ATTENDING AA/NA MEETINGS AND ABSTINENCE FROM ALCOHOL AND DRUGS

A Project

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by

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Division of Social Work
Abstract

ATTENDING AA/NA MEETINGS AND ABSTINANCE FROM ALCOHOL AND DRUGS

by

Brian Wilhite

For many clients addicted to alcohol and/or drugs, it can be difficult to obtain and maintain abstinence. The purpose of this study was to explore the relationship between attending AA/NA meetings and abstinence from alcohol/drugs. This quantitative survey research study investigated the abstinence from drugs/alcohol of 44 men and women that were attending AA/NA meetings. The sampling method was a non-probability convenience sample. Those that stated they had been attending AA/NA meetings for four months or more reported to be abstinent from alcohol or drugs for more than 90 days. Chi square tests were not significant in the relationship between attending AA/NA meetings and abstinence from alcohol/drugs. Implications for social work practice and policy are discussed.

__________________________________, Committee Chair
Maria Dinis, Ph.D., M.S.W.

__________________________________
Date
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My dearest Leah Empey, I want to thank you for all the support and precious love you have provided me over these years. You found ways to ground me and assure me that I would be successful, even if I did not believe the same. Always remember that I love you and I would not be here without you. This is just a reminder of how much I cherish your love, friendship and esteem. Because of you, my life is now complete.

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Chapter 1

INTRODUCTION

The Problem

The researcher is interested in this topic from researcher’s experience in working with adults suffering from chronic alcohol and drug abuse. It has been the experience of the researcher that adults suffering from substance abuse without treatment experience criminal activity which often leads to incarceration, loss of jobs, loss of homes and the break-up of family. As a result of these losses, those individuals may become dependent on assistance programs that receive funding from government sources. These assistance programs generally are over-burdened with the needs from individuals that far exceed the resources available by those programs. Results of chronic alcohol and drug abuse include, but are not limited to, poverty, homelessness, sickness and hunger not only from those suffering from their addictions, but by the family members that are directly affected by the substance abuser (Narcotics Anonymous, 1988).

Positive results from the findings related to successful self-help substance abuse programs such as Alcoholic Anonymous (AA) and Narcotics Anonymous (NA) may contribute to the advancement of knowledge for social work practice. If research shows a positive relationship between increased attendance in AA/NA meetings and increased abstinence in substance use, then perhaps changes in social work policy will be implemented with a focus on increased treatment programs modeled after AA/NA. Increases in community sponsored treatment programs can help to reduce the stigma of substance abusers, and therefore increase their participation in such treatment programs.
Successful treatment may result in decreases in unemployment, homelessness, broken families, and the need for funding that support such problems that result from substance abuse. In addition, decreases in criminal activity, and the resulting savings from costs related to incarceration, police enforcement, and personal insurance costs, would save State and Federal Governments billions of dollars annually (ONDCP, 2001).

In terms of social work practice, findings from this research could be the foundation that will promote the funding from government and other sources necessary that will provide the motivation for social work programs and practitioners to develop and support their clients to utilize more AA/NA based interventions that will support a clients desire to abstain from substances and therefore decrease jail and prison populations, and increase a client’s positive contribution to family, job, community and society. The research for this study will focus on substance abuse treatment; specifically the relationship between attendance in AA/NA meetings and abstinence from alcohol/drug use.

**Background of Problem**

A 2005 report from the Substance Abuse and Mental Health Services Administration indicated that 126 million Americans aged 12 or over reported current alcohol use, and 19.7 million Americans in that same age range, reported illicit drug use (SAMHSA, 2005). Additionally, an estimated 22.2 million Americans (9.1 %) were classified with substance abuse or addiction within a year prior to the report. Additionally, 51% of America’s teenagers report to have tried some form of illicit drug before finishing high school (Johnson, O’Malley, and Bachman, 2004).
Substance abuse and addiction are some of the most frequent disorders in the United States today. Substance abuse is defined by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* as a maladaptive pattern of substance use that leads to impairment or distress at least once in a period of 12 months or more in one or more of four key areas of functioning (American Psychiatric Association [APA], 2000). The areas of functioning include: (1) failure to fulfill major role obligations at work, school, family, or home; (2) continued use in hazardous situations such as operating dangerous equipment or driving while intoxicated; (3) continued legal problems associated with use such as drug possession or drug dealing; and (4) continued use despite personal or interpersonal problems related to substance use (APA, 2000). Impairments due to addiction far exceed those of substance abuse. The *DSM-IV-TR* defines substance dependence, otherwise known as addiction, as a maladaptive pattern of substance use that leads to impairment or distress for at least 12 months or more in three or more different areas of functioning. These areas include: (1) tolerance; (2) withdrawal; (3) use of greater amounts of the substance more often than was originally intended; (4) a desire or unsuccessful attempts to stop, or control using or drinking; (5) more time and activities spent around the seeking, getting, using or attempts to quit using; (6) reduction or elimination of social, occupational or leisure activities not associated with substance use and (7) continued physical and psychological problems associated with substance use (APA, 2000).

Along with the negative affects substance abuse and addiction has on the individual, family, community and society, there are the long term affects that occur
which include death (CDC, 2004). For example, there were over 75,000 preventable deaths due to excessive alcohol use in 2001. Over half of those deaths were as a result from acute conditions related to alcohol abuse such as liver failure (CDC, 2004).

Addiction is a chronic disease that shares many features with other chronic illnesses, such as type II diabetes, cancer, and cardiovascular disease, including a tendency to be inherited. The onset and course of addiction is influenced by environmental conditions and behavior, and the ability to respond to appropriate treatment. This treatment may include long-term lifestyle modification (McLellan, Lewis, O’Brien, & Kleber, 2000). The treatment of addiction is similar to the treatment of the aforementioned chronic diseases. The addict that is in treatment requires monitoring of their status on a regular basis, early interventions regarding possible problems, and proper interventions in order to maintain positive treatment results (McLellan, 2002).

Successful treatment for individuals to stop using drugs and alcohol will produce positive results for society. According to research, individuals that get into and remain in treatment stop using drugs or alcohol, decrease their criminal behavior, and improve their psychological, social and occupational functioning (NIDA, 2011).

Statement of Research Problem

People who are struggling with substance abuse and addiction appear to sometime have difficulty with treatment and successfully abstaining from alcohol and drugs. It would be useful to determine if attending support programs such as AA/NA would help people with abstaining from alcohol and/ or drugs. Although there is some research that looks at certain barriers to treatment for people suffering with substance abuse and
addiction, and why people may have difficulty with successful treatment to stop drinking or using drugs, there is little research that focuses mainly on the relationship of individuals that are attending AA/NA programs and if that attendance relates to their success at abstaining from alcohol and drugs. This study will attempt to bring more awareness about how attendance in AA/NA may possibly increase a person’s rate of success in abstaining from the use of alcohol and drugs.

**Purpose of Study**

The purpose of this study is to determine if there may be a relationship between attending AA/NA meetings and staying abstinent from using alcohol and drugs. The secondary purpose of this study is to further the amount of research that exists on this topic. There is currently minimal amount of research on the relationship between attending AA/NA meetings and abstinence from alcohol and drugs. The results of this study would affect the micro, mezzo and macro level of social work.

**Research Question**

This study will investigate the following research question: Is there a relationship between attending AA/NA meetings and abstinence from alcohol and drugs?

**Theoretical Framework**

This study will utilize the social learning theory. The research will explain social learning theory follow by a discussion of how this theory can be applied to this research.

**Social Learning Theory**

The theoretical framework that will guide this research is that from the social learning theory. Social learning theory states individuals learn from their social
environment. Individuals learn both positive and negative behaviors based both on positive or negative reinforcers (Zastrow & Kirst-Ashman, 1997). This theory suggests that people learn through the observations of and interactions with others. People learn how to be kind and nurturing through observations and interactions with others, and inversely people learn deviant and socially unacceptable behaviors in the same way. Thyer & Myers (1997) while discussing this theory, further state that to a large extent, much human behavior is learned through life experiences, and this learning occurs throughout one’s entire life. They further emphasize that this social learning process gives rise to individual behaviors across life circumstances and cultures and account for both normative and many dysfunctional thoughts, feelings and actions (Thyer & Myers, 1997). Social learning theory implies that not only do individual’s behaviors develop through learning them from others; behaviors can also be unlearned in the same way.

Many people who experiment with drinking alcohol or using drugs do so through the observations of the people. A person need only to watch how another engages in and performs the behavior of drinking or using drugs in order to learn how that behavior (Zastrow & Kirst-Ashman, 1997). They see their family and friends drinking alcohol or using drugs, and so they in turn start to drink or use drugs. They learn simply by watching it happen. People learn much of their behavior from their observance of the behaviors of those they socialize with (Siegel, 2009). Family and social attitudes toward drinking alcohol and/or illegal drug use reinforced alcoholic and addict behaviors (Shen, Locke-Wellman, & Hill, 2001). When these behaviors are alcohol and drug induced, and remain within a culturally sanctioned functional climate, such as family gatherings,
bonding experiences, career or recreational activities, the effects of the damage caused by these behaviors are often normalized or excused (Comstock, 2005). This pattern of behavior must change for there to be success in treatment. The person in treatment must develop positive behaviors of their own in order to empower themselves to be successful in treatment.

**Application of Social Learning theory**

Applying social learning perspectives to this study will explore the population of this study in relationship to their surroundings. Research has shown that individuals can learn drug and alcohol use through their social contacts and observations (Hayaki, 2011). If individuals learn substance use from peers and other influences from their social environment, then these same individuals can unlearn these behaviors through social support and interventions including those by individuals participating in self-help programs such as AA/NA. As a self-help model, those associated with AA/NA believe that those that have made positive changes in their behaviors in order to abstain from drinking alcohol and/or using drugs, can then give guidance through molding of those behaviors learned that have helped the person in recovery to maintain abstinence from alcohol or drugs.

The individuals that are seeking abstinence from alcohol and drugs must make the conscious choice to want to abstain from their drinking and/or drug use. They must then engage with people and activities that do not include the drinking or using of alcohol and drugs. One way to accomplish this is to begin participation in AA/NA and begin associations with those that have made a choice to seek recovery in order to abstain from
their drinking and using. With social learning theory as a guideline, individuals that are able to observe and learn from other’s healthy alternatives that promote abstinence from alcohol and drug use can learn how to live life without using those substances as well. Just as they modeled their drinking and drug use from family members, peers and the media, attendance in AA/NA will model healthy choices, healthy living and alternative behaviors that will change the pattern from drinking and using drugs to behaviors and life choices that will promote and support abstinence from alcohol and drugs.

**Definition of Terms**

The following terms are used throughout this project and are relevant to substance abuse and addiction, and substance abuse treatment.

**Drinking** refers to the continued consumption of alcoholic beverages (Callaghan, Taylor, & Cunningham, 2007).

**Using** refers to the use of drugs or alcohol (Callaghan, Taylor, & Cunningham, 2007).

**Relapse** refers to when an individual who has stopped using or drinking for a period of time and then begins their using or drinking again (Callaghan, Taylor, & Cunningham, 2007).

**Addiction** refers to the physical dependence resulting from the chronic use of a substance (Callaghan, Taylor, & Cunningham, 2007). Additionally, addiction is the process that although in the beginning is pleasurable, eventually becomes destructive to self and others (Orford, 2001).

**Recovery/Sobriety** refers to an individual who had a history of drug or alcohol abuse and is now abstaining from that use (Callaghan, Taylor, & Cunningham, 2007).
**Rock Bottom** is the metaphor used to describe an individual that must experience a certain level of consequences associated with their drinking or using before they are able to discontinue such using (Hiller, Narevic, Webster, Rosen, Stanton, Leukefeld, & Kayo, 2009).

**Abstinence** refers to the complete cessation from using any and all alcohol and drugs (Van Wormer, 1995).

**Assumptions**

There are many assumptions concerning those that are addicted to alcohol and drugs. Some of these assumptions are: 1) Anyone can become addicted to drugs and alcohol; 2) success from addiction requires complete abstinence from drugs and alcohol; 3) Substance abuse and addiction is a chronic condition and is highly prevalent in the United States; 4) addicts can never recover; addicts can stop using if they just wanted to; 5) the participants are individuals participating in randomly selected AA/NA meetings in the Sacramento County, CA area.

**Justification**

Drug and alcohol addition shows no sexist, racist, or religious bias. It affects men and women, young and old across all walks of life. According to a 2001 report from the Office of National Drug Control Policy (ONDCP) addiction costs governments and consumers billions of dollars annually in the form of increased taxes to fund jails, prisons, police officers, insurance costs and increased prices in goods and other services. Not only is the monitory cost high, but the cost from loss of life is even greater (ONDCP, 2001).
Many people that are using social services are those people in the grips of their addiction. These individuals and families are using resources that could be made available to those that are in need that are not addicted to drugs and alcohol. If more people were in treatment for addiction, they would have less of a need for social services and assistance programs; freeing up moneys and services for those in need that are not affected by addiction (Rice, 1999).

The goal of this research is to show that increased participation in AA/NA meetings will increase the abstinence from using drugs and alcohol for those addicted; therefore there will be a positive increase in the functioning of the individual, family, community and society. The objective resulting for this research is to increase the acceptance of AA/NA groups as a treatment option and gain the support from Federal and local governments to encourage participation and to fund additional programs modeled after AA/NA in the community.

Often, social work professionals have difficulty successfully providing services and intervention to clients due to a client’s active engagement in their addiction. While clients are actively using drugs or alcohol, it is more difficult to have these clients maintain housing, employment, or even successful treatment for mental health symptoms.

Even though working with clients that are suffering from addiction may at times seem like a no-win battle, social workers have a commitment to serve them as outlined by the National Association of Social Workers’ (NASW) *Code of Ethics*. The primary mission of those in the social work profession is to enhance people’s wellbeing and to help people meet their basic human needs, with particular attention to the needs of people
who are oppressed, vulnerable and living in poverty (NASW, 2011). Some of the principles that help to guide social workers in this endeavor include empowering clients through: (1) Service. Social workers help people in need and address social problems; (2) Social Justice. Social workers pursue social change on behalf of vulnerable and oppressed individuals and groups; (3) Dignity and Worth of the Person. Social workers treat each person with dignity and respect, being mindful of individuals difference and ethnic and cultural diversity; (4) Human Relationships. Social workers work to strengthen relationships among people in an effort to promote, restore, maintain and enhance the wellbeing of individuals, families, groups, and communities (NASW, 2011). Providing interventions and services for the reduction of active addiction using the Social Work Code of Ethics as a guide will help to restore the self esteem and empowerment of the individual and therefore enhance the relationships between individuals, family and community.

**Delimitations**

This research project does not include qualitative data to further explore possible factors or in-depth meaning related to additional activities or outside support of the individuals that responded to the survey. The information retrieved is limited to that of individuals attending selected AA/NA meetings in the greater Sacramento, CA area who happened to be attending the meetings and were willing to volunteer to complete the survey. The survey instrument was created by the researcher, and further testing would be needed to improve the instruments reliability and validity. Information related to age or if additional social support was received by some individuals compared to others were
not factored into the study. The researcher cannot guaranty the authenticity of the self-reported answers.

**Summary**

Chapter 1 included the introduction, a background of the problem, a statement of the problem, the purpose of this research and the theoretical framework. In addition, Chapter 1 contained conceptual and operational definitions of terms and a section that described limitations of the project. Chapter 2 is a review relevant literature with sections covering a description of the historical background of AA/NA, abstinence, functions of AA/NA, AA/NA and abstinence, treatment approaches, treatment effectiveness, and gaps in the literature. Chapter 3 is a description of the methodology. In Chapter 4, the data retrieved for this study is examined and analyzed. In chapter 5, the summary of the findings is presented as well as recommendation and implications for social work practice.
Chapter 2

REVIEW OF LITERATURE

Introduction

This section of the literature review will focus attention on the traditional 12 step programs of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) and abstinence from alcohol and drugs. The key areas that will be discussed include the historical background of Alcoholics Anonymous and Narcotics Anonymous. The major themes addressed: Abstinence, functions of AA/NA, AA/NA and abstinence, alternative treatment approaches, alternative treatment effectiveness, gaps in the literature, and a summary.

Historical Background of Alcoholics Anonymous and Narcotics Anonymous


Frank Buchman founded the Oxford Group Movement in 1921. The Oxford Group, as it was commonly known, was described as the preeminent movement of its time (Falby, 2003). The holiness movement prepared the way for the Group’s non-denominationalism or inter-denominationalism. Buchman echoed the message from earlier evangelicals in his emphasis on the “changed life,” or conversion. To accomplish its mission of changing people, the Group held daily meetings for about 150
undergraduates between 1931 and 1935 (Falby, 2003). These meetings aimed to provide spiritual training through Bible reading, collective prayer, and education in the psychology or religion (Falby, 2003). The Oxford Group believed that spiritual recovery must be done not through one person, but through groups of people who have learned to work together under the guidance of God. Buchman further emphasized the importance of individual surrender to the spirit of the group as well as the confessions of sins either in public or private (Falby, 2003). Interestingly enough, confession both in the holiness movement, and later with AA, were mostly about the abuse of alcohol (Falby, 2003).

Among the practices of the Oxford Group which are pertinent to the present context of the 12 steps used by AA and NA were sharing, guidance, changing and making restitution, as well as the inclusion of absolute values (Glaser, 1981). Sharing meant to the Oxford Group the open confession of sins, this often occurred at large public meetings and was viewed as a means of encouraging new converts and of confirming existing member in their current path. Guidance meant the acceptance of divine inspiration as the only indication of what one should do. Persons who accepted such guidance were said to be under the control of God (Glaser, 1981).

Changing, or conversion to the beliefs of the Oxford Group, was considered to be the most important. Conversion was a sudden, dramatic, emotional, and often public experience, instantaneous and not unlike a revelation (Glaser, 1981).

Making restitution meant that the individual could not simply repent his sins in his heart or mind and thereby be forgiven. The individual must do something about what he had done in order to make amends (Glaser, 1981). Restitution was one of the
principles-borrowed by AA, and is embodied in the ninth of the Twelve Steps of AA (Bill, 1957)).

Finally, the Oxford Group also attempted to include in its members four absolute values: absolute honesty, absolute purity, absolute unselfishness, and absolute love (Glaser, 1981). Bill Wilson, one of the founders of Alcoholics Anonymous, felt that these absolutes were too idealistic. He believed that the Oxford Groups absolute concepts were too much for the alcoholics. He believed that these absolute ideas had to be fed to the alcoholic slowly over time and not all at once. Therefore, they were incorporated in AA in less absolute forms, and their importance in AA, NA, is obvious (Glaser, 1981).

From these roots began the formulation of what would later be written as the Twelve Steps of Alcoholics Anonymous. The first version of any steps for recovery came from a childhood friend of the original founder, Bill Wilson. His name was Ebby Thatcher (Glaser, 1981). In an attempt to gain strength with his own battle with alcoholism, Ebby became a member of the Oxford Group and had experienced some length of abstinence from alcohol. Ebby wanted to share the precepts he had learned from the Oxford Group with his friend Bill Wilson. Bill, at this time, was once again in an institution due to his problem drinking (Glaser, 1981). As they talked about the principles Ebby had learned, they wrote the following six precepts:

1.  We admitted we were licked.
2.  We got honest with ourselves
3.  We talked it over with another person.
4.  We made amends to those we had harmed.
5. We tried to carry this message to others with no thought of reward.

6. We prayed to whatever God we thought there was (Bill, 1957, p.39).

Although most of the attitudes and applications from the Oxford group had proven to be unsuited for AA’s purpose, Bill Wilson did state that the early AA got its ideas of self-examination, acknowledgment of character defects, restitution for harm done, and working with others straight from the Oxford Group (Bill, 1957). A less stringent form of these ideas became the core principles to AA.

The founding member of Alcoholic Anonymous, Bill Wilson, ruined a promising career as a stockbroker due to chronic alcoholism. In 1934, after being hospitalized again for alcohol treatment, Bill had a spiritual experience unlike anything that he had before. From this point on he stopped drinking and spent the rest of his life working to bring that same freedom and inner peace to other alcoholics (Alcoholics Anonymous, 1998).

While on a business trip in 1935, Bill Wilson was tempted to drink. He felt he needed to talk to another alcoholic in order to stay sober (Encyclopedia Britannica, 2011). A local member of the Oxford Group had directed Mr. Wilson to Dr. Bob Smith with whom the group was desperately trying to help. Talking to Dr. Smith kept Bill Wilson from drinking, and Dr. Smith stopped drinking as well. Together, they sought to develop a simple program to help the worst alcoholics using the approach that empathized with the alcoholic while at the same time convincing them of their powerlessness and hopelessness (Encyclopedia Britannica, 2011). They believed active alcoholics were in a state of insanity rather than a state of sin. This idea was independent

In a 2010 article published in the American Journal of Public Health that revisited a story from the AA Grapevine celebrating the 25th anniversary of AA, Bill Wilson talked of the beginnings of Alcoholics Anonymous and the meanings behind two of the 12 steps of AA (AJPH, 2010). He admitted that he and Dr. Smith did not comprehend the positive impact that occurred from one alcoholic talking to another. It was this realization of self-help that led to the creation of the 12 steps of AA.

When discussing the meaning behind admitting powerlessness over alcohol, Wilson defined it simply as those battling alcohol have to hit bottom and hit it hard and lastingly (Alcoholics Anonymous, 1998). They believed members must admit personal hopelessness before they can move on and have hope. He and Dr. Bob Smith felt the sickness of the body also had with it a sickness of the spirit in which there must be a spiritual remedy. Therefore, one must have a spiritual awakening which is the main concept of the twelfth step. The rest of the steps came from their earlier experiences with the Oxford Group.

The first text of Alcoholic Anonymous was published in 1939 (Alcoholics Anonymous, 1998). Written by Bill Wilson, it explained the philosophy and methods of AA, the core of which were known as the 12 steps of recovery. The book also included case histories told by 30 members that had experienced recovery through the practice of AA’s 12 steps. By 1950 100,000 recovered alcoholics were reported worldwide.
Gross (2010) reported that AA has grown to over 2 million members in over 160 countries which includes more than 1.2 million members in the Unites States alone. He further reports that 12 step fellowships became interwoven into drug treatment. In the 1950s, Narcotics Anonymous began. NA elaborated on the AA program and developed its own basic text. Narcotics Anonymous reports members in over 130 countries (Gross, 2010).

Narcotics Anonymous was officially founded in 1953 in the Los Angeles area of California (Narcotics Anonymous, 2008). NA is a program that is group oriented, and based on 12 steps and 12 traditions that have been adapted from AA. NA is the second largest 12 step organization in the world. There are more than 58,000 NA meetings in over 131 countries worldwide (Narcotics Anonymous, 2008).

**Abstinence**

The Oxford Dictionary defines abstinence as a “the fact or practice of restraining oneself from indulging in something, typically alcohol”, (The Oxford Dictionary, 2011). Frequently the term refers to refraining from sexual activities. Abstinence in relationship with religion may be practiced in the form of not eating certain foods during sacred periods or holidays. Some religions may refrain from the eating of any meat, or perhaps certain foods that may contain chemicals such as caffeine (The Oxford Dictionary, 2011).

When used in the context of alcohol or drug treatment, abstinence means the complete cessation of any alcohol or drug consumption. All recreational intoxicants, both legal and illegal, are to be abstained (Narcotics Anonymous, 2008).
When looking at the success of total abstinence in alcohol or drug treatment, the rates can be very alarming. According to a 2002 report, although there are drug rehabilitation programs reporting a success rates as high as 75%, the success rates of most drug rehab programs ranges from between 2% to 20%, (Drug Rehabs, 2002).

Changes in the functioning of the brain, along with the addict’s denial of the drug or alcohol problem, are seen as precipitating factors in the difficulties with the treatment of those that are addicted. Mitchell reports that Alcoholics Anonymous has a claimed success rate of about five percent (Mitchell, 2011).

In a study by King, Chung, and Maisto, (2009), the authors highlight that adolescents are able to abstain from marijuana when they are motivated. Motivation is an efficient method to prevent drug abuse, but long term motivation is found to be difficult because the motivation tools used during the intense out-patient treatment program were not present to the participants after the end of their out-patient treatment program. Motivation levels were reduced when participants were discharged from treatment (King, Chung, & Maisto, 2009).

**Functions of AA/NA**

Alcoholics Anonymous World Services (1998) describes Alcoholics Anonymous as a fellowship of both men and women who help each other with their common problem of alcoholism by sharing their experiences and hope for sobriety with each other. There are no membership dues or fees. The only requirement for members is a desire to stop drinking. The primary purpose of Alcoholics Anonymous is to practice the 12 steps of recovery and to help other alcoholics to stay sober.
Meetings are held in local communities. Meetings can be designated as open. Anyone may attend these open meetings and all people are welcome. Closed meetings are only for those members with “a desire to stop drinking”. Still other meetings are held in hospitals, jails or other institutions and therefore are not accessible to the open public.

The belief of AA members is that an alcoholic can best understand and support another because of their common experiences with alcoholism (Alcoholics Anonymous, 1998). There is a philosophy that members did not become alcoholics in one day, so sobriety cannot be achieved all at once either. The focus on short-term goals is the root behind the term used by members of “one day at a time.” All members are encouraged to stay in the present and focus abstaining from drinking one day at a time (Van Wormer, 1995).

The heart of the AA program is a belief in and conscious engagement in working the 12 steps and 12 traditions of AA As outlined by AA World services (1998) the 12 steps are:

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

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

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

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

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

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

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

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

11. Sought through prayer and medication to improve our conscious contact with God, as we understood Him, praying 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.

There are also the Twelve Traditions of Alcoholics Anonymous that are set forth as a guideline for AA groups to follow (Alcoholic Anonymous, 1998). These traditions are:

1. Our common welfare should come first; personal recovery depends on AA unity.

2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscious. Our leaders are but trusted servants; they do not govern.

3. The only requirement for AA membership is the 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 that 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 services 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 opinion 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 all our traditions, ever reminding us to place principles before personalities.

The Twelve Steps and Twelve Traditions of AA are guidelines for members to achieve. It is suggested that members find a sponsor. A sponsor is another alcoholic that has experience in the AA program. A sponsor should also have experience with all of the 12 steps, be the same gender of the sponsored person, and keep from imposing their personal views on them (Van Wormer, 1995).
Spirituality is a key concept to the AA program. MacKinnon (2004) describes the 12 step program as a spiritual plan for recovery. Key to the success of AA is the belief in a Higher Power. A Higher Power is not meant to be equivalent to any religious denomination or one’s personal idea of God, but rather the Higher Power is an individual concept of a Spirit that is broad, all inclusive, and available to anyone who sincerely seeks it (MacKinnon, 2004).

Narcotics Anonymous functions in much the same way as AA. Narcotics Anonymous meetings are set in 12 steps and traditions that follow those from the AA program (Narcotics Anonymous, 2008). One difference between AA and NA is in the specific wording used in the first step of the twelve steps. Rather than being powerless over a specific substance, such as alcohol, NA’s first step states “We were powerless over our addiction…” thus inviting people that are addicted to all substances, including alcohol, to attend and participate in NA. With this exception, the 12 steps and 12 traditions of NA are the same as AA. The process of the Narcotics Anonymous meetings, encouragement of seeking a sponsor, and the belief in a spiritual awakening, all parallel the AA program (Narcotic Anonymous, 2008).

Cloud, Ziegler and Blondell (2004) examined Alcoholics Anonymous in an attempt to define AA affiliation. Affiliation appears to be defined differently depending on the members surveyed. Some defined AA affiliation as being when a member attends meetings on a regular basis, has a sponsor, considers themselves as a member, has had a spiritual awakening, is working the 12 steps, and is involved in higher-level activities such as being a sponsor or celebrating sobriety birthdays. While interpretation of the term
affiliation is difficult at best, AA states that a person is a member of AA when they begin to come to meetings and acknowledge themselves as a member.

**AA/NA and Abstinence**

When men and women enter treatment programs due to alcohol and drug addiction, the first goal for success in treatment is total abstinence from alcohol and drugs (Van Wormer, 1995). Comparing the Alcoholics Anonymous program to the program used by Narcotics Anonymous, there is a difference in the focus of what substance is to be abstained. In Alcoholic Anonymous, a participant is expected to completely abstain from alcohol (Alcoholics Anonymous, 1998). Compared to AA, where participants are only concerned with abstinence from alcohol, participants of Narcotics Anonymous are expected to abstain from all drugs, including alcohol. NA views alcohol to be a drug (Narcotics Anonymous, 2008). Therefore, when participating in NA versus AA, all drugs in any form must not be consumed.

There are other treatment programs that people can attend in order to try and end their addiction to drugs and alcohol (Sharma & Branscum, 2010). While many treatment facilities may require monthly fees for their services, AA and NA have no dues or fees to attend meetings and receive support from other members of the program (Alcoholics Anonymous 1976, Narcotics Anonymous, 1988). As concluded in a study by Groh, Jason and Keys (2008), Alcoholics Anonymous is not only the most commonly used program for substance abuse recovery, it is one of the few recovery models to demonstrate positive abstinence outcomes. They concluded that social support within AA was an effective mechanism in promoting abstinence and a sober lifestyle.
Although other programs may claim to have higher rates of success with alcohol and drug addiction, a study conducted by Sharma and Branscum (2010) concludes rates of abstinence in those who attend AA are about two times higher compared to those who do not attend AA. The study goes on to report that higher levels of attendance in AA result in higher rates of abstinence.

One attribute to the success of abstaining from alcohol and drugs is the consistency of attending meetings in AA or NA (McCartney, 2010). It is claimed that the more meetings a person attends, the better the success in abstaining from alcohol and/or drugs. In a 2010 study, McCartney concludes that there is a strong association between attendance in mutual-aid groups such as AA and sobriety. His research shows that the higher number of meetings attended, the lower the relapse rate. In addition he notes that becoming involved in AA service work, especially sponsorship has shown to increase sobriety even more.

One of the key features to Alcoholic Anonymous and Narcotics Anonymous is the learning about and the working of their 12 Steps (Humphreys, 1999). Even though some may wonder whether or not the 12 steps are more affective than other treatment approaches, research conducted by Humphreys (1999) demonstrates that 12 step interventions have been found to be more effective than other treatments in increasing a patient’s rate of abstinence.

Sharma and Branscum (2010) reported that a potential disadvantage in the 12-step concept lies in the spiritual messages that are integrated into the program. The religious undertones could deter some people from attending AA or NA One problem highlighted
with many studies is that of selection bias for AA participants. AA has the potential to have as its members those that attend voluntarily and those that are coerced into attending through court-ordered mandates. The volunteer participants are seen as more motivated to succeed than those that are attending non-voluntarily. AA studies also suffer from high drop-out rates. It is difficult to ascertain whether those dropping out are successfully abstaining from alcohol and no longer need AA meetings, or they have indeed relapsed.

While a randomized control trial would be ideal for program evaluation research, it may be looked at as unethical to with-hold treatment for individuals who need it. The conclusion is that while AA has many potential benefits, it is difficult to say whether it is truly effective.

Concerns expressed regarding the benefits of mutual aids, as noted by McCartney (2010), are that less than 50 percent of treatment professionals approve of mutual-aid groups such as AA, and only about one third of treatment professionals thought their clients were suitable for AA. This exhibits a pre-judgment of the treatment professional of AA and client compatibility and therefore may limit a client’s referral to such a program. Also there is concern that AA may create a dependency for the member, and that relying on a higher power may undermine a personal responsibility and development of internal strengths. Lastly, as with other studies, the religious language used by AA may create a barrier that some members will not wish to cross.

Research conducted by Humphreys (1999) focused on Twelve-Step-Facilitation interventions from treatment programs that mirrored 12 step programs such as AA and NA. These programs were of a short-term duration of 10 to 12 sessions of out-patient
Interventions that supported participants in engaging with community AA/NA programs were provided for a one-month period only. Although these interventions proved to be beneficial compared to patients that were not given the additional reminders and support, the short term of the intervention brings to question how successful patients continue to be in attending AA/NA after the one month period. There is a question concerning the ethics of this study concerning the control group that was not given follow-up interventions. The fact that they were denied the additional support and interventions again brings into view ethical concerns.

Participant bias is another concern with this study. There is no mention as to how many patients were voluntary versus mandated for treatment. Additional research is suggested that would follow patients longer than one month. If research can show how outpatient treatment programs that facilitate 12-step group involvement increases client’s attendance in AA or NA meetings, increased funding may be sought to provide increased treatment that would focus on 12 step programs. In order to pursue additional funding for such programs, it is suggested that research be conducted to examine the cost effectiveness of these twelve-step-facilitation interventions compared to treatment programs that do not facilitate 12 step interventions in the community (Humphreys, 1999).

**Alternative Treatment Approaches**

A 2003 report states that although current treatment (AA/NA) is better than nothing, more effective treatment needs to be found (Otto, 2003). In this section, alternative treatment approaches will be reviewed. Those alternate treatment approaches

One new approach to substance abuse treatment has been the increase of utilizing family therapy. This mode of treatment is called Systemic-Motivational Therapy (SMT) (Steinglass, 2009). Normally, substance abuse treatment focuses on the individual who is the abuser and the treatment is catered to that person. The use of SMT for substance user and their family has shown to have an increase in treatment outcomes (Steinglass, 2009). The use of SMT helps to keep the substance user engaged in treatment and continued support after treatment. The developers of SMT believe that even though there has been a big increase in the use of approaches like Motivational Interviewing, those approaches only focus on the individual and not the whole system of the family (Steinglass, 2009). Users of SMT believe that substance abuse is a systemic problem and therefore needs a systemic approach for treating a person and their whole family (Steinglass, 2009).

Cognitive Behavioral Therapy (CBT) has been shown to be an evidence-based practice for treating substance abuse (Thyer & Myers, 1997). CBT has shown to help individuals with substance abuse in reducing relapse and promoting long-term abstinence. However, many individuals who battle with substance abuse also have a co-occurring mental health disorder (Conrod & Stewart, 2005). There has been a rise in using CBT with individuals who have a substance abuse problem and a co-occurring mental health disorders, but there is a lack of providers that attempt to treat both the substance abuse disorder and mental health disorder (Conrod & Stewart, 2005). Research
suggests reduced substance abuse symptoms for those individuals that receive mental health treatment along with substance abuse treatment. However, substance abuse treatment alone does not tend to help people with their co-occurring mental health disorder (Van Wormer, 1995).

The Transtheoretical model (TTM) is a widely used approach to substance abuse treatment (Callaghan, Taylor & Cunningham, 2007). TTM is the idea that a substance abuser must go through four stages of change in order to eventually stop using. The four stages of change are: 1) denial, 2) pre-contemplation, 3) action, and 4) maintenance. This is a predominant theory in substance abuse treatment, but there continues to be little research to demonstrate that individuals actually go through these stages while in treatment (Callaghan et al., 2007).

The Community Reinforcement Approach (CRA) and Community Reinforcement Family Training (CRAFT) approaches to substance abuse has been widely researched and reported to be effective with treating substance abusing people and their families (Meyers, Villanueva, & Smith, 2005). However, these approaches tend to be less utilized then other approaches to substance abuse. CRA focuses on using positive reinforcement to staying sober rather than the more traditional method of focusing on negative reinforcement (Moxley, 1997). The concept is to have the individual see the positives responses and outcomes to staying sober. This focus has led to increased positive community and family involvement to helping the individual to stay clean (Meyers et al., 2005). Community Reinforcement Family Training focuses on positive ways the family
can help the substance abusing individual to stay clean and be more supportive (Meyers, et al., 2005).

Another approached examined was the Integral approach to substance abuse. The Integral approach examined ways of implementing several different aspects to an individual's life than just the basic bio-psycho-social approach (Amodia, Cano, & Eliason, 2005). The integral method adds the bio-psycho-social approach by including spiritually, cross-cultural perspective, gender, social justice, better multidisciplinary teams, and individual development (Comstock, 2005). The Integral approach includes the additional collaboration with helping professionals, medical staff, the therapist as well as the individual seeking treatment (Amodia, et al., 2005).

Acupuncture as a treatment for substance abuse is relatively new. It does appear that results from studies using acupuncture during detoxification programs are promising. A study by Shwartz and Saitz (2000) showed that that people who completed Acupuncture treatment as part of a detoxification program were less likely to be readmitted for detoxification again within six months. The results from their study found that when the clients that received Acupuncture as part of their treatment, 18% were readmitted for detox within six months. Those that did not receive the Acupuncture, 36% were readmitted for detox, thus suggesting the value of using acupuncture as part of outpatient detox programs.

It may be difficult to determine if Yoga is effective in treatment programs for substance abuse. There are many types of Yoga, and studies that focus on yoga as alternatives or additions to treatment programs appear to be limited at this time.
One such research study conducted by Brooks, Schwartz, Reece, & Nangle (2006) looks at Johrei healing. Johrei includes a belief in a higher power and the belief in the body’s ability to heal itself of both physical and mental symptoms. This is done by the application, or channeling, of spiritual vibrations. Other research was done on Sudarshan Kriya yogic breathing for the treatment of stress, anxiety, and depression. It is believed that if stress, anxiety, and depression are reduced with those in treatment for substance abuse, then those in treatment will experience a greater success in the abstinence of their alcohol/ drug use (Brown & Gerbarg, 2005). This research provides evidence of how Sudarshan Kriya Yoga has reduced stress, anxiety, PTSD, depression, stress-related medical illness, substance abuse, and has aided in the rehabilitation of criminal offenders (Brown & Gerbarg, 2005).

**Effectiveness of Alternative Treatment**

This section will look at the effectiveness of the treatment alternatives previously discussed. These treatments are: Systemic-Motivational Therapy, Cognitive Behavioral Therapy, Transtheoretical model, Community Reinforcement Approach, Integral approach, Acupuncture, and Yoga.

In regards to Systemic-Motivational Therapy (SMT), family therapy has been shown to very effective for the treatment of substance abuse especially for that of the adolescent. Research suggests that certain types of family therapy have helped to reduce certain levels of problems in a person who abuses substances as well as other problem behaviors (Hogue & Liddle, 2009). Retention rates have been suggested as a reason for
the reduction of problem behavior. Rates of completion of treatment using SMT family therapy were as high as 90 percent (Hogue & Liddle, 2009).

Cognitive Behavioral Therapy was shown to be rather effective in the treatment of co-occurring disorders for adolescents (Carroll, Hides, Catania, Mathias, Greenwood-Smith, & Lubman, 2009). At the end of their 20 week study, 73 % or the youths treated reported a reduction of their depressive symptoms and of those, 84 % reported a reduction of their drug use. Adolescents are a difficult population to engage. The effectiveness of CBT says a lot about how this therapy was able to be effective in adolescent population for treatment of substance and mental health disorders (Carroll et al., 2009). There needs to be more research and programs developed using CBT to both help with substance abuse and co-occurring mental health disorders (Conrod & Stewart, 2005).

Research conducted by Callaghan, Taylor and Cunningham (2007) concerning the effectiveness of the Transtheoretical Model found that there was little evidence in an individual's change in drinking in the action stage compared to the pre-contemplation stage; and there was some significant change in their drinking during the pre-contemplation change. However, another study looking at the same research found that TTM did show some evidence of being useful (Heather, Hönekopp, & Smailes, 2009) suggesting that predicting if someone is going from the pre-contemplation stage to the action would be the best predictor in their ability to reduce their drinking behavior.

Community Reinforcement Approach has been shown to be very effective in the treatment of opiate dependence (Abbott, 2009). CRA with the combination of methadone
and other forms of opiate treatment medication have been shown to be one of the most effective forms of treatment of opiate dependence (Abbott, 2009). In studying comparisons between a treatment group using CRA versus a control group, 89% of those in the treatment group were more likely to have three consecutive weeks free of opioids compared to that of the control group (78%). CRA and Community Reinforcement and Family Training (CRAFT) are two underutilized approaches to substance abuse that have research to support its effectiveness with different client population when it comes to substance abuse treatment (Meyers et al., 2005).

There are reported barriers to implementing programs like the Integral approach and other similar evidence-based practices (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009). The barriers stem from the perceptions of counselors and funding sources regarding the Integral approach, and other EBP, and their willingness to change their current ways of treating substance abuse (Aarons et al., 2009). Programs that plan to implement integral type programs should be aware of the potential barriers before implementing the programs (Aarons et al., 2009).

In a study by Courbasson, de Sorkin, Dullerud, and Van Wyk, (2007), positive results are shown with the use of acupuncture when used in conjunction with structured psychoeducational treatment programs: 185 women received acupuncture, and 101 did not. All 185 women that received the acupuncture as part of their treatment reported reduced cravings for drugs, felt less depressed, lower anxiety, and were better able to reflect of their difficulties than the 101 women that received no acupuncture. Their conclusion was that acupuncture along with psychoeducational treatment shows promise
in being an effective, more viable alternative treatment for women with substance addiction (Courbasson, de Sorkin, Dullerud, & Van Wyk, 2007). Otto, (2003) further states that 25 years of clinical experience has reported that ear acupuncture reduces opiate withdrawal, and cravings for all substances. However, this report acknowledges that scientific research has often been poorly designed and conclusions may be sketchy.

The results of using yoga for treatment were positive, but there are problems with the study. The study that was done was limited to a small group. There were 21 people in a residential substance abuse treatment program (Brooks, Schwartz, Reece, & Nangle, 2006). Out of these 21 people, 12 were assigned the Johrei treatment, and 9 were not. The treatment consisted of three 20 minute session per week for five weeks. The results indicate that those participating in the Johrei treatments showed decreases in symptoms related to substance relapse. Reductions were reported in stress/depression and physical pain, and increases were reported in positive emotional and spiritual feelings as well as a feeling of increased well being. Johrei healing shows promise and should be studied with a larger sample and over a longer treatment period (Brooks, Schwartz, Reece, & Nangle, 2006).

**Gaps in the Literature**

When reviewing the research conducted by Groh, Jason and Keys (2008), there are several limitations as discussed by the authors. The studies in this research did not clearly define the social support terminology they utilized. It important to define and operationalize constructs when studying social support because terms can often mean different concepts. Many of the studies used cross-sectional designs that indicated an
inability to test predictability over time and infer any directionality or causality related to social support and AA. Also, the vast majority of the studies used had employed convenience samples and nonrandom assignment thereby increasing the possibility of sampling biases. It is suggested that future studies branch out and examine more precise types of social support that have not been thoroughly studied. For example, research could focus on integration and belonging support, emotional support, encouragement or esteem support, informational and appraisal support, and tangible support such as aid with money or services.

This study in the relationship between attendance in AA/NA will fill a gap not addressed in the literature review by studying individuals in the Sacramento, California area. This study will solicit data randomly from individuals that are attending AA/NA groups in the greater Sacramento area. The participants for this study will be voluntary rather than from individuals that are court ordered or mandated to inpatient treatment by some other means or agencies. The random selection of open AA/NA groups and participants in the community may reduce responder bias as participants for this research will not believe that participation in the study may affect their success in their treatment. Volunteer participants from the community, rather than closed treatment facilities, should produce more reliable data regarding any relationship between attending the AA/NA meetings and staying abstinent from alcohol and drugs.

**Summary**

This literature review addressed the historical background of Alcoholics Anonymous and Narcotics Anonymous. Major themes such as how abstinence is defined
as well as the success of abstinence in alcohol and drug treatment, the functioning of AA and NA and how AA, NA and abstinence come together in the treatment of alcohol and drug abuse were also addressed. Additional themes related to alternative treatment approaches along with effectiveness of alternative treatment were examined. Finally, gaps in the literature were discussed along with how this research will address one of the gaps. In the next chapter, methodology is described.
Chapter 3

METHODS

Introduction

In this section, the methodology used in this research will be discussed. This will be accomplished by re-introducing the research question, discussing the study design used, defining the independent and dependent variables studied as well as defining the study population. Sampling methods, measurement instruments, data collection procedures, statistical analysis plan and human subjects protections will also be reviewed.

Research Question

The purpose of this study is: Is there a relationship between attendance in AA/NA meetings and abstinence from alcohol/drug use?

Study Design

This study consists of an exploratory quantitative survey research design, which utilized a brief survey instrument. This is considered a quantitative study as the researcher is attempting to analyze the numerical data collected rather than observations or interviews.

This study uses an exploratory survey research design at it addresses a topic for which minimal data is available. The purpose for using the exploratory survey research design in this study relates to the unstudied topic of attending AA/NA meetings and abstaining from alcohol and/ or drugs.

Survey research is useful because it can use questionnaires to collect information about people’s attitudes, feelings, beliefs, behaviors and lifestyles (Royse, 2008). Survey
research is one of the best methods available to collect original information about a population. Survey research is also useful because the information can be used to generalize the responses to a larger population of people (Royce, 2008). Survey research is also able to look at relationships between characteristics of the respondents of their reported behaviors and opinions (Royce, 2008). For example, is there a relationship between a person’s gender and their attitudes toward specific social issues?

Ruben and Babbie (2001) indicate that survey research designs have inherent strengths and weaknesses. The strengths include increased external validity, or an ability to generalize results to a larger population. Survey research studies are useful in describing large populations because they allow very large samples to be gathered, as surveying is an easy and cost effective means of obtaining information from a large group of people. In this study, for example, it would be extremely difficult to research the experiences of respondents from all over the United States by any other means but a survey. The large samples feasible through survey research allow for more accurate descriptive analysis of variables, as well as analysis of multiple variables simultaneously (Marlow, 2005). This is important for this study given the number of independent variables being examined.

Some inherent weaknesses of survey designs are important to understand as well. Rubin and Babbie (2001) suggest that survey studies, while effectively collecting large amounts of information are limited to collecting superficial information and thus demonstrate lower internal validity. They also suggest that survey research lacks in context in that it forces broad ranges of human experience into narrowly defined
categories which have been predetermined by the researcher. Another weakness of survey research is that it is inflexible with regard to changing circumstances or information. A researcher cannot change the format of a survey without invalidating previous survey responses (Rubin & Babbie, 2001). Survey research methodology cannot determine causality, though its exploration of relationships and descriptions of phenomena are important. Respondent biases can also create biased survey results, thereby lowering the reliability of a research study utilizing a survey design. In spite of these weaknesses, a survey design was deemed best suited for this study because of its descriptive nature.

Variables

The independent variable in this study was attendance in Alcoholics Anonymous/ Narcotics Anonymous meetings. This was defined as the number of months a respondent had been attending AA / NA meetings. The dependent variable was abstinence from alcohol and drugs. This was defined as the longest number of days the subject has been able to completely abstain from alcohol and drug use.

Study Population

The population for this study was men and women that are currently attending AA / NA meetings in the greater Sacramento, California area. The researcher received responses from 44 people attending AA/NA meetings. All participants identified themselves as alcoholics or addicts. The study population was attending AA/NA meetings in order to abstain from alcohol and drug use. The study population included 22 male participants and 22 female participants. The population included various ethnic backgrounds.
Sampling Population

The methods for this study were a non-probability convenience sample. The subjects for the sample were selected at various AA / NA meetings in the Sacramento, CA area. A total of 44 research subjects were recruited by the researcher. The difficulty associated with contacting people attending AA/NA meetings across a broad geographic spread of the United States created a need for the study to utilize a purposive sampling design. Purposive sampling is a non-probability sampling design. It is utilized when the total number of a population is not able to be determined. Because the exact number of people attending AA and NA meetings for support is not ascertainable, it is thus even more difficult to determine a representative sample size, thus making purposive sampling an effective means of conducting the study.

According to Royse (2008), in purposive sampling, respondents are intentionally sought out who share certain similar characteristics. In this study, all survey respondents were alcoholics and addicts who utilize AA and NA meetings for support in their attempts to abstain from alcohol or drug use. Purposive sampling then, allows this study to focus specifically on those individuals who are seeking to abstain from drinking and using through the support of AA and NA meetings. Targeting sampling then, allows this study to focus specifically on the experiences of individuals who are currently attending Alcoholics Anonymous and Narcotics Anonymous meetings, rather than the entire population of alcoholics and addicts in the United States. Targeting a local population of people attending AA/NA meetings was a practical way to gain access to a sample
population since the purpose of the study was to explore the relationship between attending AA/NA meetings and abstaining from alcohol and drug use.

**Instrumentation**

Surveys were conducted with each individual who signed an informed consent and agreed to participate in the study (Appendix A). The survey instrument used measured the length of time the subject had been abusing alcohol and/ or drugs. Other areas measured were daily, weekly or monthly attendance in AA /NA, meetings along with the total number of months the subject has been attending meetings. Also information on the number of attempts to abstain from alcohol and/ or drugs was gathered along with the longest number of days the subject has abstained from alcohol and/ or drugs. If the subject was not currently abstaining from alcohol or drug use, responses as to the reasons why were recorded. Gender and ethnicity information was also recorded (Appendix B).

Because very little survey research of people attending AA/NA meetings has been conducted prior to this study, the survey instrument used is a non-standardized instrument and could therefore show decreased external validity (Rubin & Babbie, 2001). As a means of ensuring validity of the questionnaire items, the researcher consulted with the division of Social Work faculty to ascertain the face validity of these questions. Some questions were regarded as relevant, while others were dropped because the questions did not capture the meaning intended from this researcher. Because efforts were made to improve the validity of the questionnaire, reliability was also improved. Additionally, reliability is maintained because purposive sampling is being used, which lessons the
need for e representative sample in order for the survey instrument to be reliable (Rubin & Babbie, 2001).

**Data Collection Procedures**

The researcher went to various AA/NA meetings in the Sacramento, CA. Volunteers for this study were solicited at these meetings. The survey was administered directly after the meetings. The researcher read a statement that explained the purpose of the survey, along with additional information regarding confidentiality (Attachment C). Informed consent forms and the survey instrument was distributed and completed in the room used for the AA /NA meeting. The researcher left the room while the surveys were being completed. The consent forms and survey instruments were then collected and placed in separate sealed envelopes by the researcher to avoid any identification of the participants.

The researcher had more difficulty than expected in gathering participants for this survey. The researcher approached the secretary for each AA and NA meeting selected for the research. This researcher read the statement of intent to them to insure their understanding of the research, and to insure the safety of the meeting as well as the safety of the participants (Appendix C). Some secretaries denied the request of this researcher to place the information on a table during the meeting to allow attendees of the meeting to decide if they wanted to participate. They expressed fear of their group being identified and loosing their anonymity. This researcher assured them that confidentiality would be maintained, but some still did not want to participate. Researcher was allowed at other meetings to present the information for the research. Some participants were afraid to
participate and afraid their anonymity would be broken. They were told they did not have to participate. They were thanked, and others were asked to participate in the study.

**Statistical Analysis Plan**

The responses from the survey were entered into the PASW (Predictive Analysis Software) program (version 18). All univariate data analysis included descriptive statistics, frequency distributions and charts. Bivariate analysis was also performed using the PASW. Chi-square analysis was used to examine the relationship between the aspects of the independent variable (attendance in AA/NA meetings) with those of the dependent variable (abstinence from alcohol and drugs). Statistical analysis used was both Univariate and Bivariate. Univariate analysis was used for frequency distributions, while Bivariate chi-square analysis was used to compare relationships between independent and dependent variables. Chi-square analysis was also used to examine the relationships between participant responses and demographic criteria such as race/ethnicity and gender.

**Human Subjects**

Before the data collection began, the study was approved by the California State University, Sacramento Division of Social Work Human Subjects Committee. The study was approved as a minimal risk study. Subject’s right to privacy and protection were protected because the study did not ask for information that could be used to identify them and the survey responses provided to the researcher were completely anonymous. The researcher of this study was the only one who contacted the participants, and only to inform them of the study. Subjects voluntarily decided whether to participate in the
research or not, and indicated informed consent before participating.

Research subjects were required to view an informed consent page (Appendix A), and then sign or initial the consent indicating informed consent before being allowed to view or participate in the survey. The informed consent reminded participants that their participation in the study was voluntary, and that they could end their participation in the study at any time without consequence. It also informed them of the risks and benefits of participation in the study, as well as resources for any additional support needed if their participation became distressing to them, as well as the researcher’s contact information for any further questions. Additionally, subjects were able to decide whether or not to submit the results of the survey, which provided another opportunity for them to consent to participate.

Risk of discomfort or harm while completing the survey was minimized due to several factors: First, the survey responses were anonymous and confidential; second, the researcher left the room and thus ended the participant’s face to face contact with the researcher, which reduced any potential embarrassment or discomfort; third, subjects were given the option of stopping the survey at any time, as well as the option of not submitting their answers. In this way, subjects gave additional consent to participate upon submitting their answers. Research subjects were given resources for additional support if needed. Sources of support suggested to participants were: The Effort at 1820 J Street, Sacramento, CA 95811, (916) 325-5556 for a sliding scale fee.

To protect the identity and privacy of research subjects, surveys were conducted at the AA/NA meeting locations. Confidentiality and security of the responses was
maintained as outlined in attachment 1. These protective factors greatly reduced the risk of any harm to research subjects or their confidentiality and anonymity.

Minimal risks were associated with this study because the questionnaire used did not contain questions which could be used to identify a participant. Additionally, the questionnaire consisted of topics that were not likely to present a risk greater than what many members of AA/NA meetings experience regularly as they shared their personal stories openly in the meetings from which they were solicited for this research. The fact that there was no face-to-face contact with the researcher during the completion of the surveys minimized the potential risks of this study even further by reducing the risk of discomfort, guilt, or embarrassment on the part of research subjects. In the event that a research subject might have become distressed by participating in the research study, they were already directed to an organization to support individuals struggling with depression and other mental health issues. As mentioned above, research subjects who might have felt distressed by the research process were informed that they could contact The Effort at 1820 J Street, Sacramento, CA 95811, (916) 325-5556 for a sliding scale fee.

Summary

This section included discussion of the purpose, design, and methodology of the research study. Information about the study population and study sample was discussed, as well as the survey questionnaire being used and how an analysis of the data was to be performed. The protection of human subjects was outlined in detail as well to ensure ethical practices in research involving human subjects. In the next chapter, the data analysis is presented.
Chapter 4

DATA ANALYSIS

Introduction

This chapter examines the results of the study. The demographics of the participants will be examined as well and the responses of the participants as to their participation in AA/NA meetings and their length of time staying abstinent from alcohol and/or drugs. The responses for the variable “how many months have you been attending” AA/NA meetings were re-coded to: 0-3 months and 4+ months and the variable of “longest number of days abstaining from alcohol or drugs” were recoded for responses of 0-90 days and 91+ days. The responses for variable “ethnicity” were re-coded to: Caucasian and all other ethnicities. Chi-square tests will be presented on the relationship between variables. This chapter will conclude with a summary.

Demographics

A total of 44 people attending AA/NA meetings participated in the study. Participants were equally split between genders. There were 22 female (50.0%) and 22 male (50.0%) participants (Table 4.1). About three-quarters of the participants were Caucasian and over one-tenth were African Americans (13.6%). There were very few other ethnic groups that participated in the study. Nearly 5% identified themselves as “Other,” although they did not designate their ethnic identification (Table 4.2). Demographics on age were not gathered.
What is the relationship between attending AA/NA meetings and abstinence from alcohol and drugs?

This section will explore the relationship between attending AA/NA meetings and staying abstinent from alcohol and drugs. The relationship between gender and attendance of AA/NA meetings, gender and AA/NA sponsorship, gender and abstinence, sponsorship and abstinence, and sponsorship and attendance of AA/NA meetings will also be discussed.

Table 4.1

Gender

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Male</td>
<td>22</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>22</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>44</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.2

Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Caucasian</td>
<td>32</td>
<td>72.7</td>
<td>72.7</td>
</tr>
<tr>
<td></td>
<td>African-American</td>
<td>6</td>
<td>13.6</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td>Native American</td>
<td>2</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>Asian of Pacific Islander</td>
<td>1</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>1</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>44</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
Attending AA/NA Meetings and Abstinence from Alcohol and Drugs

The purpose of this study was to determine the relationship of attending AA/NA meetings and staying abstinent from alcohol and/or drugs. Over four-fifths of the respondents attending AA/NA meetings for four months or more were abstinent from alcohol/drugs for over 91 days (Table 4.3). Even though 15% of the respondents have been attending AA/NA meetings for 4+ months, they have only been able to abstain from alcohol and/or drugs for 90 days or less. One responded reported attending AA/NA meetings for 0-3 months and abstaining from alcohol and/or drugs for 0-90 days. Although there appears to be a relationship in attending AA/NA meetings and abstaining from alcohol and/or drugs, the chi-square test was not statistically significant.

Gender and Attending AA/NA Meetings

All but one of the males in this study reported to be attending AA/NA meetings for over four months (Table 4.4). Over four-fifths of females in this study also reported attending AA/NA meetings for over four months (Table 4.4). Three females reported to be attending AA/NA meetings for three months or less. There was no association between gender and AA/NA attendance. The chi-square test was not statistically significant.

Gender and AA/NA Sponsor

In this study comparing gender and AA/NA sponsorship, over three-quarters of the males reported to have an AA/NA sponsor (Table 4.5). More than 90% of females reported to have an AA/NA sponsor. Less than 20% of the total respondents do not have
an AA or NA sponsor. Even though more women than men had sponsors, the chi-square test was not statistically significant.

Table 4.3

*Attendance of AA/NA Meetings and Abstinence from Alcohol/Drugs*

<table>
<thead>
<tr>
<th>How many months have you been attending</th>
<th>0 to 3 Months</th>
<th>4+ Months</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>% within How many months have you been attending</td>
<td>25%</td>
<td>15%</td>
<td>15.9%</td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>75%</td>
<td>85%</td>
<td>84.1%</td>
</tr>
<tr>
<td>% of Total</td>
<td>2.3%</td>
<td>6.8%</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>0-90 Days</th>
<th>91+ Days</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-90 Days</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>% within How many months have you been attending</td>
<td>25%</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>14.3%</td>
<td>8.1%</td>
<td>9.1%</td>
</tr>
<tr>
<td>% of Total</td>
<td>2.3%</td>
<td>6.8%</td>
<td>9.1%</td>
</tr>
<tr>
<td>4+ Months</td>
<td>6</td>
<td>34</td>
<td>40</td>
</tr>
<tr>
<td>% within How many months have you been attending</td>
<td>15%</td>
<td>85%</td>
<td>100%</td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>85.7%</td>
<td>91.9%</td>
<td>90.9%</td>
</tr>
<tr>
<td>% of Total</td>
<td>13.6%</td>
<td>77.3%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>37</td>
<td>44</td>
</tr>
<tr>
<td>% within How many months have you been attending</td>
<td>15.9%</td>
<td>84.1%</td>
<td>100%</td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% of Total</td>
<td>15.9%</td>
<td>84.1%</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Table 4.4

**Gender and Attending AA/NA Meetings**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>How many months have you been attending</th>
<th>% within Gender</th>
<th>% within How many months have you been attending</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 to 3 Months</td>
<td>4+ Months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>21</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>19</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>40</td>
<td>44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% within Gender: 4.5% for Male, 13.6% for Female
% within How many months have you been attending: 25% for Male, 75% for Female
% of Total: 2.3% for Male, 6.8% for Female
Table 4.5

Gender and AA/NA Sponsor

<table>
<thead>
<tr>
<th>Gender</th>
<th>Do you have an AA or NA sponsor</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>17</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>77.3%</td>
<td>22.7%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% within Do you have an</td>
<td>45.9%</td>
<td>71.4%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>AA or NA sponsor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>38.6%</td>
<td>11.4%</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>20</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>90.9%</td>
<td>9.1%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% within Do you have an</td>
<td>54.1%</td>
<td>28.6%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>AA or NA sponsor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>45.5%</td>
<td>4.5%</td>
<td>50%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>37</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>84.1%</td>
<td>15.9%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% within Do you have an</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>AA or NA sponsor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>84.1%</td>
<td>15.9%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Gender and Abstinence from Alcohol/Drugs

There were some differences when comparing gender and abstinence from alcohol and/or drugs. More than 90% of males and over three-quarters of the females were abstaining from alcohol/drugs for over 91 days (Table 4.6). Once again, fewer than 16% of the respondents reported to be abstaining from alcohol and/or drugs for 90 days or less. However, the chi-square test was not statistically significant.

Sponsorship and Abstinence from Alcohol/Drugs

When studying the relationship between having an AA/NA sponsor and abstinence from alcohol and/or drugs, over four-fifths of the respondents that have a sponsor were abstaining from alcohol and/or drugs for over 91 days (Table 4.7). Even though most respondents had sponsors and more than 91 days of sobriety, the chi-square test was not statistically significant.

Sponsorship and Attending AA/NA Meetings

Most respondents (89.2%) reported having a sponsor and attending AA/NA meetings for four months or more (Table 4.8). Fewer than 11% of the respondents that have an AA/NA sponsor have been attending meetings for three months or less. The chi-square test was not statistically significant.
Table 4.6

*Gender and Abstinence from Alcohol/Drugs*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>0-90 Days</th>
<th>91+ Days</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td>2</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>9.1%</td>
<td>90.9%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>28.6%</td>
<td>54.1%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>4.5%</td>
<td>45.5%</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>5</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>22.7%</td>
<td>77.3%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>71.4%</td>
<td>45.9%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>11.4%</td>
<td>38.6%</td>
<td>50%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>7</td>
<td>37</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>15.9%</td>
<td>84.1%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>15.9%</td>
<td>84.1%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 4.7

Sponsorship and Abstinence from Alcohol/Drugs

<table>
<thead>
<tr>
<th>Do you have an AA or NA sponsor</th>
<th>Count</th>
<th>0-90 Days</th>
<th>91+ Days</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7</td>
<td>30</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>% within Do you have an AA or NA sponsor</td>
<td>18.9%</td>
<td>81.1%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>100%</td>
<td>81.1%</td>
<td>84.1%</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>15.9%</td>
<td>68.2%</td>
<td>84.1%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>% within Do you have an AA or NA sponsor</td>
<td>.0%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>.0%</td>
<td>18.9%</td>
<td>15.9%</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>.0%</td>
<td>15.9%</td>
<td>15.9%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>37</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>% within Do you have an AA or NA sponsor</td>
<td>15.9%</td>
<td>84.1%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>15.9%</td>
<td>84.1%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.8

*AA/NA Sponsor and Attendance of AA/NA Meetings*

<table>
<thead>
<tr>
<th>Do you have an AA or NA sponsor</th>
<th>Count</th>
<th>% within Do you have an AA or NA sponsor</th>
<th>% within How many months have you been attending</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>4</td>
<td>10.8%</td>
<td>9.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>33</td>
<td>89.2%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>37</td>
<td>100%</td>
<td>84.1%</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>0</td>
<td>.0%</td>
<td>.0%</td>
</tr>
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<td></td>
<td></td>
<td>7</td>
<td>100%</td>
<td>15.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4</td>
<td>9.1%</td>
<td>9.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40</td>
<td>90.9%</td>
<td>90.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>44</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Ethnicity and Attending AA/NA Meetings

There were similarities between the data of Caucasian and other ethnicities and their reported attendance in AA/NA meetings. Over 93% of Caucasians responding stated they have been attending AA/NA meetings for over four months, while 83% of all other ethnicities reported to be attending AA/NA meetings for over four months (Table 4.9). Inversely, just over 6% of Caucasians and less than 17% of all other ethnicities reported to have been attending AA/NA meetings for less than four months. However, the chi-square test was not statistically significant.

Ethnicity and AA/NA Sponsor

When looking at the data regarding ethnicity and sponsorship, over 91% of other ethnicities reported to have an AA/NA sponsor compared to fewer than 82% of Caucasians reporting (Table 4.10). Caucasians had the greatest percentage of non-sponsorship at more than 18% versus fewer than 9% of other ethnicities. Even with this data, the chi-square test was not statistically significant.

Ethnicity and Abstinence from Alcohol/Drugs

The data pertaining to abstinence from alcohol and/or drugs is virtually split evenly between Caucasian and other ethnicities. Over 84% of Caucasians and over 83% of other ethnicities reported to be abstaining from alcohol and/or drugs for over 90 days (Table 4.11). Less than one-fifth of both Caucasians and other ethnicities were abstaining from alcohol and/or drugs for less than 90 days. The chi-square test was not statistically significant.
### Table 4.9

*Ethnicity and Attending AA/NA meetings*

<table>
<thead>
<tr>
<th>How many months have you been attending</th>
<th>Count</th>
<th>% within How many months have you been attending</th>
<th>% within Ethnicity Caucasian or All Others</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 3 Months</td>
<td></td>
<td></td>
<td>Caucasian</td>
<td>All Others</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>50%</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4+ Months</td>
<td>30</td>
<td>75%</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>72.7%</td>
<td></td>
<td>27.3%</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>44</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 4.10

*Ethnicity and AA/NA Sponsor*

<table>
<thead>
<tr>
<th>Do you have an AA or NA sponsor</th>
<th>Count</th>
<th>% within Do you have an AA or NA sponsor</th>
<th>% within Ethnicity Caucasian or All Others</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26</td>
<td>70.3%</td>
<td>81.3%</td>
<td>59.1%</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>85.7%</td>
<td>18.8%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>72.7%</td>
<td>100%</td>
<td>72.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% within Do you have an AA or NA sponsor</th>
<th>% within Ethnicity Caucasian or All Others</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>All Others</td>
<td>Total</td>
</tr>
<tr>
<td>26</td>
<td>11</td>
<td>37</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>32</td>
<td>12</td>
<td>44</td>
</tr>
</tbody>
</table>
Table 4.11

*Ethnicity and Abstinence from Alcohol/Drugs*

<table>
<thead>
<tr>
<th>What has been the longest number of days you have been able to abstain from alcohol or drugs</th>
<th>Count</th>
<th>Ethnicity</th>
<th>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</th>
<th>% within Ethnicity Caucasian or All Others</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0-90 Days</strong></td>
<td></td>
<td>Caucasian</td>
<td>All Others</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>71.4%</td>
<td>28.6%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within Ethnicity Caucasian or All Others</td>
<td>15.6%</td>
<td>16.7%</td>
<td>15.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>11.4%</td>
<td>4.5%</td>
<td>15.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>91+ Days</strong></td>
<td></td>
<td>Caucasian</td>
<td>All Others</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>27</td>
<td>10</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>73%</td>
<td>27%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within Ethnicity Caucasian or All Others</td>
<td>84.4%</td>
<td>83.3%</td>
<td>84.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>61.4%</td>
<td>22.7%</td>
<td>84.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>Caucasian</td>
<td>All Others</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>32</td>
<td>12</td>
<td>44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within What has been the longest number of days you have been able to abstain from alcohol or drugs</td>
<td>72.7%</td>
<td>27.3%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within Ethnicity Caucasian or All Others</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>72.7%</td>
<td>27.3%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Summary

In this chapter, the demographics of the participants of this study were presented. This chapter also explored the relationship between attending AA/NA meetings and abstinence from alcohol and/or drugs. The next chapter will analyze the data gathered and present the conclusions, limitations and implications for social work practice and policy.
Chapter 5

CONCLUSIONS

Introduction

This chapter summarizes the main findings gathered in this study. The demographics of respondents were used to compare with having a sponsor in AA/NA. Other variables tested include: attending AA/NA meetings and length of time abstinent from alcohol and/or drugs, sponsorship compared to attending AA/NA meetings and abstinence from alcohol and/or drugs, and the difference between attending AA/NA meetings and abstinence from alcohol and/or drugs. Limitations of the study will be presented. Finally, implications of the findings or practice, policy and future research will be discussed.

Summary

Little research has been conducted of the direct relationship between attending AA/NA meetings and abstinence from alcohol and/or drugs. This study explored the relationship between attending AA/NA meetings and abstinence from alcohol and/or drugs. For the demographics of this study, chi-square tests were not significant. However, more males than females had been attending AA/NA meetings for four months or longer. Inversely, more females than males reported to have an AA/NA sponsor while more males than females were abstinent from alcohol and/or drugs for 91 days or more. Within the demographic of ethnicity, over 72% of the respondents reported to be Caucasian, and less than 18% of those responding were other ethnicities. Given this fact, it was reported that about the same percentage of Caucasian respondents and all other ethnicities
responding had been attending AA/NA meetings for four months or more. A larger percentage of all other ethnicities had an AA/NA sponsor than Caucasians, and virtually an equal percentage of Caucasian respondents and all other ethnicities reported to have been abstinent from alcohol and/or drugs for 91 days or more. Lastly, those with an AA/NA sponsors were attending AA/NA meetings for four months or more and were abstinent from alcohol and/or drugs for 91 days or more.

All of the chi-square tests had no statistical significance. However, most respondents that had been attending AA/NA meetings for four months or more had remained abstinent from alcohol and/or drugs for 91 days or more. Furthermore, most respondents that reported an AA/NA sponsor had also remained abstinent from alcohol and/or drugs for 91 days or more.

**Discussion**

This study was created to explore the relationship between attending AA/NA meetings and abstinence from alcohol and/or drugs. The researcher compared attending AA/NA meetings and abstinence form alcohol and/or drugs within the demographics of the participants, including gender, ethnicity and AA/NA sponsorship. When using the social learning model to examine the findings, it is important to be aware that various social influences that may be affecting a person’s ability to abstain from alcohol and/or drugs, and to be mindful of the social influences that may be influencing a person to continue using drugs and/or alcohol. It has been stated that within a person’s immediate social network, there will always be somewhere you can go where a person can find others to drink and/or do drugs with (Comstock, 2005). Comstock continues to state that
even within our own families, there can be an atmosphere that could influence and reinforce alcoholic behaviors.

Ethnicity does not appear to play a role in a person’s ability to abstain from alcohol and/or drugs. As shown in this study, the same percentages of all other ethnicities were abstaining form alcohol and/or drugs as those reporting to be Caucasian. There does not appear to be a significant difference when comparing gender as well.

Even though this study did not address why respondents may have had difficulty staying abstinent from alcohol and/or drugs, literature again suggests that the main reason for continued relapse and lack of prolonged abstinence from alcohol and/or drugs is connected to a person’s social contacts and relationships (Comstock, 2005). If a person maintains the same social contacts and networks that they had when using alcohol and/or drugs, then the ability to maintain sobriety is reduced (Comstock, 2005; Van Wormer, 1995; Zastrow & Kirst-Ashman, 2010). If a person attempting abstinence from alcohol and/or drugs maintains relationships that minimizes and promotes alcohol and drug use, then that person will continue to have difficulty staying abstinent. What is encouraged is for those who desire abstinence from alcohol and/or drugs is for those individuals to create new associates and become involved in new activities that do not involve substances (McCartney, 2010). This could be accomplished by a continued attendance and participation in AA/NA meetings and activities (Alcoholics Anonymous, 1998; Narcotics Anonymous, 2008). This study supports this idea that people who attend AA/NA meetings are more likely to stay abstinent from alcohol and/or drugs.
Within the context of Social Learning Theory, addict behaviors, and the subsequent negative results that affect the individual, can be unlearned through the observation and interactions with those people that are attending AA/NA (Thyer & Meyers, 1997). Since it has been noted that many people who started to use drugs and/or alcohol did so through observing others (Hayaki, 2011), then attending AA/NA meetings and other AA/NA related activities will expose the addict to an environment of abstinence from alcohol and/or drugs. Furthermore, it will also expose those attending meetings to others that may have developed positive behaviors that have assisted them to maintain their abstinence while away from meetings. This exposure to positive behaviors that promotes abstinence may help the individual to unlearn those negative behaviors that lead to the use and subsequent abuse and addiction to alcohol and/or drugs in the first place (Hayaki, 2011)

Social support within AA/NA meetings is an effective way to demonstrate and promote a lifestyle spearheaded by sobriety and abstinence from alcohol and/or drugs (Groh, Jason & Keys, 2008). This study supports other research that has shown that consistency of attending AA/NA meetings, along with having a sponsor, has been shown to be an effective method in the continued abstinence from alcohol and/or drugs (Humphreys, 1999; McCartney, 2010).

**Limitations**

The limitations of this study include the sample size (N=44), which is small to conduct statistical tests. The collection methods of going to AA/NA meetings to complete the surveys may have precluded individuals from participating because they might have
felt afraid to complete a questionnaire from a stranger. Individuals that had less than 90
days abstinence, or had been attending AA/NA meetings for less than 4 months, may have felt that they should not participate since their short-term participation may not show a relationship in attendance of meetings and abstinence from alcohol and/or drugs. Additionally, there may have been those that did not want to participate due to feelings of shame and self-loathing when they reflected on their addiction and the negative results it had caused to themselves and those around them. The survey itself may be flawed. The survey may have been too confusing with its questions regarding past substance abuse, and present attendance of AA/NA meetings. The survey should be re-examined and corrected so its presentation would appear to be less formal and scientific. Lastly, the researcher may have introduced bias into all phases of the study. The researcher may have implied that since the study was to look for a relationship in AA/NA meetings and abstinence, the researcher was looking for respondents that had long-term attendance in AA/NA meetings with long-term abstinence from alcohol and/or drugs. Since the researcher was looking for a relationship between attending AA/NA meetings and abstinence from alcohol and/or drugs, then the survey may have been biased with only those that have experienced success with AA/NA meetings responding to the survey. Further research that includes adjustments to the survey tool and a larger number of participants should be completed in order to reduce the problems and/or bias that may have occurred with this study.
Implications for Social Work Practice and Policy

This study presents implications for social work policy and practice. There appears to be little research directed specifically at the relationship between attending AA/NA meetings and abstinence from alcohol and/or drugs. Results from this study suggest that further research would be warranted in this area.

On the micro level, it would be ideal for individuals and families to be aware of AA/NA meetings and the association between attending AA/NA meetings and abstinence from alcohol and/or drugs that was presented by this research. It would also be important for individuals and families to seek out more information and research regarding alcohol and drug abuse and the difficulties that people seeking and participating in treatment of addiction face. If the information that was presented in this study is utilized by individuals and families that are suffering from or affected by someone with an alcohol and/or drug addiction, then it would hopefully increase their own self-awareness of their need for substance abuse treatment, and that continuous participation in treatment may increase their success in continued abstinence.

On the mezzo level, the findings of this study can better educate and inform social workers, police, and health professionals of the association between attending AA/NA meetings and remaining abstinent from alcohol and/or drugs. By knowing there may be an association between attending AA/NA meetings and abstinence from alcohol and/or drugs, and that attendance in meetings may be a long-term commitment by addicts seeking to abstain from alcohol and/or drugs, social workers and health care professionals may provide the appropriate interventions and referrals to support this long-term
commitment. For example, rather than providing short-term interventions and support to addicts and other suffering from alcohol and/or drug abuse, longer treatment programs could be developed in the community knowing that longer periods or treatment participation produce longer periods of abstinence from alcohol and/or drug use. After all, longer periods of abstinence may result in positive changes in an addict’s social system that could increase the likelihood of the addict’s ability to maintain abstinence from alcohol and/or drugs.

On the macro level, local, State and Federal policy on substance abuse and addiction interventions and treatment could focus on long-term treatment with an emphasis on the self-help model that is used by AA/NA meetings. Possible policy changes could include long-term treatment alternatives for those facing criminal charges associated with substance abuse and/or addiction, including longer participation in community AA/NA meetings. Also, since the self-help model eliminates the need for licensed psychiatric or medical professionals, costs for such treatment programs could be reduced from current expenditures and therefore availability for such programs and meetings in local communities could be financed by non-profit groups and other charity organizations. Since CBT and other family treatment programs require a trained and licensed profession to provide treatment, the cost savings from such expenditures could be used to create additional treatment programs and meetings that would follow the self-help model.

Further research should be conducted that would validate the need for increases in self-help interventions rather than the more formal and clinical interventions that are
currently used. Additionally, research studies may need to be focused on what treatment policy changes and implementation methods are useful for self-help programs.

**Recommendations**

The purpose of this study was to explore the relationship of attending AA/NA meetings and abstinence from alcohol and/or drugs. The following section is a list of recommendations developed for future alcohol and/or drug programs, social workers and substance abuse treatment providers:

- Community programs that currently provide clinical treatment for substance abuse issues, such as CBT and other clinical therapies, should implement self-help programs that may include AA/NA models of meetings and beliefs. AA/NA meetings are less formal, and do not require a trained and licensed clinician to conduct the meetings. This allows for more meetings to be held, and the reduction of the financial burden on the community program. Additionally, participants can join the groups at any time as AA/NA meetings are on-going; they are not limited to a number of weeks or months. This allows the freedom of individuals to begin at anytime, and also the elimination of a “waiting list” that may reduce a person’s interest in attempting abstinence from alcohol and/or drugs. Community programs that implement AA/NA meetings, along with formal clinical therapies, can also compare the results between the self-help model and the formal clinical model. This comparison may help to determine which interventions have better results.

- Longer terms of sentencing of self-help treatment options, such as 6 months to one year, should be implemented by the judicial court system for all persons
convicted of a crime that may have resulted from the abuse or addiction to alcohol and/or drugs. According to Social Learning Theory, individuals can learn to change their behaviors by observing and becoming socially integrated with others that are engaged in the same positive behaviors. If individuals have been abusing substances for a long period of time, such as years or decades, then they should be exposed to positive behaviors for longer periods of time. Therefore, longer-term sentences for treatment should be mandated by the judicial system for persons convicted of a crime related to substance abuse and/or addiction to alcohol and/or drugs.

- Further research shall be conducted on this topic in order to better determine the relationship between attending AA/NA meetings and abstinence from drugs and/or alcohol. Specific areas that shall be addressed include the relationship between attendance of AA/NA meetings and abstinence from alcohol and/or drugs and the role, if any, that AA/NA sponsorship may have on attendance of AA/NA meetings and/or abstinence from alcohol and/or drugs. Other studies shall include qualitative research and larger study populations.

**Conclusion**

The primary purpose of this study was to examine the relationship between attending AA/NA meetings and abstinence from alcohol and/or drugs. The secondary purpose of this study was to increase the amount of research that exists on this topic because there is presently a minimal amount of research. The findings of this study suggest that additional research needs to be conducted on this topic so that it could be
better understood and applied. Future application of research findings may increase an individual’s success in abstinence from alcohol and/or drugs through the increase of community-based self-help interventions patterned after AA/NA meetings, and from the changes in sentencing of individuals from the judicial system. This study should be duplicated in order to obtain the larger number of participants needed to validate any findings for this topic. Future quantitative and qualitative research studies may enhance and add to the current research on AA/NA programs.
APPENDIX A

Consent to Participate in Research

You are invited to participate in a research study that will be conducted by Brian Wilhite, a Master of Social Work student at the Division of Social Work, California State University Sacramento. This study will explore the relationship between attending AA/NA meetings and abstinence from alcohol and drug use.

Procedures:
After reviewing this form and agreeing to participate you will be given a survey containing multiple choice and fill-in questions. The survey should take approximately five (5) minutes to complete. The survey is confidential and no names will be recorded.

As a participant in the survey, you can decide at any time not to answer any specific question, skip questions or stop taking the survey.

Risks:
The discussion of some of the topics on the survey may illicit some emotional responses as you think about your participation in AA/NA meetings and your past alcohol and/or drug use. If needed, you can seek mental health support at The Effort at 1820 J Street, Sacramento, CA 95811, (916) 325-5556 for a sliding scale fee.

Benefits:
The research gained by completing this survey may help others to understand better the relationship of attending AA/NA meetings and how attendance in those meetings can help to abstain from alcohol and drugs. This information, in turn, could be used to enhance service providers in the recommendation and support to such programs as AA and NA. In addition, by being a part of this study you may gain insight into reasons for your own relationship between your participation in meetings and abstinence from alcohol and/ or drugs.

Confidentiality:
All information is confidential and every effort will be made to protect your anonymity. Your responses on the survey will be kept confidential. Information you provide on the consent form will be stored separately from the completed surveys in a locked cabinet in a secure location at the researcher’s home. The researcher’s thesis advisor will have access to the completed surveys for the duration of the project. The final research report will not include any identifying information. All of the data will be destroyed approximately one month after the project is filed with Graduate Studies (June of 2012) at California State University, Sacramento.
Compensation:
Participates will not receive any kind of fiscal compensation.

Rights to withdraw:
If you decide to participate in this survey, you can withdraw at any point.

If you have any questions you may contact the researcher, Brian Wilhite at (916) 397-5178 and at bw389@saclink.csus.edu

Or, if you need further information, you may contact the researcher’s thesis advisor:
Maria Dinis, Ph.D., MSW
c/o California State University, Sacramento
(916) 278-7161
dinis@csus.edu
Consent to Participate as a Research Subject

I have read the descriptive information on the Research Participation cover letter. I understand that my participation is completely voluntary. My signature or initials indicate that I have received a copy of the Research Participation cover letter and I agree to participate in the study.

Signature or Initials: ________________________________ Date: __________

If you have any questions you may contact the researcher, **Brian Wilhite at 916-397-5178 or at bw389@saclink.csus.edu**

Or, if you need further information, you may contact the researcher’s thesis advisor:

Maria Dinis, Ph.D., MSW  
c/o California State University, Sacramento  
(916) 278-7161  
dinis@csus.edu
APPENDIX B

Survey Instrument

Please answer the following questions about your attendance in AA/NA and alcohol and drug use. Please be honest. To insure anonymity, DO NOT put your name, or any other identifying information on this questionnaire. Thank you for your participation.

How long have you been using alcohol and/or drugs? ____ years ____ months

Have you ever attended AA/NA in the past? ____yes ____no

How many months have you been currently attending AA/NA meetings? ____0-3, ____4-6, ____7-9, ____10-12, ____12+

Do you attend meetings daily? ____yes ____no

Do you attend meetings weekly? ____yes ____no

Do you attend meetings monthly? ____yes ____no

How many days per month do you attend on average? ____0-5, ____6-10, ____11-15, ____16-20, ____21-25, ____more than 25

Do you have an AA/NA sponsor? ____yes ____no

Have you attempted to abstain from alcohol and/or drugs before? ____yes ____no

If so, how many times? ____1-3, ____4-6, ____7-9, ____10-12, ____more than 12

What has been the longest number of days you have been able to abstain from alcohol/drugs? ______

What has been the longest number of months you have been able to abstain from alcohol/drugs? ______

If not currently abstinent, reasons why? ______peer pressure, ______not attending NA/AA meetings, ______family culture, ______personal trauma, ______other (please state)____________________

Sex: ____Male, ____Female

Ethnicity: ____Caucasian, ____African American, ____Native American, ____Asian/ Pacific Islander, ____Hispanic, ____Other
APPENDIX C

Purpose of Study

“My name is Brian and I am a graduate student in the Division of Social Work at California State University, Sacramento. I am currently administering a survey for my thesis on the relationship between attending AA/NA meetings and abstinence from alcohol and drug use.

I would appreciate it if you would take some time and complete the survey to the best of your ability. It is completely voluntary and anonymous. If you wish to participate, please read and fill out the consent form and keep the first page. It should only take five to ten minutes to complete the survey. When you are done with the survey, please return the survey and consent form to me face down. If you have any questions you can ask me while I am here, or you can contact me through the e-mail address on the consent form.”
References


http://www.drug-rehabs.org/


