side causes.” According to Fiorentine (1993), supply-side causes find the causes of inequality within the service system itself. Demand-side causes locate the source in the attitudes and behaviors of the potential clients (Fiorentine 1993). A few states have taken considerable measures to study rehabilitation services available to their residents. In order to offer rehabilitation services equally to everyone statewide regardless of socioeconomic status, race, class or gender, these states have attempted to determine the best way to eliminate existing barriers which prevent these populations from seeking treatment (McDaniel et al. 2006). Many people seeking treatment are underserved, and may be unaware of the rehabilitation services offered within and around their communities (Fiorentine 1993). Private and public health insurance programs have a significant impact on the availability of different types of rehabilitation services and facilities as well as the length of stay for patients (McDaniel 2006). Although there are infinite treatment programs and facilities, research has shown that there is a gap in the accessibility of rehabilitation services specifically based upon gender, race, ethnicity, religion, social class, and age (Fiorentine 1993). Current literature suggests that with the recent shifts in the structure of treatment facilities, there may be a push for shorter inpatient stays, which many believe will directly increase an individual's chance of alcohol and drug relapse (Fiorentine 1993).

One study, based in Philadelphia, focused on twelve diverse treatment facilities, all of which traditionally offered various treatments and services. All twelve of the facilities relied on Medicare as a form of reimbursement. Of the twelve programs, four were controlled study groups, which received no additional treatment enhancements,

while the additional eight groups received further care of various degrees. The results were as expected: both groups showed various improvements, while the enhanced treatment groups showed a 25-49% improvement (McLellan et al. 1998). This study finds that enhancements to the traditional services offered may greatly increase a patient's ability to remain sober (McLellan et al. 1998).

In order to generate equal access to treatment services, limit the length of care, measure quality, and reduce the cost of treatment, America's health care system shifted from private care to managed care in the late 1980's and 1990's (McDaniel et al. 2006). The dramatic shift in length of treatment provided and paid for through private insurance and public assistance programs left many treatment providers feeling rushed. One counselor from a California residential treatment facility stated, "It's too short....It doesn't work. Guys leave here...they might not have drunk or used the whole 30 or 45 days they're here. They got some drug and alcohol education, but they haven't learned any coping skills, any living skills" (McDaniel et al. 2006).

Although there are currently many studies regarding rehabilitation treatment services and facilities, few seem to measure relapse rates and which services may be most effective of preventing relapse. The significance of the few studies which have been done indicates that such services and facilities are extremely important to the general public's health (McLellan 1998). The services provided by communities, private facilities, and group supports services may all play an important role in preventing problem drinkers from relapsing (McLellan 1998).

Alcohol Abuse Intervention Programs

Research has shown that an estimated 75% of alcohol abusers can overcome an addiction without the help of professional treatment (Harvard Health Publications 2007).

Advice and encouragement from a doctor, family member, friend, or peer can have a significant impact on one's relationship with alcohol (D'Agostino, Barry, Blow, & Podgorski 2006; Hansson, Rundberg, Zetterlind, Johnsson, & Berglund, 2006; Hecht, Graham & Elek, 2006; Hensold, Guerico, Grubbs, Upton, & Faw 2006; Ståhlbrandt, Johnsson, Berglund, & Mat 2007). For purposes of this study, intervention will be defined as a group process which seeks to motivate an alcoholic to overcome addiction. Such strategies have shown to be very successful in helping individuals overcome addiction by allowing the abuser to realize the extent of their problem, and illustrating how their addiction affects their loved ones (D'Agostino et al 2006; Hansson et al. 2006; Hecht et al 2006; Hensold et al. 2006; & Ståhlbrandt et al 2007). The success of intervention programs is generally studied across age groups.

The Success of Intervention

Minors. Few studies have shown that different intervention programs can cut down on alcohol abuse among young adults (Hecht et al. 2006). One study, conducted at Pennsylvania State University, aimed at evaluating the Drug Resistance Strategies project, a substance abuse program popular in Arizona middle schools (Hecht et al. 2006). Half of the 6,298 seventh graders who were participants in the study went through the program. The other half, the control group, did not. Hecht and his colleagues found that, compared to students in the control group, those who had gone through the program were significantly less likely to report recent alcohol abuse.

College Students. College-aged individuals are among the most likely to succumb to addiction. A large host of studies within the realm of alcohol abuse prevention have been aimed at assisting abusers of this age group (Ståhlbrandt et al. 2006). A 2007 study

conducted in Swedish universities found that live lectures, discussion groups, and skills training programs are the most effective forms of interventions for students who engage in high-risk consumption (Ståhlbrandt et al. 2006).

Another study focused on university students whose parents struggled with alcohol addiction (Hansson et al. 2006). In the study, 82 students who were children of alcohol abusers were randomly assigned to one of three different intervention programs. The first was a standard alcohol intervention program, the second, a coping program, and the third was a combination of both methods. These three strategies targeted both the biological and sociological aspects of addiction. The results showed that students going through the different programs, not only improved their own drinking patterns, but also became better able to cope with their parents' drinking problems (Hansson et al. 2006).

The USA Higher Education e-CHUG, implemented in 2002, is an alcohol intervention program focusing on college students. This internet based program, now used in over 250 colleges and universities in 42 states, has proven to be a very effective method in cutting down binge drinking among students (e-CHUG 2007). Information packets that were sent to students included a drinking behavior profile, a cost calculator, abuse statistics, and lists of risk factors. Charts are also sent to students that compare the caloric content of alcohol to cheeseburgers, and display how much money could be saved if students cut down on drinking even slightly. A study conducted at San Diego State University, was given to a number of students who had prior alcohol-related disciplinary violations (Curley 2006). Researchers found that after completing e-CHUG, students cut their alcohol consumption by an average of 13 drinks per week.

Adults. Adults, of all ages, are also very likely to become alcohol abusers. They are, however, highly underrepresented in intervention research (D'Agostino et al. 2006). In one study conducted in Rochester, New York, the effectiveness of the Geriatric Addictions Program was analyzed (D'Agostino et al. 2006). This intervention program focuses strictly on older adults, and works at addressing physical and psychological problems associated with substance abuse. Of the 120 seniors who were put through this program, a large percentage of them recovered from their addiction (D'Agostino et al. 2006). Similar results were also found in a study by Hensold et al. in Illinois (2006). This study found that adults of all ages benefit from alcohol intervention programs, most specifically those based around live-in treatment and self-monitoring.

The Future of Intervention

Numerous studies have shown that intervention strategies are successful at reducing alcohol abuse (D'Agostino, et al. 2006; Hansson et al. 2006; Hecht et al. 2006; Hensold et al. 2006; et al. 2007). However, little research has been done to suggest how long intervention programs should last, or how results may differ by demographic characteristics. Professor Mary Larimer, is working at answering these questions (Curley 2006). Distributing surveys to her students, Larimer has found that even brief interventions can be effective at cutting down drinking. A study conducted by the World Health Organization found similar results (Curley 2006).

Intervention strategies have proven to be very effective in reducing alcohol consumption among abusers (Ståhlbrandt et al. 2007; Hensold et al. 2006; Hect et al. 2006; Hansson et al. 2006; & D'Agostino 2006). Such strategies are important to consider when dealing with an individual who is a high-risk drinker. Future research

should aim at comparing different intervention strategies to see which is the most effective at helping abusers overcome addiction. Further research should be done with adults as the focus as such individuals are underrepresented in data on such programs. Finally, the outcomes of intervention programs should be compared across different groups, and demographic variables should be considered.

Inpatient Treatment versus Outpatient Treatment

While early research suggests that the treatment of alcohol abusers primarily focused on inpatient strategies, some studies find that outpatient treatment for problem drinkers has become more popular (Bottlender and Soyka 2005; Thomassen 2002). Standard outpatient treatment may be described as the following: manual-guided active-treatment components within individual sessions and group sessions, and attendance at a minimum of two Alcoholics Anonymous (AA) or Narcotics Anonymous meetings each week (Rychtarik, Connors, Whitney, McGillicuddy, Fitterling & Wirtz 2000). According to Rychtarik et al. (2000), inpatient treatment may consist of the following: group therapy sessions, individual counseling sessions, problem solving, relapse prevention, group lectures, Alcoholics Anonymous steps, medical aspects of drug/alcohol abuse, and family group sessions.

The results of a study measuring the relapse rates during outpatient treatment and dropout ratio by Bottlender and Soyka (2005) found that 70 participants were sober during the whole treatment, while 32 participants relapsed during the treatment. The researchers also found that 14 of the participants who had relapsed became sober again and rejoined the treatment program, portraying the value of the outpatient program for long-term problem drinkers (Bottlender and Soyka 2005). The same researchers also

found that outpatient treatment may be just as effective as inpatient treatment. This shows the significance of outpatient treatment for problem drinkers, but also for problem drinkers who have relapsed and would like to receive treatment again. According to Rychtarik et al. (2000), the outcomes from the two treatments, inpatient and outpatient, may be influenced by alcohol participation: inpatient treatment may yield better results for persons with high alcohol involvement, while persons with low alcohol involvement may benefit greatly from outpatient treatment.

Although this research may provide valuable insight to problem drinking and inpatient and outpatient treatment, it is also subject to limitations. Many of the studies focusing on problem drinkers and rehabilitation discuss issues with their study's sample (Bottlender and Soyka 2005; Rychtarik et al. 2000). One study states that the sociodemographic characteristics of the participants may prevent their sample from being representative of the population of problem drinkers as a whole, since it required a relatively stable social situation (such as marital status and employment) (Bottlender and Soyka 2005). Furthermore, their study is limited by its small sample size and its 28% dropout rate by participants within the study. Rychtarik et al. (2000) found similar limitations within their study: their sample was comprised solely of participants who consented to random assignment, and when grouped, characterized a more severe problem within the inner-city population than expected. Although there are many studies researching the effects of inpatient and outpatient treatment on problem drinkers, more research within this area is necessary.

Alcoholics Anonymous

“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...Our primary purpose is to stay sober and help other alcoholics to achieve sobriety” (Alcoholics Anonymous 2007).

Not only has AA been praised by members for its positive influence, it was also given the Lasker Award for its outstanding medical progress (Alcoholic Anonymous 2nd edition, as cited by Vaillant 2004). The twelve step method to recovery from alcoholism, which AA uses, is unlike any other form of treatment provided by a rehabilitation facility. Members of AA get a sponsor who they can talk to outside of meetings about their progress or thoughts of relapse. The sponsor is there to help prevent the problem drinker from relapsing, and to provide emotional support throughout their recovery. This support is beneficial to the problem drinker because their sponsor becomes someone that they have just met, as opposed to their friends and family who may have seen them hit rock bottom (Vaillant 2004). AA is also known for the variety of social activities that it plans for its members. These activities allow the members of AA to become actively involved with their community with the intent of reducing the importance of and need to drink alcohol (Vaillant 2004). A study conducted by Thomassen (2002) found that social involvement or fellowship with Alcoholics Anonymous, such as interacting during, after, and outside of meetings, may contribute to abstinence in regards to alcohol.

Despite the perceived strengths of Alcoholics Anonymous, research has shown that there are also weaknesses and criticisms of the organization and its actions. Vaillant (2004) is critical of the organization because he believes that AA has no interest in research. Furthermore, researchers state that the side effects of being a member of AA could cause more harm than good; many individuals may experience unenthusiastic group meetings, or come in contact with inadequate sponsors (Vaillant 2004). Lastly,

AA has been criticized for promoting dependence, which Vaillant (2004) reports can either serve as a strength or a weakness, depending on the individual.

The Effectiveness of Court Mandated Attendance to AA

Research suggests that in order for the individual to successfully recover from their addiction, the individual must be motivated to do so (Brecht, Anglin & Wang 1993, as cited by Klag, O'Calaghan, & Creed 2005). Rapp, Li, Siegal, and DeLiberty (2003) report that motivation is an important factor in a patient's recovery, but it is not the sole determining factor. In their study, they found that the severity of the patients' addiction was correlated with their motivation. The more severe their addiction was at their entry into rehabilitation, the better their motivation was to quit (Rapp et al. 2003).

There is an ongoing debate as to whether attending Alcoholics Anonymous (AA) through coercion is effective in the recovery of problem drinkers (Vaillant 2005). Today with the growing number of drug related arrests, several states have created drug courts, where offenders are sentenced directly to treatment (Wolfer 2006). Alcohol abuse related sentences often involve programs which last for 12 months, and require a five step program (Wolfer 2006). Many of the court mandated strategies require participation in Alcohol Anonymous (AA) programs on a daily or weekly basis (Wolfer 2006). More than 17% had been rearrested on drug related charges (Wolfer 2006). Though AA has been helpful for many alcoholics who attend willingly, its effects on coerced attendees is questionable.

There are many other issues regarding court mandated attendance to Alcoholics Anonymous. The healing process of the individual may be jeopardized by persons who are legally mandated to attend (Speiglmán 1997). Those who attend the meetings willingly are deprived the opportunity of surrounding themselves with other individuals

who are personally motivated to rid their lives of their addiction to alcohol (Vaillant 2005). Due to this conflict, those who are legally required to attend are denied the full bonding process that takes place as part of the healing method; they are frowned upon by those who are there on their own free will (Vaillant 2005). Ethics is another issue that is quite commonly discussed in regards to the forcible attendance of Alcoholics Anonymous (Vaillant 2005). There is no pressing evidence that proves that rehabilitation is actually effective, therefore, without informed consent from the offender, the requirement of attending AA could be considered “illegitimate punishment” (Speigman 1997).

The research that has been done on court mandated treatment has many restrictions. First and foremost, the reasons that offenders’ punishments result in Alcoholics Anonymous attendance varies from state to state, as do the types of programs that they are required to attend (Dill and Wells-Parker 2006). This variation from state to state makes it hard for researchers to effectively compare results. The offenders who are forced into AA have been placed there for a variety reasons. Thus, researchers have a difficult time analyzing data and measuring the effectiveness of AA (Dill and Wells-Parker 2006).

There has been a lack of studies looking at the effects Alcoholics Anonymous on legally coerced attendees. Most of the research focuses on the efficiency of coerced rehabilitation services on substance abusers (as opposed to alcohol abusers). Future research in this area should further consider the relapse rates of court mandated attendees.

Through our review of the literature, we have found that there has been a limited amount of substantial research done on the success rates of court mandated treatment for

alcohol abusers and the effectiveness of Alcohol Anonymous. Alcohol abuse is a growing problem among the American population and further research on alcohol treatment is critical in order to put an end to this widespread addiction. This study attempts to explore the effects of AA on alcohol abusers, and highlight differences in outcomes of patients who are required by law to attend.

Methods

Participants Using a purposive non-probability sample 81 participants from New Hampshire and Massachusetts were surveyed. There were 55 males and 26 females, with ages ranging from 22 years of age to 75 years of age, with an average of 35 years. Approximately 50% of the participants were either married or in a civil union. About 98% of our sample graduated high school, and 50% of our respondents received at least a 4-year college degree. To ensure confidentiality and anonymity, we did not ask respondents about their race or their religious affiliations due to our small sample size.

Measures and Procedure We created a survey to be distributed at each of the Alcoholics Anonymous we planned on attending. The survey consisted of questions regarding demographics, involvement with Alcoholics Anonymous, and relapse rates. Each of our variables was coded appropriately to be measured and analyzed within Small Stata. All of the questions on our survey which required a 'yes' or 'no' response were coded as '1' and '0' respectively. Survey questions that included multiple answers were also coded accordingly. Open-ended survey questions were not measured in a quantitative manner. Instead we took a more analytical approach; the most frequent

responses were analyzed to determine the strengths and weaknesses of Alcoholics Anonymous.

Surveys were distributed at Alcoholics Anonymous meetings throughout New Hampshire and Massachusetts. We selected meetings based on their type, as we were only allowed to attend Alcoholics Anonymous meetings that were classified as 'open meetings.' We arrived at each meeting approximately 45 minutes early and requested to speak with the group leader or secretary. We then explained to the group leader/secretary the purpose of our survey, and our intentions to have our survey completed by voluntary participants. We assured the group leader/secretary that all responses were voluntary, and we guaranteed confidentiality and anonymity. Surveys were then left at each meeting, along with food we provided, as well as a sealed box for completed surveys. We then left each meeting, and returned after the meeting had concluded. The surveys were then collected and placed in a secure area.

In addition to our survey, we also conducted an interview with an Alcoholics Anonymous member. To ensure anonymity and confidentiality, the participant's name was not written on any of the notes taken by the researchers. This interviewee contacted us through information left on their completed survey. We then contacted this participant and set up a designated time and meeting place. The interview was relatively informal, but was mainly structured around the format of our survey. We were open to any and all responses that the interviewee was willing to share with us, especially since they indicated an interest in speaking with us. During the interview, we took notes on what the participant communicated to us verbatim. During the interview, we asked more in-

depth questions based on the open-ended questions from in our survey. All of the interview notes were then kept in a secure location until they were used for data analysis.

Upon reviewing completed surveys, we found that some of our questions were confusing. For example, question 9 of our survey asked participants, “How many weeks/months/years have you been a member of Alcoholics Anonymous?” Respondents answered this question in many different ways, partly because it was an open-ended question, but also because we did not clearly indicate how to accurately answer the question. Due to the ambiguous nature of some survey questions, we were unable to analyze several of the responses to our questions. Although our objective was to sample Alcoholics Anonymous members, by doing so this created a sampling bias. We also found that the attitude of the group leader/secretary had a significant impact on the number of completed surveys we received. If the group leader/secretary seemed receptive to our survey, we usually received a greater number of completed surveys, as opposed to an unreceptive group leader/secretary.

Results

Descriptive Statistics

Our sample consisted of 81 Alcoholics Anonymous members within New Hampshire and Massachusetts. Of the participants, 55 were male and 26 were female (see Table 1). The average age of our participants was 35, while the majority of the participants were within the age range of 50-59 (see Table 2). Approximately 50% of the participants were either married or in a civil union. Of the remaining participants, 26% were single, 22% were divorced or separated, and 2% were widowed (see Table 3). Approximately 98% of our sample graduated high school, and 50% of our participants

received at least a 4-year college degree (see Table 4). Of our 81 participants, only two were court-mandated to attend Alcoholics Anonymous; the remaining 79 participants suggested that their attendance to Alcoholics Anonymous was voluntary. Length of membership among participants varied greatly, ranging from less than 6 months to more than 20 years (see Table 5). Ninety-seven percent of participants suggest that Alcoholics Anonymous has been “very helpful” in assisting with their recovery and the other 3% suggest that Alcoholics Anonymous has been “somewhat helpful.” None of the participants found Alcoholics Anonymous to be “Not very helpful” or “Not helpful at all” (see Table 6). While attending Alcoholics Anonymous, 56% of participants had indicated that they had not relapsed, while 44% of participants indicated that they had relapsed, since becoming a member (see Table 7).

The results from our interview demonstrated support for the general findings of our study. Although weaknesses of Alcoholics Anonymous were indicated throughout the interview, the overall perception of the program was that it is extremely effective. The interview provided extremely important insight for future research regarding Alcoholics Anonymous. The results from the interview suggested that negative life events may have a significant impact on the drinking habits. Our survey did not contain any questions regarding negative life events, so any responses from the interviewee regarding such events were analyzed for more qualitative purposes. The interview also highlighted the importance of the “high power” aspect of Alcoholics Anonymous. The interviewee referred to Alcoholics Anonymous as being a tool for “spiritual” relief, while many members have the misconception that Alcoholics Anonymous is a “physical” relief. Again, we did not anticipate answers regarding the issues of “high power” within

Alcoholics Anonymous, so any responses considering this were used for analyzed in a qualitative manner only.

Statistical Analysis

To test whether those who frequently attend Alcoholics Anonymous (multiple meetings per week) are less likely to relapse than those who do not frequently attend Alcoholics Anonymous (less than one meeting per week), a chi square analysis was performed (see Table 8). The test revealed no significance between attendance to Alcoholics Anonymous and relapse rates, suggesting that the two variables are independent of each other. Therefore, we fail to reject the null hypothesis. It is important to note that 37 of the 40 respondents who answered this question attended Alcoholics Anonymous meetings multiple times per week. Of these 37 participants, over half indicated a decrease in their relapse rates. Statistical significance may not have been found due to the low number of participants who only attended Alcoholics Anonymous meetings “about once per week.”

A chi square analysis was performed to test whether those who are currently court-mandated to attend Alcoholics Anonymous are more likely to relapse than those who attend Alcoholics Anonymous on a voluntary basis. In Table 9 we find that the analysis revealed no significance between the variables. Therefore, we fail to reject the null hypothesis. This test revealed that 38 of the 40 respondents to this question were not court-mandated to attend Alcoholics Anonymous. One of the two respondents, who was court-mandated to attend Alcoholics Anonymous, indicated an increase in their relapse rate, while the other court-mandated respondent indicated a decrease in their relapse rate. Twenty-six out of the 40 respondents to this question saw a decrease in their relapse

rates, while 3 respondents saw an increase, 7 respondents stayed the same, and 4 respondents answered, “I don’t know.”

To test whether age has a significant effect on relapse, a chi square analysis was performed (see Table 10). We hypothesized that the younger members (ages 20-39) of Alcoholics Anonymous would report more instances of relapse than the older members (ages 40 and older) of Alcoholics Anonymous. In Table 10, we find that our chi square analysis revealed no significance between age and instances of relapse. Therefore, we fail to reject the null hypothesis. Although no significance was found, it is important to note that there were only 18 respondents that fit within our definition of “younger Alcoholics Anonymous members,” while there were 50 respondents that fit within our definition of “older Alcoholics Anonymous members.” It should also be noted that 63% of the total respondents to this question had never previously relapsed. The number of respondents for each age category is also significant: ages 20-29 received 5 responses, ages 30-39 received 13 responses, ages 40-49 received 18 responses, ages 50-59 received 22 responses, and ages 60 and above received 10 responses. Clearly, the majority of the respondents within the study were between the ages of 50-59. The unequal distribution among the age categories may be responsible for the lack of significance found between variables.

To test whether membership with and attendance to Alcoholics Anonymous predicts relapse rates, a hierarchical regression analysis was performed in which membership was entered into step one, and attendance into step two. In Table 11, we find that statistical significance was found for neither step one nor step two ($R^2 = 0.03$, $F(2, 34) = .58$, $p > .05$), ($t(34) = -0.39$, $p > .05$) and ($t(34) = 0.94$, $p > .05$), respectively.

To test whether age has a significant impact on length of Alcoholics Anonymous membership, a chi square analysis was performed (see Table 12). We hypothesized that the older the age (ages 40 and older), the longer the membership with Alcoholics Anonymous than members of younger age (ages 39 and younger). In Table 12, we find that our chi square analysis revealed significance between the two variables ($p < .00$), and we reject the null hypothesis. It is important to note that the positive relationship between older age (ages 40 and older) and length of Alcoholics Anonymous membership may be attributed to increased lifespan.

Discussion

Our study suggests that Alcoholics Anonymous is a very effective program for individuals who attend Alcoholics Anonymous with the intentions of achieving sobriety (see Table 6). Several respondents suggested that Alcoholics Anonymous is most effective if the individual attending has a strong desire to stop drinking. Sixty-eight percent of respondents suggested that Alcoholics Anonymous had no weaknesses. Many respondents indicated that fellowship was one of the greatest strength of Alcoholics Anonymous. Despite the suggested weaknesses of the program, all respondents agreed that Alcoholics Anonymous was “very helpful” in assisting them with their problems with alcohol abuse. We found an overall decrease in relapse rates among those who indicated they attend Alcoholics Anonymous multiple times per week, as well as for those who attend Alcoholics Anonymous less than one time per week (see Table 13). Although the majority of our respondents were within the age range of 50-59, there were more instances of relapse for those ages 49 and younger (see Table 14). The majority of our respondents voluntarily attended Alcoholics Anonymous, while two respondents (less

than 3 percent of our sample) indicated they were court-mandated to attend Alcoholics Anonymous (see Table 15). Based on our findings, there is no statistically significant relationship between Alcoholics Anonymous attendance and relapse rates. Overall, Alcoholics Anonymous is perceived to be a very effective program for achieving sobriety.

Value of Findings

Our findings are sociologically significant while providing insight to the strengths of Alcoholics Anonymous, though very few of our quantitative analyses were found to be statistically significant. Through open-ended survey questions, we were able to measure the strengths and weaknesses of Alcoholics Anonymous, as suggested by the respondents.

Limitations

Our study has limited generalizability because we did not use a random sample. Not only was our sample size relatively small, it was also limited in its diversity. Therefore, one must use caution when generalizing our results to larger populations. Equally of importance, negative life events were not considered within our study, and may have a significant impact on a person's drinking habits.

Future Research

Future research should consider the effectiveness of Alcoholics Anonymous in comparison with other alcohol rehabilitation programs and facilities. Future research should also consider negative life events and their effects on drinking habits and relapse rates. The religious aspect of Alcoholics Anonymous, such as the "higher power" should be researched to determine its impact on membership and relapse rates. Finally, future

research should examine the effectiveness of the program for those who are court-mandated to attend Alcoholics Anonymous.

Given the literature and results of our study, it is obvious that alcohol abuse and dependence are significant sociological problems in the United States today. Our research attempted to determine how Alcoholics Anonymous may be affecting this problem, but encountered various problems in the process. The majority of the issues experienced in this survey, and suggestions to improve this survey were based on resources. Sufficient funding may provide researchers the opportunity to distribute surveys in more than just two states; not only would this allow more insight to Alcoholics Anonymous, but it would provide a more representative sample. Improving research focusing Alcoholics Anonymous may produce fundamental results on the effectiveness of this world-wide program, but how it compares to other rehabilitation programs and facilities for alcohol abuse as well.

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APPENDIX

Table 1

Gender	Freq.	Percent	Cum.
male	55	67.90	67.90
female	26	32.10	100.00
Total	81	100.00	

Table 2

age	Freq.	Percent	Cum.
20-29	5	6.25	6.25
30-39	15	18.75	25.00
40-49	21	26.25	51.25
50-59	26	32.50	83.75
60 and above	13	16.25	100.00
Total	80	100.00	

Table 3

Marital Status	Freq.	Percent	Cum.
single	21	25.93	25.93
married/common law/civil union	40	49.38	75.31
widowed	2	2.47	77.78
seperated/divorced	18	22.22	100.00
Total	81	100.00	

Table 4

Education	Freq.	Percent	Cum.
did not complete h.s.	2	2.47	2.47
h.s. diploma/GED	16	19.75	22.22
tech. school	7	8.64	30.86
some college	16	19.75	50.62
college grad.	25	30.86	81.48
postgrad.	15	18.52	100.00
Total	81	100.00	

Table 5

Membership Length	Freq.	Percent	Cum.
less than 6 months	10	13.33	13.33

6 months to a year	10	13.33	26.67
2-4 years	12	16.00	42.67
5-9 years	10	13.33	56.00
10-14 years	8	10.67	66.67
15-19 years	9	12.00	78.67
20+ years	16	21.33	100.00

Total	75	100.00	

Table 6

Overall AA Rating	Freq.	Percent	Cum.
very helpful	75	97.40	97.40
somewhat helpful	2	2.60	100.00

Total	77	100.00	

Table 7

Relapse	Freq.	Percent	Cum.
no	44	55.70	55.70
yes	35	44.30	100.00

Total	79	100.00	

Table 8 Attendance to Alcoholics Anonymous and Relapse Rates

Attendance	Relapse Rate				Total
	increased	stayed same	decreased	don't know	
about once per week	0	0	3	0	3
	0.00	0.00	11.54	0.00	7.50

multiple times per we	3	7	23	4	37
	100.00	100.00	88.46	100.00	92.50

Total	3	7	26	4	40
	100.00	100.00	100.00	100.00	100.00

Pearson chi2(3) = 1.7464 Pr = 0.627

Table 9 Currently court-mandated to attend AA and Relapse Rates

Court	Relapse Rate				Total
	increased	stayed th	decreased	I don't k	

no	2	7	25	4	38
	66.67	100.00	96.15	100.00	95.00
yes	1	0	1	0	2
	33.33	0.00	3.85	0.00	5.00
Total	3	7	26	4	40
	100.00	100.00	100.00	100.00	100.00

Pearson chi2(3) = 5.7220 Pr = 0.126

Table 10 Age and time relapsed

Times Relapse	Age					Total
	20-29	30-39	40-49	50-59	60 and ab	
0	3	8	11	14	7	43
	60.00	61.54	61.11	63.64	70.00	63.24
1	1	1	5	4	1	12
	20.00	7.69	27.78	18.18	10.00	17.65
2	0	2	1	1	0	4
	0.00	15.38	5.56	4.55	0.00	5.88
3	1	0	0	0	0	1
	20.00	0.00	0.00	0.00	0.00	1.47
4	0	0	0	2	1	3
	0.00	0.00	0.00	9.09	10.00	4.41
6	0	1	1	1	0	3
	0.00	7.69	5.56	4.55	0.00	4.41
10	0	0	0	0	1	1
	0.00	0.00	0.00	0.00	10.00	1.47
20	0	1	0	0	0	1
	0.00	7.69	0.00	0.00	0.00	1.47
Total	5	13	18	22	10	68
	100.00	100.00	100.00	100.00	100.00	100.00

Pearson chi2(28) = 32.2272 Pr = 0.265

Table 11
Rate of relapse, Attendance, Membership

Source	SS	df	MS	Number of obs =	37
				F(2, 34) =	0.58

Model		.663435675	2	.331717837	Prob > F	=	0.5680
Residual		19.6068346	34	.576671606	R-squared	=	0.0327

Total		20.2702703	36	.563063063	Adj R-squared	=	-0.0242
					Root MSE	=	.75939

raterelapse	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
Attendance	-.18161	.4609104	-0.39	0.696	-1.118293	.7550725
Membership	.0553109	.0587685	0.94	0.353	-.064121	.1747428
_cons	3.086665	1.40152	2.20	0.035	.2384336	5.934897

Table 12

Membership Length	Age Categories		Total
	Below 49	50 and up	
less than 6 months	10	0	10
	26.32	0.00	13.70
6 months to a year	8	2	10
	21.05	5.71	13.70
2-4 years	7	4	11
	18.42	11.43	15.07
5-9 years	6	4	10
	15.79	11.43	13.70
10-14 years	2	5	7
	5.26	14.29	9.59
15-19 years	3	6	9
	7.89	17.14	12.33
20+ years	2	14	16
	5.26	40.00	21.92
Total	38	35	73
	100.00	100.00	100.00

Pearson chi2(6) = 26.0246 Pr = 0.000

Table 13 Frequency of Attendance and Relapse Rates

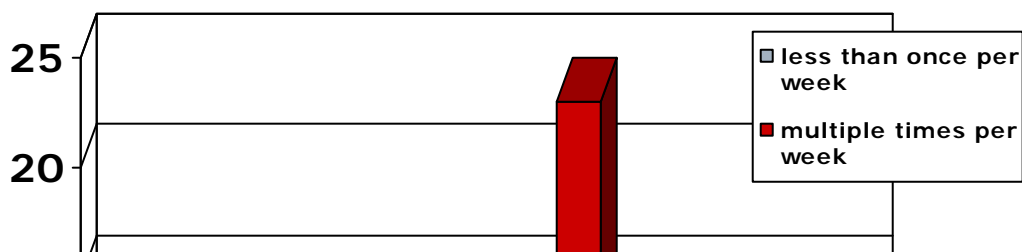


Table 14 Relapse and Age

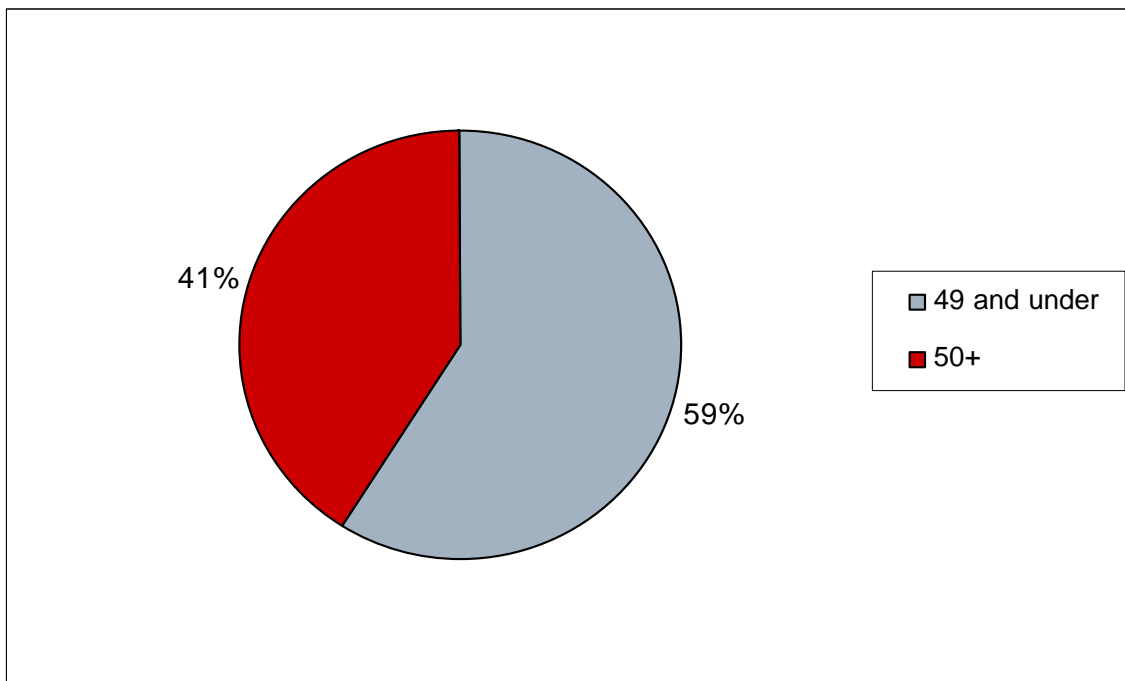


Table 15 Reason for Attending and Relapse Rates

