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INVESTIGATING SIMILARITIES AND DIFFERENCES AS MEASURED BY THE
DUREL AND GSQ BETWEEN THREE SUBGROUPS ATTENDING A LOCAL AA
MEETING TO DEVELOP A PROFILE OF LONG TERM ATTENDEES.

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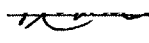
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Requirement for the Degree of


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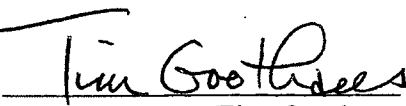
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ABSTRACT

Investigating Similarities and Differences as Measured by the DUREL and GSQ Between Three Subgroups Attending a Local AA Meeting to Develop a Profile of Long Term Attendees.

Keesha Masean Kerns
Old Dominion University, 2013
Director: Dr. Nina W. Brown

Alcoholics Anonymous groups are growing in popularity due to their cost effectiveness and history of dependability. Although the program clearly has the numbers to support its popularity, skeptics continually analyze its claims of effectiveness through research. While research pertaining to AA is diverse, very little is presented concerning factors that contribute to retention in the program. The primary purpose for this quantitative study was to investigate the similarities and differences in the various stages of participants of a sample attending a local AA program, identify variables that contribute to retention in the AA sample, and to use Grounded Theory to develop a profile of long term attendees in the local AA program. This study analyzed the answers from an instrument that combined a demographics form used by the program Recovery for the Life, the Duke University Religion Index, and the Group Selection Questionnaire to determine the variables and characteristics of participants who attended and were retained in AA. Results indicated age and negative group demeanor were significant similarities for participants in the three groups of Newcomers, Chronic Relapsers, and Endurers and contributed to long term attendance in the local AA program. Results also indicated that age and negative group demeanor are inversely related to whether Newcomers and Chronic Relapsers have the potential to become Endurers. Discussion of the results and

how they relate to the literature, implications for practitioners and recommendations for future research are also included.

This dissertation is dedicated to my family and friends.

Though they are not here to see this accomplishment, much love and appreciation goes to my grandparents Rudolph and Ethelle, Uncle Billy, friends Deketa and Bruce for their roles along the way in fostering the strong and confident person I am today.

My appreciation and love for my dear friends and family near and far for kind words, listening ears and unconditional support over the years which was instrumental in achieving this goal. Especially my dad Scott, brother Tony, Tanya, Mia, Denise, Sheri, Keisha, Clarissa, Venita, Eryka, Sean, Imogene, Von, FI, Trina, Cassandra, Paul, Shannon, Stu, Jennifer, Scott and Mandy for being the best cheerleaders.

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And last to my son Trey who the drive for everything I am in life. I love you more than you will ever know.

Mark 9:23

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Chapter I

INTRODUCTION

According to the Substance Abuse and Mental Health Administration, more than five million people attend AA or its sister program NA every year (The NSDUH Report, 2008). Although the program clearly has the numbers to support its popularity, skeptics continually analyze its claims of effectiveness through research. The research pertaining to AA is very diverse, covering everything from attendance to demographics to outcomes (Krentzman et al, 2011). Even with diverse areas, there is still little research on whether there are factors that can predict if participants will complete the course of AA. Some qualitative studies may accidentally find out personal motivation for entering AA; however, the factors past motivation are not investigated. There has been no research establishing a connection between those beyond motivation factors and retention in the AA program. This study sought to add to the body of knowledge by developing profiles of three groups of attendees that complete a group based AA program.

Background

The consumption of alcoholic beverages such as wine and ale is recorded throughout history. Typically wine and ale were served at festivals, celebrations, and meals. There are also recorded incidents of individuals consuming alcoholic beverages outside of its intended purpose to the point of intoxication. It is when an individual feels that intoxication is needed to function that it becomes classified as a problem or a disorder.

The Temperance movement in the United States was a century old before prohibition became constitutional. National policy efforts around prohibition in the

United States began in 1913 (facilitated by the Webb–Kenyon Act) followed, a few years later, with the passing of the War Prohibition Act in 1918 which banned the manufacture and sale of all beverages with more than 2.75% alcohol. During this time, the homicide rate in the United State increased by 11%, prompting the government to define the negative affect of liquor on the population (Asbridge & Weerasinghe, 2009). Thus the development of Volstead Act, which defined ‘intoxicating liquor’ as any beverage containing more than 0.5% alcohol, was passed in October of 1919. In January 1920, the Eighteenth Amendment took effect, which in essence recognized that Americans needed laws to govern the use of alcohol (Asbridge & Weerasinghe, 2009).

According the DSM-IV TR, alcohol is considered a substance and substance-related disorders fall into two groups: substance use and substance induced. The substance use group includes dependence and abuse. The substance-induced group includes intoxication, withdrawal, delirium, dementia, amnesia, psychosis, mood disorder, anxiety, sexual dysfunction and sleep disorders (DSM, American Psychiatric Association, 2000). Upon further reading, the DSM-IV TR distinguishes the difference between use and induced to be that induced is a change in behavior due to the use of substance; while use is a pattern of maladaptive behavior occurring over a twelve month period of time.

SAMHSA or Substance Abuse and Mental Health Administration is a branch of the United States government dedicated to improving the quality and availability of substance abuse prevention, alcohol and drug addiction, treatment, and mental health services. SAMHSA uses the DSM-IV’s definition of substance abuse as well as its definition of dependency. (Epstein, 2002). SAMHSA estimates that over 5 million

Americans currently abuse alcohol (The NSDUH Report, 2008). That is roughly .013 percent of the population. SAMHSA noted that the teen statistics on alcohol abuse has risen notably in last decade according to research (Wagner, 2009). This is noteworthy considering the abuse of alcohol by teens, meaning persons under 21 has out grown the adult rate by 3 times (Kelly, Myers & Brown, 2005).

The treatment for substance abuse disorders is to change the pattern of behavior. This can be done by use of individual therapy which includes outpatient and inpatient therapy, group therapy, or a combination of both. One of the most common group treatments does not involve therapy, but employs a self-help approach. The self help approach is a 12 step self help program called Alcoholics Anonymous (AA). AA has a 75 year history of treating individuals with alcohol use and abuse issues (Gross, 2010). AA is one of the more traditional ways of treating individuals with alcohol dependence issues. Its sister program narcotics anonymous treats individuals with narcotic dependence mixed with alcohol issues.

The AA Model

Alcoholics Anonymous was founded in Akron, Ohio by surgeon Dr. Bob Smith and New York stockbroker Bill Wilson on June 10, 1935 (Gross, 2010). Wilson struggled with sobriety as much as he struggled at being a business entrepreneur. Wilson dealt with trying to stay sober for years before attempting to “fix” other drinkers. He attended a program in New York called the Oxford Group, a religious sect seeking to reproduce the practices of Christianity without the religious doctrine in order to accommodate individuals with agonist, atheistic and other non Christianity beliefs (Stafford, 1991). Wilson was hopeless after years of ineffective willpower to stay sober

and was open to learn their principles to trying anything including turning to a higher power or God, though he was agnostic. Wilson was contemplating taking a drink after a failed business trip when he decided to turn to the Akron Oxford Group for help. Bill Wilson was put in contact with Bob Smith, a surgeon battling alcohol dependence. Wilson needed Smith's help as a "buddy" to strengthen his resolve. Thus alcoholic anonymous was born using the buddy system for support and integrating Christian principles.

When Wilson and Smith developed AA, their vision deviated from the Oxford Group. While the Oxford Group wanted alcoholics to focus on Christ, AA focused on helping alcoholics stay sober. The vision of AA was to be a fellowship of alcoholics dedicated to helping each another stay sober through spirituality, recognizing no specific denomination, and open to all religious or beliefs persuasion including atheists(Stafford, 1991).

They developed a twelve step model that is in current use today. The twelve steps of AA are as follows.

1. We admit we are 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 morel inventory or ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Five of the twelve steps involve the use of God directly and four of the steps involve moral inventory with personal improvement. One step requires admitting powerlessness to alcohol while another acknowledges a higher power, not necessarily God. It does specify “God as we know Him” which leaves room for various religious and belief persuasions to interpret God to their own means. The last step sums up all the previous steps as it fosters a spiritual experience or awakening and sharing this spirituality with other alcoholics while reflecting in daily life. The history of AA not only explains the basic principles behind self help groups, but also lends to the understanding of the alcohol recovery; add to the traditional methods used by clinicians.

The more traditional alcohol addiction treatment methods range from individual and family counseling to use of medical models. Counseling and therapy models include behavior modification such as Cognitive Behavioral Therapy and Motivation Enhancement Therapy. Cognitive Behavioral Therapy works at changing the thoughts, beliefs, and action while Motivation Enhancement Therapy uses motivational strategies to activate a personal change mechanism. (Longabaugh et. al., 1998) The medical model of treatment, such as Detoxification therapeutic medications, is always under the direct supervision of a physician. In detoxification there is a protocol for purging the body of alcohol while dealing with the withdrawal symptom in a controlled environment. Therapeutic medications such as ReViaT and Antabuse are used to produce unpleasant physical reactions like vomiting when alcohol is ingested while the medications are in the body's system (Mark et. al., 2003) The medical model of alcohol treatment is often used in inpatient therapy as well.

Purposes of the Study

The purposes of this study were to:

1. Investigate the similarities and differences in the various stages of participants of a sample attending an AA program
2. Identify variables by using the Duke University Religion Index (DUREL), the Group Selection Questionnaire (GSQ) and demographics that contribute to long term attendance in the program
3. To use Grounded Theory to develop a profile of Newcomers, Chronic Relapsers, and Endurers in the program.

Significance of Study

This study was to contribute to the current research in three ways. First, it defined retention and success of completing an AA program. Second, the study added to the current research by establishing a relationship between certain selected variables in the attending sample and measured factors that determine retention outcomes. Finally the study added to the current research by investigating the similarities and difference and use the information obtained to generate a theory on what variables or combination of variables can describe participants who successfully complete the AA treatment program and return for more than one cycle.

To investigate this possible connection between those factors and retention in the program, a sample was to be drawn from a program that emphasizes the AA treatment approach. A local AA program called Recovery for Life provided the needed sample. Since its launch in 1998, Recovery for Life is a non-profit organization that offers AA as an alternative to outpatient therapy for people struggling with addictions and compulsive behaviors. This sample was used to predict retention in this local AA program

Recovery for Life

Recovery for Life is a state grant funded program that provides 12-step programs of AA and NA services to residents in the Hampton Roads areas of Virginia. Recovery for Life is a faith-based 501 (c) (3) non-profit organization that began in 1998 as an alternative program for people struggling with addictions and compulsive behaviors. The meetings are held in three locations: Tuesday and Thursday nights in Chesapeake, Wednesday nights in northern Norfolk and Friday nights in southern Norfolk. Each meeting offers a meal and take-home snacks to participants. At some meetings child care

is provided for participants. Every measure is taken to reduce barriers to and encourage attendance.

The population that attends the meetings is diverse. The participants range from homemakers to doctors and lawyers to priests. Many attend due to court orders compelling them to seek any kind of treatment for their addictions (Brooks & Penn, 2003); while others are compelled by their outpatient mental health provider. Other individuals that may attend include the family and friends of a substance abuser, seeking to support family member in the recovery process while learning more about the nature of substance abuse. Generally due to the confidentiality of the group, supportive family member are encourage to go to ALANON (Room & Greenfield, 1993)

The meetings are set up in a two types of groups: a large group session which includes more than 100 people and smaller groups that are no larger than twenty in size. The large group is where people eat, mingle and receive teaching on the 12 steps of AA. The large group also opens with a moment of silence for prayer or mediation. After the opening prayer, the large group facilitator sets up a microphone in the front of the group so group participants can speak freely about their motivations for coming, past substance abuse, or whatever comes to mind. Individuals who chose to speak in the front of the group are greeted with encouragement and support from the audience. During the confessional phase chips are handed out based on achieving period of sobriety. Then the presentation of information on the step begins. The large group is together for an hour followed by facilitator directing participants to break into the smaller group sessions.

The smaller groups are divided into gender, age, and type of group. There are groups for couples, men, women, an under 21 group, and combination alcohol and drug

abusers. The group facilitators have a focus or subject matter that is directly related to the large group topic which was one of the steps. The smaller group last for no more than forty-five minutes and participants are dismissed to leave after the small group sessions. Each week group participants can choose to go to the same group each meeting or a different group based upon their personal needs for the night.

At the beginning of each step in the AA process, the program director asks new participants to fill out an anonymous survey. It is explained that the surveys are used for research and funding purposes only. They fill out a survey that contains questions about years of abuse, motivation for attending, barriers to attending such as childcare and transportation and demographic including race, age, gender, income, martial status, education and religious affiliation. The program director takes all information from the surveys and makes adjustments to the meeting process to reduce attendance barriers such as transportation and childcare. Participants are asked to fill out similar anonymous surveys upon completion of the program. The exit survey collects demographics again, but is more focused on participant's experiences and how effective the 12 step process was in their lives.

Description of Study

This study investigated at the answers from the demographics form used by Recovery for Life, the Duke University Religion Index, and the Group Selection Questionnaire to determine the variables and characteristics of participants who are retained. AA is an open group based in a completely anonymous setting which means that attendees cannot be tracked. Due to the anonymity, it was important to collect data on participants attending the last meeting of the 12 step cycle (Newcomers). The same

data was collected from participants who completed more than one cycle of the program (Chronic Relapsers) and those who chose to continue with the program as mentors, group leaders, or by providing help in other ways (Endurers). The items on the demographic form ask the number of meetings attended, how many years the individual attended AA meetings, court ordered attendances, and previous therapy attempts in addition to participant characteristics. Information collected aided in identifying Endurers, court mandated persons, and Chronic Relapsers.

The DUREL or Duke University Religion Index is designed to measure organizational, non-organizational, and intrinsic dimensions of religiousness (Parker et. al., 2003), and was be used to identify participants with religious affiliation. The GQS or Group Selection Questionnaire (Burlingame et. al., 2011) is used to manage group selection and composition, but has been useful in generating predictive factors for positive group participants and for group deviants in relation to group outcomes. Its reliability was tested in two phases, first with high school students, and secondly with college aged individuals. In both phases, the GSQ was successful in predicting group process and outcomes. Thereby establishing the content validity of the instrument for evidence based practices in group work and research (Burlingame et. al., 2011).

No participants under the age of 18 were allowed to participate. Basic inferential statistics gathered the necessary information involving the demographics. A multiple analysis of variance analyzed the similarity and differences between the three identified groups: Newcomers, Chronic Relapsers, and Endurers.

All questionnaires and other instruments were anonymous because they required no identification of the participant. The demographic form cannot be administered to the

identified groups separately because that would single out individuals. At the beginning of the large group meeting before the participants break up into small groups, a brief explanation of the purpose of the study and the reason for the waiver of signing was read aloud to the group before starting the data collection instrument. The large group was the targeted time to collect the information from the sample. The instrument was administered at the end of the last meeting of the cycle. There were multiple meeting settings in which the instrument will be administered and the data collected.

The scores on the DUREL and the GSQ established whether participants could be considered as having a religious affiliation and are group therapy cooperators. Descriptive statistics were used to generate general demographic information about the sample. This data procedure established common factors in the participants of the sample that completed the program. The results were categorized as variables in determining which category participants will be considered for membership.

The quantitative method of discriminate analysis was used for the data analysis. Discriminate analysis is a measure that can separate subjects or participants of a study into categories after another data analysis has been already used on the data. In discriminate analysis, the categories are the independent variables and will be used to generate similarities and difference of participants in the study. It is theorized that the dependent variable is attendance in the program and independent variables are the factors that will establish comparability between the 3 groups that attend the program.

Rationale

The concept of retention in relation to 12-step treatment programs is similar to dropping out of group therapy. A 12-step treatment program is in essence a group that has similar dynamics. People in 12-step programs share personal history and emotional experiences with opportunities to give and receive feedback (MacNair & Corazzini, 1994). MacNair's study was roughly based on Yalom's (1985) work and investigated client factors that influenced drop out or continuation in group therapy. With a group such as the 12-step treatment program, the basic concept is self help. With self help groups, there is a degree of motivation involved in enrolling and completing the program. Motivations for self help groups are either intrinsic, thus the word self, or external meaning by some outside influence or a combination of both. Once a participant enters the group by whatever motivation, the question then arises of what influences compel them to stay. With 12-step treatment programs, there is a basic goal in addition to participant's success in a group setting.

Theoretical Foundation

The theoretical foundation for this study was derived from group therapy theories and from studies conducted using grounded theory. The group focal conflict theory was a solid basis for the theoretical approach of this study. In group focal conflict theory the group members join together to solve an unconscious conflict to alleviate tension and anxiety. The conflict always contains a disturbing motive or wish and a fear or reactive motive (Bernard & Mackenzie, 1994). In AA the wish or motive is sobriety and the fear or reactive motive varies. It may range from powerlessness (Milhouse & Fiorentine, 2001) to perception of AA as being for "skid-row drunks" (Laudet, 2003). As the AA

group members join together to alleviate anxiety by working on the wish to move to sobriety, the fears are diminished the by the sharing of experiences which expounds on the commonality of the group.

The theoretical foundation for studies that focus on factors that create barriers to participating in 12-step programs, group member selection and outcomes related to barriers was used for this study. These barriers range from participants' demographics to the spiritual nature of 12-step programs. Many findings suggest race, gender and age are the most occurring barriers to success in 12-step treatment programs due to the nature of some of the steps. The steps that involve participants to admit a sense of powerlessness creates a barrier for various races (Hillhouse & Fiorentine 2001) while the spiritual component does not reach participants under a certain age (Kelly & Myers 2007).

Though the theoretical foundations deal with different aspect of research, there are similarities in each. The differences are mainly looking at the outcomes. With AA research the outcomes are dealing with abstinence from substance use, and any demographic characteristics that make participants amenable to the group process. The studies based in group member selection research were the beginning work of Irvin Yalom in the 1960s and continues throughout group work today. Burlingame et. al. (2011) defined group member selection by developing a questionnaire designed to identify factors that would predict member cohesion. Merging the two theoretical foundations will give insight not only to whether some subgroups are better suited to succeed at 12-step treatment programs, but also what characteristics of the general participants can predict whether they will participate in the group process and complete the program.

In addition to using the group theory, case study and grounded theory were used in this study to develop a profile of participants of the AA sample. Case study research is important to understanding complex issues and can add merit to what is already known through previous research. Case study research is a qualitative research method and puts emphasis on analysis of a certain event(s) or conditions and their relationships. It is designed to examine real-life situations in a sample and/or controlled environment then use the information to provide the basis for the application of ideas and extension of methods in a larger population or situation. The case study research method is valued as an empirical inquiry that investigates a contemporary phenomenon within its real-life context where multiple sources of evidence are used, but the boundaries between phenomenon and context are not clearly evident.

Case study is akin to grounded theory in that the methods are similar. Case studies use a six step process in research and these six steps are: process and techniques, determine and define the research questions, select the cases and determine data gathering and analysis techniques, prepare to collect the data, collect data in the field, evaluate and analyze the data, and prepare the report. In determining and defining the research questions, the focus of the study is established. Once the research question has been established, then the designing of the study takes place by selecting the cases and determining data gathering and analysis techniques. When preparing to collect the data, preparation include anything from training researchers and investigators to developing categories to help organize data. The collect data in the field step ranges from observation to interviews to field notes. In the evaluation and analyze the data step, the raw data is examined to find relationships between the research object and the outcomes

with reference to the original research questions (Roberts, 2008). In this step the use of multiple data collection methods and analysis techniques, can assist in triangulating data in order to strengthen the research findings and conclusions (Goldkuhl & Cronholm, 2010). The final step is to prepare the report so the information gathered through the process can be clearly understood by any interested parties beyond the researcher.

Grounded theory is a qualitative theory similar to case study that is used to generate inductive development theories about sampled populations (Skeat & Perry, 2008). Grounded theory involves collecting data from a sample or subject in a certain area, analyzing the data to find concepts, patterns or relationships, and developing a theory to explain the investigation. For data collect, grounded theory uses qualitative sources such as interviews and memos and quantitative sources such as surveys and questionnaires. In analyzing data, various statistical methods are used to look for patterns, concepts, or links that exist within the data and any relationship with the sample or subject area. Finally a theory or hypothesis is generated from the investigated relationship, pattern, or link.

Glaser (2004) clarifies that ground theory explains the main concern of the participants as it relates to the research area. It uses the data gathered to create hypotheses about the sample and study through a technique known as theoretical sampling and data collection. Theoretical sampling and data collection is a distinguishing characteristic of ground theory that allows more information about selected participants to be discovered and core categories emerge through data collection and analysis. The statistical analysis typically used for grounded theory is cross tabulation, Chi-square and Discriminant Analysis. Discriminant Analysis is used to

establish like attributes of the participants and cross tabulation and Chi-square are used to establish significant of relationships with the emerged or developed categories and the core area of concern (Häggman-Laitila & Pietilä, 1998).

Limitations

One of the main focal points of this study was to identify variables associated with successful attendance in AA and the possibility that those variables can predict future long term attendees in the program. A limitation was that the study focused on an AA program locally. Another limitation of the study was the anonymous nature of the program may have affected possible participation. That in turn may have affected the targeted number of completed usable surveys. This study did not consider whether any outpatient therapy contributes to the participant's retention in the AA program, although such information can be a positive for the participants. Finally another limitation was the location of the program. This study only focused on AA meetings in church settings.

Assumptions of the Study

For the purposes of this study, it was assumed that all the participants in the sample are in attendance for alcohol abuse purposes even though participants may also have had other addition abuse issues. The next assumption was that the sample participants will fill out an instrument questions honestly. Another assumption of the study was that all the participants filling out the surveys were be able to read and comprehend the questions on said surveys. Furthermore, it was also assumed that all participants were comfortable completing a questionnaire on the instrument pertaining to their religious affiliation. The next assumption was that all participants of the sample were not coerced into answering the instrument questions with bias. Finally, it was

assumed that the DUREL and GSQ will have the capacity to be used to measure what they suppose to measure.

Overview of the Study

This study investigated what variables are best associated with retention of a sample in 12 step structured treatment programs for alcoholics and alcohol abusers. The data was collected through the instrument as participants attended the last meeting at the end of the program. It was explained to participants that completing an anonymous survey at the end of the program was an option and the information collected will be used for further research for the program. A criterion for the instrument to be used for the study was that it had to be completed and included the demographics. The questions on the Recovery for Life exit demographic form established the demographics of the participants while the questions from DUREL established whether the participants are considered to have a religious affiliation which may be considered a factor. Questions from the GSQ were used to establish group deviants in the sample.

Chapter I of the study detailed the basic nature and design of the research including the source of the participants in the sample. Chapter I will also included a history of the 12-step treatment program AA. Chapter II presented a comprehensive review of the literature pertaining to retention and other studies. Chapter III provided a description of all procedures and methods to be used in the collection and analysis of the data from the sample. Chapter IV analyzed and presented the data and a summary of the findings. Finally, Chapter V summarized the study, included a conclusion, and offered recommendations for further research.

Definition of Terms

12-Step Program

A 12-step program is a form of mutual-help or mutual aid conducted in a treatment group based on the premise that individuals who share a common behavior that they identify as undesirable can collectively support each other and eliminate that behavior (Laudet 2003).

Alcoholic Anonymous

A 12-step self help treatment program with a spiritual base that offers a set of principles and uses group member narrative to provide support for individuals with alcohol abuse and dependence issues. The combination of the program' principles and the support encourage its members toward sobriety and abstinence.

Alcohol Abuse

A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by one or more of the following: recurrent alcohol use resulting in a failure to fulfill major role obligations, results in legal problems, causes physical hazards and causes persist social and interpersonal problems. The symptoms from use cannot met the criteria for alcohol dependence (DSM-IV TR, 2008)

Chronic Relapsers

Chronic relapse is the cycle that happens when a person completes a drug rehabilitation or treatment program, becomes clean and sober for an amount of time, then goes

back to using. They will get help again, only to go through treatment, and again be clean and sober, before going back to using. In AA, common terminology for a person that has a pattern of relapse is called a recidivist.

Comparability

Side by side assessment of two or more characteristics to determine if they have enough common ground, equivalence, or similarities to permit a meaningful comparison (Dictionary of Business and Management. 2006).

Court Mandated

another

Individuals that are required by court or courted related via agency to attend AA meetings.

Endurers

Individuals that continuously attend AA meetings through numerous cycles and numerous years. In AA, common terminology for a person that has been involved in AA for over a number of years with mostly continued sobriety is called a lifer.

Group Selection

selection Questionnaire

A measure intended to aid clinicians in managing group and composition (Burlingame et. al., 2011).

Narcotics Anonymous

A non-profit fellowship or society of men and women for who drugs had become a major problem but are considered recovering addicts who meet regularly to help each other stay clean. In this is 12-step program of complete

abstinence from all drugs there is only one requirement for membership, the desire to stop using (Wells, 1987).

Newcomers

Individuals that have been clean and sober for less than two years and/or are participating in their first 12 step cycle of the

12 step program. Newcomer is common terminology in AA.

Religiosity

The term religiosity encompasses religiousness, orthodoxy, faith, belief, devotion, holiness and piousness. It incorporates a number of dimensions connected to religious beliefs and involvement. These dimensions include but are not limited to measures of religious knowledge, intellectual or cognitive understanding and extrinsic/intrinsic commitment to living what is believed and practiced (Holdcroft, 2006).

Retention

The act of completing the course of the 12 step program inclusive of meeting program requirements and returning after the first 12 step cycle for additional cycles.

Self Help Groups

The term "self-help groups" refers to groups of people with common or similar problems, as for example diabetics, alcoholics, addicted, mentally ill, or to psychotherapeutic groups that focus on personal growth through the common

working-out of experiences and solution of the problems of fellow-sufferers (Flora & Raftopolous, 2007).

Chapter II

LITERATURE REVIEW

Introduction

The primary purpose for this study was to investigate the similarities and differences in the various stages of participants of a sample attending an AA program, identify variables that contribute to retention in the program, and to use traditional Glaser and Strauss Grounded Theory to develop a profile of Endurers in the program. The literature review will cover many of the current topics in AA research relevant to this study. The topics range from outcomes and attendance to barriers and dropping out. The literature review in this chapter will also briefly highlight self help 12 step treatment groups. The history and validity of both the DUREL and GQS will be discussed in this chapter. Finally closing out the chapter will be a section on the qualitative research method base.

The literature dealing with 12-step programs, AA, self-help groups and the group therapy process is endless, exploring everything from outcomes to spiritual relationships. While studies on group therapy date back to the 1930s, studies on 12-step programs began in the 1980 as momentum began for self help programs. One reason there was little research in the area of AA and 12-step programs initially is the historical use of outpatient group therapy to treat additions (Humphreys, 1999). The literature on outpatient group therapy outnumbers literature on 12-step programs nearly 10 to 1, inclusive of both quantitative and qualitative studies (Gross, 2010).

Literature concerning AA is abundant; however, literature on characteristics of participants in AA is limited. The literature focuses on dropout and factors that cause

dropout and encourage attendance of participants in AA and other self help programs.

Another area of focus in the literature explores barriers to participation and completing the program. Beyond the 12-step self help literature is the literature concerning factors in group selection for various types of therapy groups.

Perception and outcomes related to participation is another area of focused research. Most qualitative research in the field deals with interviews some time after the participants have completed the program. This was done to study the effectiveness over a period of time, in some studies ranging from one year up to five years (Vederhus, Laudet, et. al., 2010). Again, these areas of literature are more directed at outcome only. In reporting the results, these studies also include reasons or factors of why their participants were or were not successful in the program as well as success with not relapsing.

Although the research on AA inadvertently may touch on reasons for successful or unsuccessfulness, the research for singling out what characteristics determine success in a group setting lies in part in the literature based in therapy groups. While factors in group work has been proven numerous times, the only area that really uses an established characteristic as predictive in AA centers around adolescent in alcohol treatment programs. Again that is one characteristic studied pertaining to age appropriateness, not other characteristics such as race or education.

Another research area that has been studied by both academic researchers and theological scholars is the religious underlying aspect of AA. Literature produced by both of the aforementioned parties has cited successes and failures based on the religious aspect. Theologians insert the religious reference to a higher power holds participants accountable for their success while academic researchers note no significant contribution

to success but was significant to being a barrier (Hillhouse & Fiorentine, 2001).

Theological research found that age combined with religiosity show a link to success in AA (Zemore, 2007). Academic research shows no link with other demographics as contributing to religiosity as being a barrier. Neither area of the research could connect religiosity with any other factors.

Self Help 12-Step Treatment Groups

The literature on AA is interwoven with 12-step self help groups (TSG) and 12-step facilitation (TSF). Literature that credits AA as the grandfather of all 12-step self help program often includes mutual help groups and AA's younger brother program Narcotics Anonymous or NA in that credit as well (Ellison, 1954). The principles of AA have been adopted, altered, and incorporated into spin-off groups ranging from Chronic Fatigue Immune Dysfunction Syndrome Group to Racism and Bigotry Anonymous (Room & Greenfield, 1993). Research shows that 12-step self help groups are extremely popular due to their accessibility, low cost, and confidentiality (Shrikhande et. al., 2008). Hagarty and Clark(2009) noted that aside from cost, TSG and TSF provides positive effects on recovery and are known to contribute to sustained abstinence from not only substances but also the addiction behaviors as well.

Research reports that self help groups are essential to post residential treatment because it holds individuals responsible for their recovery as they understand the nature of addiction and its affects (Chen, 2006). Over periods of time ranging anywhere from 3 months to over 20 years, participating in TSG and TSF, even being affiliated with these groups, has proven positive for individuals versus those that were inconsistent in participation (Weiss et. al., 2005). While the literature notes that although popular and

effective, for the maximum effect in treatment of addictions and the conjunctive behaviors, other therapies such as outpatient and residential need to be utilized as well (Fiorentine, 2004).

Self Help 12-step Treatment Groups are popular and useful and should be used in conjunction with other therapies to receive utmost benefits

Newcomers in AA

Alcohol over the years has been documented to have addicted tendencies, both physical and mental (Becker, 2008). Thus process of sobriety is a long and difficulty one. When a person first attends AA meetings there are a mix of emotion ranging from confusion to apprehension (AA Grapevine, 2010). Along with the mixed emotions are also the physical symptoms associated with withdrawal that include fatigue, dry mouth, body tremors and blurred vision. In dealing with the physical and mental aspects, the existing members of AA strive to show the new faces at the meeting unconditional support and understanding (AA Grapevine, 2010). Many group leaders during the first part of the meeting ensure complete anonymity of the group activities and communication which encourage newcomers to share their story as part of the group process. Other members including the group leader will disclose their own person experience to create a safe environment for sharing and to develop a rapport with the newcomers. In the meetings group leaders engage newcomers in activities that range from small, unplanned, informal discussions, with newcomers doing most of the talking and a different leader each time, to large sessions, prearranged in a series, with one continuing leader giving prepared talks on specific A.A. subjects (AA Grapevine, 1980).

Newcomers are given support to stay sober in a variety of ways that range from developing a 24 hour sobriety plan and utilizing a buddy system or sponsors in AA to changing their environment which includes friends. One key strategy that is consist through AA and is emphasized with newcomers is attendance. The more the newcomer is associated with the desired goal of sobriety and people who understand their experiences as a newcomer, both fellow members and sponsor, the more patience, time and support is available to stay sober (AA Grapevine 2010). The goal of AA with the newcomer is to provide the encouragement and support to attend all twelve steps of the program, knowing that the first three will be the hardest. Once completing one twelve step cycle, the group leaders of AA will encourage the newcomer to continue attendance for life long sobriety.

Another area noted in research of AA and newcomers is the phenomenon of the 13th step. This is often viewed by members of AA to be a blithe to the reputation of the program and a deterrent of newcomers returning. The so called 13th step phenomenon occurs when pre-existing members of AA target newcomers for sexual activity (McGinness, 2011). Group leaders do not bring unnecessary attention to activities of a personal nature between members outside of group. However, at times it must be addressed to help newcomers avoid any activities that may be detrimental to their progress and/or prevent them from returning to another AA program cycle (AA Grapevine, 2010).

AA to the newcomer are given support to stay sober and encouraged to persistently attend after the first cycle for life long sobriety.

Chronic Relapsers in AA

Chronic relapse is the cycle that happens when a person completes a drug rehabilitation or treatment program, becomes clean and sober for an amount of time, then goes back to abusing alcohol again. This cycle of repeated sobriety then abuse can be attributed to the presence of withdrawal symptoms may contribute to relapse after periods of abstinence (Becker, 2008). Withdrawal symptoms are both physical and mental which presents a challenge to sobriety. The physical symptoms which include but are not limited to tremors, nausea, dizziness, sweating and fatigue that can last a few day or a few weeks (Becker, 2008). The mental withdrawal symptoms can be akin to symptoms associated with a psychological diagnosis.

The symptoms often experienced with mental withdrawal are the same as experienced with general anxiety. Those symptoms include irritability, agitation, anxiety, sleep disturbance, anhedonia, psychosomatic complaints such as aches and a reduction in threshold for pain sensitivity (Becker, 2008). To alleviate these symptoms, individuals will re-consume alcohol for temporary relieve. The need for temporary relief increases back to the point to dependency. This increase to the point of dependency can happen in a short amount of time or over a period of years. Nonetheless, relapse into the alcoholism is the result.

Relapse can be defined as the resumption of alcohol drinking following a prolonged period of abstinence (Becker, 2008). Relapsing is also largely attached to coping behaviors or the lack of coping behaviors. Coping behaviors have a central role in a relapsing back into addictive behaviors. Coping behaviors are comprised of coping skills which are cognitive or over behaviors patterns effective deal with problematic

situations (Gossop et. al., 2002). The coping skills needed to achieve sobriety include changing a person's physical environment which will influence their emotional and mental mindset. If these coping skills are not enough to maintain adequate coping behaviors, reconsumption of alcohol occurs. These relapse and attempts at sobriety become habitual behavior that overcomes coping behaviors.

However the motivation aside from coping behaviors keeps individuals attempting sobriety after each relapse. After each relapse, seeking help for sobriety begins again. Rehabilitation treatment such as inpatient or outpatient can become costly; especially if the pattern of relapsing occurs frequently over a long period of time and is considered chronic. When the chronic relapse cycle of behavior overwhelms the financial resources available to an individual, many turn to Alcoholic Anonymous as the alternative. According to Voet Smith (2011) the chronic relapser has a history of repeatedly working Steps 1, 2 and 3, but has never completed all 12. In the same article, Voet Smith also discusses one of the treatment strategies for dealing with the chronic relapser needs to emphasize the mental and spiritual nature of the disease and that "the solution through the 12 Steps is spiritual in nature". Finally Voet Smith suggests that working all 12 steps with a sponsor is a requirement for the chronic relapsers to be successful in AA due to the accountability aspect.

Chronic relapsers struggle with maintaining sobriety but participation 12 steps programs can help change the behaviors associated persistent re-consumption, sponsor coping skills to deal with withdrawal and foster accountability for treatment.

Endurers in AA

AA has been shown to be effective as long as there is a commitment to attending to all twelve 12 steps. In attending AA meetings, participants are supported in developing coping behaviors to assist in maintaining sobriety. Coping behaviors have a central role in whether individuals relapse back into addictive behaviors. The coping skills which lead to behaviors needed to achieve sobriety include changing a person's physical environment meaning social support, their emotional frame of minds and their outlook on sobriety. Many individual struggle with these concepts even after completing one 12 step cycle, the newcomer, or attempting to complete many cycles with mixed results, the chronic relapser. Research as shown that attendance to many cycles over a period of years can increase the chances of sustained sobriety (Kelly & Yeterian, 2011).

A longitudinal study by Moos and Moos (2006) reported on participation in AA which was referred to as a non clinical treatment after 16 years. The study reported that at the 1 year mark and 3 year mark, participants in AA were 50 percent more likely to maintain sobriety than the participants that chose clinical treatment. That same study reported that at the 8 year mark participants in AA maintained sobriety around the 50 percent range, which was 3 percent higher than those that received clinical treatment. Finally the study noted that individuals that participated in AA and clinical treatment had the highest sobriety rates (53%) at the 8 year mark.

Other research discusses the importance of long term attendance in AA in relation to sponsorship and spirituality. The spiritually aspect has been researched and documented numerous times as contributing to longevity of members in AA. Sponsorship in AA has had some mention in research, but nothing that formally linked

sponsorship to be a requirement for Endurers. Most sponsors have spent years in attending AA cycles as just members and eventually become sponsors for newcomers (AA Grapevine, 2010). The responsibility of sponsorship continues to support attendance in AA meetings and is a basic part of recovery from alcoholism to continuing sobriety (AA Grapevine, 2010).

Research done by Kelly and Yeterian (2011) reported that past researchers attempted to explain extended period of attendance as it related to abstinence based on the social network support in AA. The research focusing on the social aspects of AA as a treatment intervention versus clinical cognitive-behavioral treatment interventions found that participants in AA were abstinent 20 percent more days than participants in the clinical treatment and were more involved in AA at 2-year follow-up. Other research done by Fiorentine in 1999 found that 13 percent of initially AA participants maintained a long-term relationship with AA. Fiorentine also lamented that voluntary participation and adhering to the 12-step philosophy was directly related to whether participants were motivated to maintain abstinence which foster sobriety (1999).

Endurers have been documented to have a long term relationship with AA that can be attributed to attendance, social network support, sponsorship to help others and motivation to maintain sobriety.

Attendance and Participation

The literature pertaining to participation in AA centers on abstinence outcomes. The literature reports on both current and longitudinal studies. There have been numerous articles that establish a relationship between participation and reported continued abstinence. Furthermore, participation in outpatient treatment along with AA

can be associated with higher rates of abstinences than just AA alone (Fiorentine & Hillhouse, 1999). Studies show participants that continually attend after their initial AA 12-step cycle, report long term abstinence (Hagarty & Clark 2009). According to Fiorentine and Anglin (1996) frequent AA participation is essential as post-treatment.

The key to participation is basically attendance. The effectiveness of AA is tied to reinforcement from participation which requires frequent attendance. Studies have shown positive outcomes are associated with frequency and duration of attendance in AA (Brown et al, 2001). More than positive outcomes are the documented advantages of frequent attendance. These advantages range from the constant contact with a sponsor to fellowship among a group. Basically attending AA meetings encourages the recovery process by reducing the feelings of isolationism and the stigmata of alcoholism (Adams, 2007). Thus participants who frequently attend receive the full advantages (effects) of the AA experience.

One area the literature emphasizes is continued attendance over a period of time. Studies show that attendance to AA over a period of years reinforces an individual's continued abstinence (Fiorentine & Hillhouse, 2000). The support and consistency of continued attendance after the initial 12-step AA cycle was completed, provides ongoing support and deters relapse as reported by the participants in the Fiorentine study (1999). This proves that frequent attendance and participation are important and when combined with longevity, confirms the overall effectiveness of AA.

Literature on participation and attendance in AA programs focuses on how the combination of the two effect abstinence outcomes.

Outcomes and AA

The outcome literature on AA is extensive because outcome reflects effectiveness of the intervention. The research on outcomes shows that the effects of AA have both long term and short term effects. In multiple studies by Gossop, Marsden and Stewart, in 1999 and 2002, and Fiorentine in 2001 with six months being the least amount of time and five years being the most, the general consensus is that participants that engage in the AA program in either one cycle of 12-step or repetitive cycles, reported higher levels of abstinence of substance abuse which included drug abuse.

The short term outcome studies on AA focuses on participants' immediate cessation of substance use. The research looks at whether participants are not drinking by the end of the 12-step cycle. In studies done by Laudet & Hilhouse (1999) and Bogenschutz, Geppert, & George (2006) clients in inpatient therapy with AA as part on inpatient services reported higher and more instantaneous result than those with no AA services in inpatient therapy.

One five year study investigated whether attendance in AA/NA meetings as post residential treatment would have a more affect on the outcome that period of time. The study reported that on the five year follow up, attendance of religious services disguised between those who completed the 12-step treatment program and had a positive outcome versus those who did not (Gossop, Stewart, & Marden, 2007).

Many other researchers such as Johnson, Finney and Moos (2006), Forys, McKellar and Moos (2007) and Magura, Knight, Vogel, Mahmood, Rosenblum and Laudet (2003) have done research on factors that determine success in outcome combined with AA participation. Bogenschutz, Geppert and George (2006), Toumbourou,

Hamilton, U'Ren, Stevens-Jones, Storey (2002) and Fiorentine (2001) found that participants that attended AA who had any experiences with outpatient services did better than those participants with no prior exposure to outpatient or inpatient services.

Research suggests the outcomes, whether positive or negative have direct correlations to attendance in AA programs.

Dropout Studies in AA

Studies concerning dropping out of AA include investigation into group therapy dropouts. In studies completed on dropping out of short term group therapy, factors such as diagnosed personality disorder, no previous experience in group therapy, poor levels of interpersonal functioning which limited self disclosure, motivation, mood in therapy, and negative expectations about group therapy were cited (McCullum, Piper, & Joyce, 1992). In that same studies the authors found that demographics had little to do with dropping out of the group therapy. Although the authors studied psychological mindedness, outcomes, and therapy expectations as factors that they hypothesized would effect dropping out of short term group therapy, the factor that actually proved to predictive in of remaining in the group was psychological mindedness. The authors defined this as the ability to identify conflict, dynamic components, and to relate the client's personal difficulties (McCullum, Piper, & Joyce, 1992). The study stated in its limitations that the results could only be applied to short term group therapy and not long term or any other group processes such as self help.

MacNair and Corazzini produced a study that not only discussed factors influencing dropping out of group, but also a factor that predicted remaining in or retention in group therapy. The study used a discriminate analysis to identify the

predictors which were alcohol/drug problem, somatic complaints, roommate difficulties, general fighting, fighting with partner (male or female), and the interpersonal factor labeled as introversion. The initial analysis revealed there were no significant differences between participants that remained in group and those who dropped out on age, gender, or race; thus ruling out demographics as a true predictor. The results found that a client's interpersonal preferences and tendencies, alcohol/drug use, somatic symptoms, and previous history of counseling were worthwhile as screening measures and useful to ascertain whether clients would stay with the group until completion (MacNair & Corazzini, 1994).

The studies addressing dropout rates focus on the reasons why participants are not compatible with groups and investigate the predictive factors that cause individuals to terminate group therapy early.

Barriers in AA

In dealing with research on barriers to attending AA, accepting the AA beliefs and completing the program, the studies were investigating diverse areas, but appeared to have a general consensus. The four reoccurring barriers in the literature were perception of AA, individuals' social networks, age group, and the spiritual aspects. The perception of AA created a barrier for both participants and clinicians. Research done by critics and proponents alike in the early 70s discussed the barriers to attending an AA meeting were perception because AA was considered to be the choice of treatment for the impoverished. Historically, 12-step groups such as AA were considered group therapy for deviants with undesirable behavior (Laudet, 2003). Since its inception over 7 decades ago, AA has added the perceptions of being for persons with mediocre alcoholic problems, a way to

enlighten participants spiritually, an unproven phenomenon, and a treatment for Caucasian middle class males (Kurtz & Fisher, 2004). These same perceptions not only fueled defamation of the program in general, but also with the clinical community as well. Verdhus, Laudet, Krestensen and Clausen (2010) noted in a study where they compared Norway to the United States in perceptions of AA, that 75% of American clinicians encouraged their patients to participate in twelve steps programs such as AA or NA. In comparison, Norwegian clinicians were reluctant to refer patients to AA due to what they viewed as controversial fellowship, religiosity, and an emphasis on powerlessness. Hillhouse and Fiorentine found the emphasis on powerlessness was more than just a perception. In their 2001 study, the findings actually proved that powerlessness is a barrier to participation for both women and ethnic minorities.

Interwoven in the basic principles of AA is a reference to a higher power and God. This reference to a higher power having control over the humanistic uncontrollable addiction does not harmonize with every participant. Polcin and Zetmore (2004) found in their study on psychiatric severity and AA, that individuals with higher psychiatric severity needed assistance understanding and developing a spiritual life, thus making AA not ideal for the severe psychiatric population. Laudet (2003) had similar barrier findings in his study when he reported the emphasis on spirituality contradicted the cultural norms and beliefs of the western culture which promotes self reliance and secularism.

Finally, the spiritual aspect and language associated with it, creates a barrier for both participants with and without religious affiliations. Although a participant has a religious affiliation, it may not be one that answers to "God" per se. Religions such as Moravian and Rastafarian subscribe to one deity; however that deity goes by a name that

may have another meaning other than the word “god”. As for individuals that do not have a religious affiliation such as agnostics and atheists, the fact of having to acknowledge a higher power or greater being generates resistance, again fostering a barrier (Best et. al., 2001).

Social networks are important both as barriers and aids to AA participants. As aids, social support and networks can promote sobriety and abstinence. However, when participants fraternize with associates and family who continued to exhibit addictive behaviors and who participate in negative lifestyles, that social network promotes regression. By associating with individuals who are not supportive in the ideals of AA, participants are exposed to counterproductive influences that form barriers to both attendance and adopting the essence of AA.

The age barrier is another matter originated by AA being mostly appealing to Caucasian middle age males (Kurtz & Fisher, 2004). The fellowship and support of most AA programs consist of individuals over 25. Also, the content is not developmentally and cognitively appropriate for persons under 21. The self actualization atmosphere is not compatible with individuals whose identity is closely riding on acceptance by their peers (Tate & Copas, 2011). This means AA meetings contain very little benefit for individuals whose age group is younger than 25.

Research in the area of barriers to attending AA indicates that while there are some physical barriers such as no transportation to meetings, most barriers are related to individual and societal perceptions.

Religiosity

Religiosity is linked to AA in literature because the nature of AA is intertwined with a religious aspect or spiritualness as it is sometime referred to in literature (Bristol-Braitman, 1995). Research shows religiosity is a considerable factor in areas from attendance to outcomes to perception. Laudet did several studies on religiosity and participants' perceptions of AA. He did this study first in the United States then replicated the study in Norwegian to compare the results. He found the religious aspect of AA deterred only a small percentage of the US participants. In comparison, he found the Norwegian sample was much more affected by the religious nature of AA than the US participants. Laudet did not limit his research to religiosity and perception only; he also investigated whether outpatient therapy had an effect on AA participants. He framed the research questions to investigate if the combination of outpatient therapy in conjunction with AA affects outcomes, particularly in abstinence. Laudet found outpatient therapy in concurrence with AA showed a significant difference in participants that received both interventions versus participants that just joined AA (Vederhus, Laudet, et. al, 2010).

In the Atkins and Hawdon (2007) study which investigated religiosity and participation in AA, it was found that participants with a non religious affiliation were less likely to participate in 12-step groups such as AA. Although the study did separate religiosity and spirituality, there were minimal differences in participation. Again there was a significant difference in participation in individuals who had a religious affiliation, claimed attachment to established religions and membership to particular sects, and those

who had no religious affiliation, professed atheism or had no association with any spirituality.

Though research seems to focus on the religiosity aspect of AA, the spiritual element does not get equal attention. The spiritual aspect again can be a barrier, but to many participants it is central. The spiritual side provides participants with an unsuspected inner resource that adds to their own sense of the ‘higher power’ that is greater than themselves (Galanter, 2007). The Galanter study also discusses the spiritual aspects, in that it can be detached from the “God” part of AA and has a certain appeal to participants that are agnostics and religiously affiliated but non denominational. The AA ‘Big Book’ actually addresses agnostic membership in chapter one by pointing out a spiritual basis for life needs to be acknowledged to nurture a sense of fellowship and achieve recovery (aa.org, 2011).

Research in AA programs shows religiosity is a major factor that affects every area in AA from attendance and outcomes to barriers and perception.

Duke Religious Index

The Duke University Religion Index or DUREL is a five-item measurement of religious involvement. The DUREL was developed to assess three areas of religiosity-organizational religious activity, non-organizational religious activity, and intrinsic religiosity or subjective religiosity (Koenig & Büssing, 2010). It is designed for use in large cross-sectional and longitudinal observational studies. The history of the current DUREL was 10 years in the making. In 2001, Koenig noted thousands of studies were conducted on the relationship between religion and health. However, none were done comprehensively and longitudinally. Seeing this need, Koenig developed a measure that

was comprehensive, brief, non offensive, and a low-burden measure of religiosity that may be easily included in large cross-sectional and longitudinal studies (Koenig & Büssing, 2010).

Although the DUREL consist of only five questions, it contains three subscales- organizational religious activity, non-organizational religious activity, and intrinsic religiosity. Organizational religious activities means public religious activities like attending religious services (church services) or participating in other group-related religious activity (bible studies, new membership classes). The non-organizational religious activities are the private religious activities such as prayer, mediation, or listening to religious based music. Intrinsic religiosity or subjective religiosity involves pursuing religion for the sake of committing to that religion (Koenig & Büssing, 2010). The items on the DUREL are used to evaluate the degree of intrinsic religiosity.

In 2004 the DUREL was established as a valid instrument for measuring religious belief. A study was conducted by Storch, Roberti, Heidgerken, Storch, Lewin, Killiany, Baumeister, Bravata, Geffken, at the University of Florida, Gainesville of 871 college students in two different samples. An exploratory factor analysis was used on the first sample and a confirmatory factor analysis was used with the second sample (Storch et. al 2004). The study found that internal consistency was established with both samples confirming a significant correlation between the DUREL and its ability to measure religious beliefs; thus confirming the reliability and valid construct of the DUREL.

The DUREL was developed to assess three areas of religiosity-organizational religious activity, non- organizational religious activity, and intrinsic religiosity or

subjective religiosity. Through various studies, the DUREL has been proven a valid instrument to measure religious beliefs.

Group Selection Questionnaire

The Group Selection Questionnaire or GSQ is a measure designed to assess whether a client is a good candidate for group therapy. It is a method for clinicians to prescreen individuals for group selection and group composition. The GQS is self-reporting and consists of 19 items that cover three subscales. Low scores on the GQS indicate an individual is a good candidate for group therapy. High scores on the GQS indicate a poor forecast in group therapy for an individual.

The GQS is comprised of three subscales: expectancy, ability to participate, and social skills. The expectancy subscale evaluates the degree to which an individual believes that group therapy will be beneficial to them. The ability to participate subscale investigates the individual's perceptions regarding attitudes and skills associated with interpersonal exchange in small groups (Burlingame et. al., 2011). The third subscale, social skills, examines selected behaviors that might be problematic in small group settings and those behaviors that may be viewed as deviant behaviors in a group.

The GSQ was given in two phases in two studies that started in Bosnia and ended in the United States to validate its structure (MacNair-Semands, 2006). The first phase of validation was using the GSQ as a precondition to group therapy as part of a program evaluation for a group intervention for trauma-exposed Bosnian adolescents (Layne et. al., 2008). The second phase involved administering the GQS along with two other questionnaires to individuals in group therapy at a Bingham Young counseling center. The U.S. sample was given a version of the GQS that added new items and two new

subscales. The results of the two samples showed that both samples were successful in predicting group process and outcomes (Burlingame et. al., 2011). Between the U.S. sample and the Bosnia sample, the main three subscales of expectancy, ability to participate, and social skills were proven to be valid in prediction of success in group therapy and lending reservation to the revised item.

The GQS is a measure that contains the three subscales of expectancy, ability to participate and social skills and with the three areas combined, has been proven valid in predicting group processes and outcomes in group therapy.

Case Study

Case study is the basic level of qualitative research. Although case studies are commonly used, there is no one definition of a case study, just what it involves. General research shows there is a consensus that case studies are phenomenological in nature. Phenomenology has been defined by some as a strategy of investigation in that identifies the core of human experiences about a phenomenon that can include, but not limited to events, persons, programs, services, groups, policies, and instances of something or perceptions as described by participants. Phenomenology does not use scientific measurements but instead uses subjective, descriptive approaches (Welford et. al, 2011). Thus the focus of phenomenological studies is the participants' first hand experiences not the etiology or what causes the experiences. Thus, case studies are based in participants' experiences.

Radford and Grimwade (2010) explained case studies are important for many reasons. It offers the richness of the dynamics of the participants' experience and greater understanding of the complexities within the given context. Case studies allow clinicians

to share studied experiences with a large audience. It also presents a resource for reflecting and considering phenomenon at greater depths of outcomes and processes. Finally, it provides an opportunity for clinicians to understand how and what other clinicians are studying and their approaches to studies are effective.

Case studies involve four basic steps: design, data collection, analysis and reporting. The design of a case study can be longitudinal, triangulation or purposive instance (Walshe, 2011). Data collections methods are three types of sources which are comprehensive, flexible, and multiple data source which can include surveys, interviews and observations. In the analysis step, it can be done concurrent with the data collection, search for disproving–proving evidence, and uses chain-of-evidence and pattern matching techniques (Walshe, 2011). The fourth step is reporting which is done on the actual instances but in a persuasive manner; which is the basis of criticism of case studies-partisanship.

Hougaard (2008) described case study as research that is a systematic in approach and can provide a more explicitly, formulated and improved data base for clinical reasoning. This clinical reasoning has ramifications beyond the case in study. Often case studies are about a sample of a population so any information discovered about the sample can be generated to the entirety of the population. With this information in place, generated information about a population can be actually and factually based on the evidence proven by qualitative and quantitative research.

Though the basic level of qualitative research, case studies are effective in providing investigation into human experiences of a sample that can be generated to a larger population.

Grounded Theory

Grounded theory is a qualitative research method designed to collect data and analysis data to generate a theory or research question about a phenomenon or population. Grounded theory was developed out of the empirically based sociological theorizing by Glaser and Strauss in 1967 (Goldkuhl & Cronholm, 2010). Grounded theory has systematical organized stages of analyzing and abstracting empirical data into categories and theoretical constructs. Since its origination in 1967 grounded theory has divided into different disciplines. This rift began when one of the two originators Strauss wrote a book on grounded theory with Juliet Corbin in 1994 (Dunne, 2011). Strauss and Corbin remained true to the basis of grounded theory, but deviated by added pre-existing categories to the data collect process of their grounded theory. These pre-existing categories are generated in part by an extensive literature review.

Glaser, in his 1992 book, criticized Strauss and Corbin for digressing from the orthodox grounded theory method. In his and Strauss' original theory there were no pre-existing categories, the data analysis generates patterns preceding the categories. Glaser (2002) objected the Strauss and Corbin version and the lack of preciseness concerning the inductive way of analyzing data. Glaser was emphatic that the conceptualizations should emerge from the data instead of being forced through the use of preexisting categories (Goldkuhl & Cronholm, 2010). Glaser's second objection to Strauss and Corbin was the use of an extensive literature review. He believed the literature most relevant to the research may not be known at the onset of the study; therefore conducting an extensive review of publications in a specific substantive area may be wasteful and cause bias. For Glaser, a detailed literature review conducted at the onset of the study may 'contaminate'

the data collection, analysis, and theory development by leading the researcher to impose existing frameworks, hypotheses, or other theoretical ideas upon the data, which would in turn undermine the focus, authenticity, and quality of the grounded theory research (Dunne, 2011). From these two founders, divergent visions grounded theory has continued to evolve into many different versions.

Regardless of the version of the theory, all ground theory version include the basic premise of discovery through research by data collection and analyzing which lends to categorizing concepts and patterns; thus leading to developing a theory. Even before the discovery begins there is a problem or research question. This can be a vague or specific question concerning what the researcher wants to know or again, discover. With the question in mind the next step or phase is the data collection. During this time, concept building, data classification, or categorization about the problem or phenomenon takes place. Concepts are basic units derived from data gathered in the study as this is where the researcher begins to look at the similarities and differences that exist at the concept level (Skeat & Perry, 2008). In analyzing data, the various statistical methods are used to establish links and patterns that exist within the data and hypothesize its relationship with the problem or research question. Next, there is the means of evaluation in which hypothesis, predictions, and/or reports on the data are generated.

There is one final controversial segment that is included-the literature review. Some proponents of grounded theory (Strauss and Corbin) argue the literature review should come after the identification of the problem or researcher question and before the data collection. Traditional grounded theorist (Glaser) believe that if a literature review is needed it should come after the hypothesis. Some traditional grounded theorists

believe the literature review is not a necessity but optional to the study, and is only necessary for expansion on the results. (Dunne, 2011)

Grounded Theory has grown since its inception in 1967 by branching off into multiple disciplines of the traditional theory; however, it continues even in multiple approaches to be a solid effective qualitative research method for investigation.

Chapter III

METHODOLOGY

Purpose

The studies reported in Chapter II show the importance of participation in twelve step programs for various outcomes for participants. The primary purpose for this study was to investigate the similarities and differences in the various stages of participants of a sample attending an AA program, identify variables that contribute to retention in the program, and to use traditional Glaser and Strauss Grounded Theory to develop a profile of Endurers in the program. Some studies have indicated the spiritual component of the AA program can contribute to a life long commitment; but the same studies do not identify the participants' characteristics beyond motivation that are related to completing the program more than one cycle and continuing limitless attendance. This study investigated this possible connection between those factors of comparability between three distinct groups and generated a predictive hypothesis about the participants in the short term two groups as it relates membership in the long term group.

Research Questions

The research questions were:

1. What variable or combination of variables as measured by the Duke University Religion Index (DUREL), the Group Selection Questionnaire (GSQ) and demographics contribute to long term attendance in an AA program?

2. What are the similarities and differences for participants in three stages of recovery; (Newcomers, Chronic Relapsers, and Endurers) of a sample attending an Alcohol Anonymous program?
3. What combination of test scores and participant characteristics for Newcomers and Chronic Relapsers can be used to identify the potential to become Endurers?

Participants

Participants consist of members from 4 different groups of AA programs sponsored by Recovery for Life (N=210). The average sizes of the groups ranged from 20 to 80 participants per night. Each of the groups had members of the three target subgroups- Newcomers, Chronic Relapsers and Endurers. Newcomers will often come with misconception of sobriety. Most Newcomers have been clean and sober: physically and emotionally, for six months or more (aa.org, 2011). Newcomers were classified as participants that have completed their first cycle of their first ever AA meeting. Chronic Relapsers are individuals that have numerous failed attempts to stay sober. Chronic Relapsers have attending previous AA meetings and completed several cycles. Chronic Relapsers were classified as participants that have completed several cycles of AA meetings inconsistently with spells of relapse (Smith, 2011). Endurers are individuals that have years of prolong sobriety. Endurers have attended AA meetings continuously for years. Endurers were classified as participants that have completed several cycles of AA meetings over the course of 10 years or more.

Participants in the programs varied in characteristics depending on the location of the facility holding the meeting. The areas that are in a more suburban location had

participants that drove to the meeting. Thus the participants were diverse in age, education, income levels, and social class. The locations that are more urban and close to public transportation had a similar make up to the suburban group and included participants from the lowest economic quartile. The more urban location will also be accessible to foot traffic.

In general, the meetings were located in area churches. The Chesapeake church locations serviced the eastern Chesapeake area. The Norfolk church locations serviced the northern and southern areas of Norfolk. The locations were solely controlled by which churches allowed the program to be housed in its building.

In addition to the location, one other factor determined participants in the meetings: whether the AA meeting offers child care assistance and meals. Those locations included parents and added more variation to the participant sample. Regardless of the location, each meeting offered an assortment of participants both voluntary and court ordered; educated and uneducated; atheist, agnostic, and denominational; married and single; wealthy and low income; and finally striving to get clean and those who have been clean and sober for years.

Instruments

Duke University Religion Index and the Group Selection Questionnaire

The instruments that were used are the Duke University Religion Index (DUREL) and the Group Selection Questionnaire (GSQ). The DUREL measures organizational, non-organizational and intrinsic dimensions of religiousness while the GSQ is used to manage group selection and composition, but has been useful in generating predictive factors in group. The two instruments were incorporated into the Recovery for Life

exit demographic data form which investigates barriers to treatment, years of alcohol use, use of other services, and composition of participants attending.

The DUREL was created to assess multiple dimensions of religious beliefs in a comprehensive format. The DUREL is a five item self-reporting scale that assesses religion in terms organizational, non-organizational, and intrinsic dimensions. The items have six possible answers rating from 1=more than once a day to 6=rarely or never. The scoring guidelines range from one to twenty five with the higher score indicating higher levels of religious involvement in a person's life. The DUREL is the questionnaire thus far that has proven creditability as a validated measure of religious beliefs and/or involvement (Storch et. al., 2004).

The Group Selection Questionnaire is used to manage group selection and composition, but has been useful in generating predictive factors in group outcomes. Its reliability was tested in two phases on two different levels. In both phases, the GSQ was successful in predicting group process and outcomes. The proven reliability of the GSQ makes it a valid instrument for evidence base practices in both group work and research. The three subscales of expectancy, deviant social behavior, and ability to participate utilize Likert-type items. The expectancy questions measures attitudes and expectations about participating in the group. The participation questions relate to the participant belief that they can participate in the group. The deviant social behavior, also called demeanor, investigates the clients' insight into the possibility of abnormal behaviors that cause them to become outcast or bullies (Burlingame et. al., 2010). The nature of the GSQ proves it to be an appropriate instrument for predicting group outcomes such as

individuals who improved during group psychotherapy, participated and felt as though they were part of the group and displayed retention in the group (Krogel et. al., 2009).

Demographics Data Form

To create an instrument to meet the needs of this study, it needed be completely anonymous yet provide information through a combination of questions to generate general information on the sample's participants. Questions in this section included areas pertaining to race, gender, education, age, marital status, substance abuse in years prior to attending meetings, number of meetings attended, previous level of behavior, and perceived effectiveness of program. The human services questions included any social services, legal or incarceration involvement. The substance abuse questions allowed participants to include other substances such as prescription and club drugs.

The demographic questions concerning marital status, previous level of behavior and education will only have four responses. A question on program expectation was answered on a scale of 1 to 10. The questions on whether participants ever attended and completed a previous AA program cycle; how many times, if any, there was a relapse and return to an AA program and how many cycles of AA attendance without relapse were added as participant identifiers for categorization in one of the three groups. Questions pertaining to gender, age, years of alcohol use, barriers to treatment, attitude toward treatment were included. A section with the DUREL and GSQ questions was added at the end of the program's instrument. All the questions in each section were grouped together on the instrument for ease of coding.

Procedure

The need of confidentiality and anonymity and how it will be addressed

The subject of addiction recovering is a very sensitive area. Due to the anonymous make up of the group, informed consent was waived. To obtain informed consent required participants' signatures and that would negate the anonymity of group. This loss of anonymity would jeopardize the employability and reputations of participants in the group which could, in turn, causes harm to some participants. The purpose of the study was to use information gathered to help participants thus, names and any other identifying information need to be waived to comply with the rules of anonymity.

That fact that the research is completely anonymous and participation is voluntary was emphasized. If a member of the group does not want to take the instrument, then that action was be taken as refusal to participate. Otherwise, filling out the instrument was understood as giving consent. An additional sheet explaining the purpose of the study and the definition of waiver of signing was attached to the front of the instrument. The information on the waiver of signing was presented and read aloud to the group before starting the instrument in addition to the oral explanation of the study. No one under the age of 18 was allowed to participate in the study. Participants were allowed to tear the cover sheet off and keep it to ensure anonymity.

Data Collection

The data was collected at the end of each group's 12 session cycle at the last group meeting. Two weeks prior to the end of each cycle, the director of the program included an announcement about the study. The Recovery for Life Demographics Data

Form, the Duke University Religion Index and the Group Selection Questionnaire were administered to participants at the beginning of their last large group before the successful program completion reception. At the last meeting, there was the large group in the beginning to discuss the last step, then a celebratory reception. At the end of the discuss of the last step in large group, the consent information and oral explanation of the study was read aloud to the group, and the fifteen to twenty minutes timeframe for the completion of the instrument time was announced. Then the instrument was administered. A pencil or pen was attached to instruments. Upon completion of the entire instrument, participants were asked to deposit the instrument in the designated box placed around the room. Participants were asked to fold the survey in half before turning it in to decrease influence, peer or otherwise, to complete the survey and allowed participant that did not feel comfortable doing the survey another discrete option.

The instrument was distributed at the 4 designated sites of Chesapeake and Norfolk. Data collection from each site was staggered over six weeks because the various sites started the cycles at different times. The six week window allowed time for as much data as possible to be collected at the completion of the cycle of the 12 weeks of the program at the various sites. The order of which sites were collected depended on when each site began and ended its cycle.

Demographic Data/Coding

Each participant was asked 10 questions designed to help describe the participants of this study. The questions were as followed: 1) age, 2) race or ethnicity, 3) highest level of education, 4) occupational field, 5) gender, 6) martial status, 7)any other human services involved (including legal), 8) attitudes toward treatment effectiveness, 9) degree

of behavior before attending AA meetings and 10) years of alcohol use, with and without attempts at sobriety. Questions on age and years of alcohol use were grouped by years by nine year increments. For example years of use start at zero and extend to nine years, and then another group started at ten years and end at nineteen years.

The answers provided for the education question were grouped according the years or completion in the areas of high school to high school diploma, attendance to a community college or hold certification of any kind, some college or received a degree and education after undergraduate or post four year degree. The questions pertaining to martial status and human services involvement included legal involvement and were a yes or no question. Questions on gender only included the answers female or male. The attitudes toward treatment question allowed a positive or negative response. Questions on barriers to treatment allowed participants to respond under motivation and or perception of the program. The race or ethnicity allowed participants to classify themselves as Asian and/or Pacific Islander, Hispanic or Latino, European and/or Caucasian, Native American, African American, bi-racial, or other. Each group for all the questions was assigned a numerical value to be used in data analysis.

The questions from the DUREL were used to measure religiosity and grouped into religious affiliation or non religious affiliation. Those two groups were assigned a numerical value for data analysis. The questions from the GSQ were used to establish common factors in the sample, rate participants on the subscale, and determine participants that have group deviant traits.

Statistical Analysis

The research design for the study was comprised of a multiple group and multiple measurements quasi-experimental design. The design was a multiple measurement because each participant completed a Recovery for Life Demographic Form, the Duke University Religion Index and the Group Selection Questionnaire at the beginning of the last meeting of the program's 12-step cycle. Descriptive statistics were used on the data collected to give an overall representation of the sample. The statistical analysis typically used for traditional grounded theory is cross tabulation, Chi-square, and Discriminant Analysis. For this study, Discriminant Analysis was used to establish commonalties of attributes of the participants, Multiple Analysis of Variance was used to compare the identified attributes or factors for similarities and differences and effect size was used to determine the strength of the relationship of variability found between groups.

The quantitative method of discriminate analysis was used for the data analysis of this sample. In discriminate analysis, the dependent variables were used to predict which participants in the study will fall into certain groups. Discriminate analysis is a measure that can separate subjects or participants of a study into categories after another data analysis has been already used on the data. It was theorized that the dependent variable is attendance in the program and independent variables are the factors beyond comparability lend to various levels of attendance in the program. The study looked at the answers in the instruments from the Recovery for Life demographic form, the Duke University Religion Index, and the Group Selection Questionnaire relevant to determining dependent variables and the attendance in the 3 groups which is the independent variable.

A Multiple Analysis of Variance was used to test the identified similarities and difference between the 3 groups. MANOVA is a simple analysis of variance of more than two groups. In ANOVA, the variability occurring between two groups and occurring within each of the groups is determined by the independent variables relationship to the dependent variable. In MANOVA there is more than one dependent variable. So by using MANOVA, several allowances that can be investigated include how changes to the independent variable or variables can significantly effect more than more dependent variable and whether there is any significant correlation between the dependent variables. MANOVA can be used to compare the scores of multiple groups on a dependant variable to discover if there is a significant difference between the groups. By using MANOVA the comparisons between groups can be used in a predictive blueprint; thus generating hypotheses about the study sample. The scores on the DUREL and the GQS were compared between the three target subgroups of Newcomers, Chronic Relapsers and Endurers using MANOVA.

Effect size was used to establish the strength in relationships between these three sample groups and the population. Cohen's d will be used to reduce the chance of Type II errors (Cohen, 1992).

Developing Hypothesis

Once the statistical analyses on the data was completed, next there was the means of evaluation in which hypothesis, predictions and/or reports on the data will be generated. The hypothesis, predictions, and reports are needed to develop a theory that explained the investigation of the study. This theory or hypothesis was generated from the investigated relationships, patterns, or links. For this study, hypotheses was generated

about each group, the Newcomers, Chronic Relapsers, and Endurers and their categorization as religious or non religious affiliations are determined by the DUREL. A hypothesis was also generated about each group, the Newcomers, Chronic Relapsers, and Endurers and their performance on the GSQ. Finally, a predictive hypothesis was generated based on the similarities and difference between each group, the Newcomers, Chronic Relapsers, and Endurers and the possibility of Newcomers and Chronic Relapsers to become Endurers.

Chapter IV

RESULTS

The purposes of this study were to investigate the similarities and differences in the various stages of participants of a sample attending an AA program, identify variables by using the Duke University Religion Index (DUREL), the Group Selection Questionnaire (GSQ) and demographics that contribute to long term attendance in the program and use Grounded Theory to develop a profile of Newcomers, Chronic Relapsers, and Endurers in the program. Characteristics of attendees at an AA meeting were investigated using two instruments combined with demographic items into one instrument. The two instruments used were the DUREL, or Duke University Religion Index, which measures organizational, non-organizational, and intrinsic dimensions of religiousness and the GQS, or Group Selection Questionnaire, which is useful in generating predictive factors for positive group participants and group deviants. The remainder of the questions on the instrument were demographic and pertained to areas such as race, gender, education, age, marital status, substance abuse in years prior to attending meetings, number of meetings attended, addiction behavior, and effectiveness of program. There were also questions about human services agency involvement; meaning social services or court mandated hospitalizations or incarcerations, and types of substance used.

Research Questions

The research questions that form the foundation for the study were:

1. What variable or combination of variables as measured by the Duke University Religion Index (DUREL), the Group Selection

Questionnaire (GSQ), and demographics contribute to long term attendance in an AA program?

2. What are the similarities and differences for participants in three stages of recovery; (Newcomers, Chronic Relapsers, and Endurers) of a sample attending an Alcohol Anonymous program?
3. What combination of test scores and participant characteristics for Newcomers and Chronic Relapsers can be used to identify the potential to become Endurers?

The religious affiliation of participants was measured using two of the three areas on the DUREL. Participants' religiosity was assessed by scale scores on the intrinsic dimensions of religiousness and non-organizational dimensions. Participants' characteristics for group participation were measured by the GSQ which also identified participants with identified negative demeanor. The research used quantitative methods for data analysis.

Participants

Participants were 210 attendees from four different Recovery for Life AA/NA meetings. This study's protocol was approved by the Institutional Review Board of Old Dominion University, Norfolk, Virginia. Participation in this study was voluntary and anonymous. All participants in the study were provided written and verbal information about the research including the parameters of participation and the study's complete anonymity. All participants were instructed to submit a study folded in half, to maintain anonymity to members of the meeting that chose not to participate. Participants were members of AA groups from Norfolk and Chesapeake locations.

Participants (N = 210) were from two sites in Chesapeake (n = 181) and two in Norfolk (n = 29) from six different completed cycles. The two Chesapeake sites completed one cycle in October, and another in January. The two Norfolk sites completed their cycles in December. All the meetings were held in the evening after 6:00 pm and each was held in a church location. The two Chesapeake meetings were held at the same church in eastern Chesapeake. The Norfolk meetings were held at two different churches, one in northern Norfolk and the other in a southern area of Norfolk.

Procedure

The need of confidentiality and anonymity and how it was addressed

Due to the anonymous make up of the group, informed consent to participate was waived. Participants' signatures would allow for participants to be identified; thus negating the anonymity of group. Any loss of anonymity would cause harm to the participants as well. At the onset of participants filling out the instrument, they were provided with notification of anonymity as well as a brief explanation of the study in letter form. In addition to this letter being attached to the instrument, the letter was also read out loud by researcher for clarification purposes. After the letter was read out loud, participants were instructed as to what to do upon completion of instrument, meaning folding the instrument in half and placing it in one of three instrument collection boxes stationed in the back, middle aisle and front of the room. Although participants were made aware of the location of the instrument collection boxes, some participants decided to hand their instrument to researcher. This interaction with researcher still did not negate anonymity.

The Chesapeake location was larger than the Norfolk groups and therefore all the instruments collection boxes were needed. The Norfolk locations were considerably smaller and the number of instrument collection boxes was the only part of the procedure that was modified. Only one instrument collection box was needed for the Norfolk locations.

The remainder of this chapter is organized to report the findings of this study. The first section presents the findings from the demographic section of the instrument. The second section presents the attributes generated based on the findings of the DUREL and GSQ in combination with the demographics. The third section presents variables as common identified factors, concepts, patterns or relationships shared among the three groups that include religious affiliation, or non religious affiliation, and identified negative demeanor. The fourth section presents how the attributes, patterns and relationships lead to developing a theory to explain the investigation. The final section contains a summary of all the findings.

Findings Related to Demographics

The first five questions on the instrument collected participants' basic demographics such as (1) Race (Caucasian, African American/Caribbean Islander, American Indian, Hispanic/Latino, Asian/Pacific Islander and Other); (2) Are you married? (yes, no); (3) What is your gender? (male, female); (4) What is your age group? (18-29, 30-39, 40-49, 50-59, 60-69, 70-79 and 80 & older); and (5) What is your education level? (high school/ high school diploma, community college/ certifications, some college/ received a degree and post four year degree).

Table 1 presents the summary of participants' demographics. The highest number of participants in the race variable were Caucasians (n = 114, 54.3%); male (n = 106, 50.5%), and age group 40-49 (n = 58, 27.6%). The marital status of the participants was almost evenly split with participants that described themselves as not married (n = 106, 50.5%) being only slightly larger than participants that described themselves as married (n = 100, 47.6%). Participants that had some college education or received a degree were the slightly larger group (n = 69, 32.9%), the high school education and/or received high school diploma (n = 65, 31%). The majority of the participants were classified as Newcomers (n = 95, 45.2%) with Endurers as the next highest group (n = 87, 41.4%).

Table 1

Demographic Data of Participants

Variable	Frequency	Percentage
<u>Race</u>		
Caucasian	114	54.3
African American/ Caribbean Islander	65	31.0
American Indian	9	4.3
Hispanic/Latino	6	2.9
Asian/Pacific Islander	4	1.9
Other	11	5.2
Missing	1	.5
<u>Marital Status</u>		
Married	100	47.6

Unmarried	106	50.5
Missing	4	1.9
<u>Gender</u>		
Male	106	50.5
Female	98	47.6
Missing	6	2.9
<u>Age group</u>		
18-29	47	22.4
30-39	46	21.9
40-49	58	27.6
50-59	36	17.1
60-69	16	7.6
70-79	2	1.0
80 & older	0	0.0
Missing	5	2.4
<u>Education</u>		
High school/ High school diploma	65	31.0
Community college/ Certifications	30	14.3
Some college/ Received a degree	69	32.9
Post four year degree	37	17.6
Missing	9	4.3
<u>Attendance</u>		
Newcomer	95	45.2

Chronic Relapser	24	11.4
Endurer	87	41.4
Missing	4	1.9

Instrumentation

The instruments used were the Duke University Religion Index (DUREL) and the Group Selection Questionnaire (GSQ). Each survey instrument will be discussed in separate detail as it relates to the study.

Duke University Religion Index (DUREL)

The DUREL was created to measure multiple dimensions of religion using a five item self reporting scale that assesses the organizational, non-organizational and intrinsic dimension of religiousness (Koenig & Büssing, 2010). Scoring all items will generate a score between 0 and 25, which is indicative of a participants' overall religiosity. However for the purpose of this study the intrinsic and non-organizational dimension of religiousness were the targeted questions from the DUREL. According the Koenig and Büssing (2010) combining all the three subscales in a single analysis can result in the subscale scores nullifying the effects of each other. Intrinsic religion has been linked to motivation in studies concerning AA and religiosity (Atkins & Hawdon, 2007). Participants whose scores fell at the or below the mean on the DUREL were considered to have a religious affiliation. Those participants whose scores were higher than the mean on the DUREL were classified as non religious affiliated. The majority of participants described themselves as having a religious affiliation (n = 119, 56.7%) as presented in Table 2.

Table 2

<i>Religious Affiliation Demographics</i>		
Religious affiliation as scored on the DUREL	Frequency	Percentage
Religious Affiliation	119	56.7
Non Religious Affiliation	82	39.0
Missing	9	4.3

Table 3 present the separate subscales means and total mean of the DUREL. The described composite scores for selected dimensions for each participant were used in the subsequent analysis.

Table 3

<i>Duke Religious Index Scale Level Descriptive Statistics</i>					
	Spends time in private religious activities	Presence of the divine	Religious beliefs	Religious dealings	DUREL total
N Valid	209	208	206	208	202
Missing	1	2	4	2	8
Mean	2.574	1.557	1.752	1.730	7.658
SD	1.412	0.860	1.017	0.970	3.303
Skewness	1.025	1.633	1.662	1.716	1.220
Std. error of skewness	0.168	0.169	0.169	0.169	0.171
Kurtosis	0.342	2.611	2.602	2.959	1.455
Std. error of kurtosis	0.335	0.336	0.337	0.336	0.341

Group Selection Questionnaire (GSQ)

The Group Selection Questionnaire is used to manage group selection and composition, and has been useful in generating predictive factors in group outcomes. The GSQ has three subscales which are expectancy, demeanor and participation. Expectancy measures attitudes and expectations about participating in a group. Participation measures the participants' belief that they can participate in the group process. Demeanor, which is also called deviant social behavior, measures participants' possible abnormal behaviors that may cause them to become outcast or bullies (Burlingame et. al, 2010). Table 4 presents the means and standard deviations for the subscales of the GSQ. Participants with higher demeanor scores and overall GSQ scores are poor candidates for group based pursuits. Thus, participants with scores higher than the mean score on both the subscale of demeanor and the overall GSQ total were considered participants with identified negative demeanor. The described composite scores for each subscale for each participant were used in the subsequent analysis. Compared to Burlingame's study in 2010, the expectancy subscale mean in this study was higher by 1.54 and the standard deviation lower by 0.63; the demeanor subscale mean in this study was lower by 5.9 and the standard deviation lower by 0.4; the participation subscale mean in this study was higher by 6.57 and the standard deviation lower by 1.57; and the total mean in this study was higher by 2.47 and the standard deviation lower by 0.14

Table 4

<i>Group Selection Questionnaire Scale Level Descriptive Statistics</i>				
	GSQ Demeanor	GSQ Expectancy	GSQ Participation	GSQ Total
N Valid	190	205	194	181
Missing	20	5	16	29
Mean	5.178	8.756	38.438	52.580
Median	5.000	9.000	38.000	52.000
Mode	3.00	9.00	35.00	49.00
SD	2.313	1.444	5.430	6.890
Skewness	1.165	0.474	0.237	0.515
Std. error of skewness	0.176	0.170	0.175	0.181
Kurtosis	1.133	-0.080	-0.474	0.307
Std. error of kurtosis	0.351	0.338	0.347	0.359

Findings related to between group differences

Table 5 presents the chi square results for the cross tabulation between attendance for the three identified groups; Newcomer, Chronic Relapser and Endurer; and religious affiliation, identified negative demeanor, the general demographics of age, race, gender, and education. A cross tabulation analysis was calculated to determine significant difference between membership in one of the three groups in AA and each selected demographic, classification as religious affiliated or non religious affiliated and being identified as having a negative demeanor. Results indicated no significant difference between the demographics of marital status, gender, age, education, and race and attendance at any level (Newcomer, Chronic Relapser, and Endurer) in AA. There was also no significant relation between participants identified as having a religious affiliation and attendance at any level in AA. However, there was a significant

difference between participants identified as having a negative demeanor as reported by their scores on the GSQ and attendance at any level in AA ($\chi^2 = 8.530, p < 0.014$).

Table 5

Values of Attendance and Demographic Variables

Independent Variable	Variables/Demographic	χ^2	df	<i>p</i>
Attendance in at identified levels in AA	Marital Status	2.275	2	0.321
	Gender	3.878	2	0.144
	Age	16.217	10	0.094
	Education	2.916	6	0.819
	Race	0.386	2	0.825
	Religious Affiliation	1.142	2	0.565
	Negative Demeanor	8.530	2	0.014

A Discriminant Analysis function was computed to determine how the three identified groups attending AA differ on a variable or combination of variables including responses on the DUREL and the GSQ with selected demographics. The independent variables were: religious affiliation, negative demeanor, marital status, gender, age, education, and race. Race was regrouped into white and non-white because the race classifications other than Caucasian and African-American/ Caribbean Islander were less than 30, which is less than a tenth of the participants. The dependent variable was attendance in AA.

A discriminant function analysis was conducted to determine the dimensions of values that differentiate attendance in AA in the three identified groups of Newcomer, Chronic Relapser and Endurer. The values included the extent to which the individuals were affected by the various influences of religious affiliation, negative demeanor, marital status, gender, age, education, and race. Box's M was calculated to determine

homogeneity of covariance of the variables. As presented in table 6, Box's M indicated no statistical significance in the homogeneity of covariance ($F_{(56)} = 1.316, p = 0.057$).

Table 6

<i>Box's M Test of Homogeneity</i>				
Box's M	F	df1	df2	<i>p</i>
82.461	1.316	56	7906.855	0.057

Wilks' Lambda was chosen to determine if there were any main effects for religious affiliation, group deviant, marital status, gender, age, education, and race which were significant. The only two variables that were statistically significant were age ($F = 6.695, p < .002$) and identified negative demeanor ($F = 4.754, p < .010$). Table 7 presents the results of all of variable means including their determined significance.

Table 7

<i>Test of Equality of Group Means</i>					
Variable	Wilks Lambda	F	df1	df2	<i>p</i>
Race	0.988	0.961	2	159	0.385
Negative Demeanor	0.944	4.754	2	159	0.010
Religious Affiliation	0.994	0.466	2	159	0.628
Marital Status	0.983	1.367	2	159	0.258
Gender	0.992	0.657	2	159	0.520
Age	0.922	6.695	2	159	0.002
Education	0.999	0.082	2	159	0.921

Two discriminant functions were obtained for the analysis. Table 8 presents the Eigenvalues for the variable obtained on the discriminant function 1 and 2. The first

function accounted for 89.1% of the total among-group variability and the second function accounted for 10.9%.

Table 8

<i>Eigenvalues</i>			
Function	Eigenvalue	% of Variance	Cumulative %
1	0.179	89.1	89.1
2	0.022	10.9	100

The first discriminant function was statistically significant $\Lambda = 0.830$, χ^2 (df = 14, N = 162) = 29.072, $p < 0.010$, but the second was not $\Lambda = 0.979$, χ^2 (df = 6, N = 162) = 3.377, $p < 0.760$). Table 9 presents function coefficient means of function 1 and 2.

Table 9

<i>Variable Means on the Discriminant Function</i>		
Variable	Function	
	1	2
Race	-0.285	-0.039
Negative Demeanor	0.690	-0.366
Religious Affiliation	0.225	0.065
Marital Status	0.038	0.612
Gender	0.107	0.586
Age	-0.838	-0.049
Education	0.137	-0.148

Finally the discriminant analysis yielded predictions and probability on intra-group membership, which is the likelihood that one group member can move to have

membership in another group. In this case the study was looking at whether Newcomers and Chronic Relapser could have membership in the same group as the Endurers, the group that has the longest retention in AA. The analysis results showed a 25.3% probability of the Newcomers to become Endurers while there was a 16.7% probability of Chronic Relapsers to become Endurers. As presented in Table 10, 19 of the 75 newcomers were predicted to become Endurer and 3 of the 18 Chronic Relapsers were predicted to become Endurers.

Table 10

Discriminant Analysis Classification Results

		Predicted Group Membership			
	Attendance	Newcomer	Chronic Relapser	Endurer	total
Group N	Newcomer	40	16	19	75
	Chronic Relapser	7	8	3	18
	Endurer	18	6	45	69
%	Newcomer	53.3	21.3	25.3	100.0
	Chronic Relapser	38.9	44.4	16.7	100.0
	Endurer	26.1	8.7	65.2	100.0

A multivariate analysis of variance (MANOVA) was calculated to explore potential differences within the three identified groups that attend AA related to responses on the DUREL, GQS, and selected questions concerning demographics. Levene's Test of equality of error of variance was used to determine if the groups had similar variances for each instrument and demographic. The results of Levene's Test presented in table 11 indicated no statistically significant differences in error variance for religious affiliation ($F_{(159)} = 1.381, p = 0.254$), race ($F_{(159)} = 1.937, p = 0.147$), marital status ($F_{(159)} = 2.410, p = 0.093$), gender ($F_{(159)} = 2.088, p = 0.127$), age ($F_{(159)}$

=.074, $p=.928$) and education ($F_{(159)} = 0.940$, $p = 0.393$). The Levene's Test indicated a statistically significant difference in error variance for the variable of negative demeanor ($F_{(159)} = 22.561$, $p = 0.000$).

Table 11

Levene's Test of Equality of Error of Variance

Variable	F	df1	df2	<i>p</i>
Negative Demeanor	22.561	2	159	0.000
Religious Affiliation	1.381	2	159	0.254
Race	1.937	2	159	0.147
Marital Status	2.410	2	159	0.093
Gender	2.088	2	159	0.127
Age	0.074	2	159	0.928
Education	0.940	2	159	0.393

Table 12 reports the results of the multivariate analysis. Wilk's Lambda was used to determine if there were any main effects for identified negative demeanor, religious affiliation, marital status, gender, age, and education. There were no statistically significant multivariate effects for religious affiliation ($F_{(2)} = 0.466$, $p = 0.628$), race ($F_{(2)} = 0.961$, $p = 0.385$), marital status ($F_{(2)} = 1.367$, $p = 0.258$), gender ($F_{(2)} = 0.657$, $p = 0.520$), and education ($F_{(2)} = 0.082$, $p = 0.921$) which indicated that there were no statistically significant differences between attendance in AA and the demographics of race, marital status, gender, and education. It also indicated that there were no statistically significant differences between attendance in AA and being identified as having a religious affiliation. Statistically significant mean squares values were found for the effects of negative demeanor $F_{(2)} = 4.754$, $p = 0.010$) and age ($F_{(2)}$

=6.695, $p=0.002$) indicating a main effect for age range and identified negative social traits in a group as measured by the GQS. Thus a statistically significant difference in age and negative demeanor exist in the three identified groups of Newcomer, Chronic Relapser and Endurer in this sample.

Table 12

Test of Between Subject Effects

	Mean Square	F	df1	p	e^2
Age	9.320	6.695	2	0.002	0.078
Education	0.107	0.082	2	0.921	0.001
Gender	0.166	0.657	2	0.520	0.008
Negative Demeanor	0.850	4.754	2	0.010	0.056
Marital Status	0.337	1.367	2	0.258	0.017
Race	0.240	0.961	2	0.385	0.012
Religious Affiliation	0.116	0.466	2	0.628	0.006

Pairwise comparison of the marginal means for all the dependent variables were calculated posthoc using Tukey HSD to investigate any significant differences of the means of the identified groups in this sample. The Tukey HSD ($p < 0.022$) on the variable of identified negative demeanor indicated statistically significant differences between the groups of Newcomers and Endurers. The Tukey HSD ($p < 0.001$) on the variable of age indicated statistically significant differences between the groups of Newcomer and Endurer as well. Table 13 presents the results of age and negative demeanor on the Tukey HSD post hoc test.

Table 13

Posthoc Pairwise Comparison

Negative Demeanor			
	(I) Attendance	(J) Attendance	Sig.
Tukey HSD	Newcomer	Chronic Relapser	0.809
		Endurer	0.022
	Chronic Relapser	Newcomer	0.809
		Endurer	0.057
	Endurer	Newcomer	0.022
		Chronic Relapser	0.057
Age			
	(I) Attendance	(J) Attendance	Sig.
Tukey HSD	Newcomer	Chronic Relapser	0.762
		Endurer	0.001
	Chronic Relapser	Newcomer	0.762
		Endurer	0.251
	Endurer	Newcomer	0.001
		Chronic Relapser	0.251

Summary of Findings as Related to Grounded Theory

Findings of the various analyses discovered selected demographics and variables as measured by the GQS were useful in ascertaining common characteristics of Newcomers and Chronic Relapsers and their potential to become Endurers. Results of analysis to establish any relation between variables of demographics and identified traits as measured by the DUREL and GSQ indicated a statistically significant relation between attendances and negative demeanor. Non-statistically significant relations were found between attendance and the remaining identified variables. Discriminant analysis conducted to determine if variables measured by the DUREL (religious affiliation) and

GQS in combination with selected demographics yielded statistically significant values for the two variables of negative demeanor and age. The classification results of the analysis indicated that there was a low probability of Newcomers and Chronic Relapsers to become Endurers. The MANOVA indicated that the identified three levels of attendance in AA were significantly affected by age and negative demeanor.

Next, Grounded Theory was employed to find concepts, patterns and/or relationships in the outcomes. The statistically significant findings develop on a theory of predication on Newcomers and Chronic Relapsers becoming Endurers with the similar demographics, identified religious affiliation as measured by the DUREL, and identified negative demeanor as measured by the GSQ. Based on findings from the cross tabulation, discriminant analysis and the MANOVA, the only statistically significant variables were identified group deviants as measured by the GSQ and age. Theoretically, attendance in any identified group of Newcomers, Chronic Relapsers and Endurers in AA will be significantly affected by whether a participant is a group deviant and their age. Other variables such as race, gender, marital status, education level, and religious affiliated or non- religious affiliated will not have a significant affect on attendance in any identified group of Newcomers, Chronic Relapsers and Endurers in AA.

Chapter V

SUMMARY, CONCLUSIONS and FUTURE RESEARCH

Chapter 1 laid the foundation for the study by stating the purpose and the significance of this research. Chapter 2 provided a review of the literature pertaining to (1) self help 12-step treatment groups, (2) Newcomers, Chronic Relapsers and Endurers in AA, (3) attendance and participation as it relates to AA, (4) outcomes in AA, (5) dropout studies in AA, (6) barriers in AA, (7) religiosity, (8) the instruments of the Duke Religious Index and Group Selection Questionnaire, and (9) case studies and Grounded Theory. Chapter 3 detailed the research procedures and measures utilized in the study. Chapter 4 outlined the results of the data analyses conducted to answer the research questions and develop a theory based on the analyses. This chapter consists of an overview of the study, a summary of the findings, conclusions based on the findings, the relationship of the findings to the current literature and a discussion of possibilities for future research.

Overview of Study

AA groups are growing in popularity due to their cost effectiveness and history of dependability. Once thought to be for drunks and degenerates, the changing public perception sparks interest in what AA can do for its participants. Although the program clearly has the numbers to support its popularity, skeptics continually analyze its claims of effectiveness through research. Historically substance abuse treatment has been inpatient programs, outpatient individual and group therapy (Humphreys, 1999) which influenced research in the area of AA and 12-step treatment programs. The literature on outpatient group therapy outnumbered literature on 12-step programs nearly 10 to 1,

inclusive of both quantitative and qualitative studies (Gross, 2010). While literature concerning AA grows; literature on characteristics of participants in AA continues to be limited. The literature focuses more on dropout and attendance of participants, barriers to participation, and perception as it relates to mixed outcomes of completion of AA and other self help programs. Literature concerning factors in group selection for various types of therapy groups is to an extent intermingled with literature on participants in AA.

The qualitative research in AA is longitudinal and deals with interviews some time after the participants have completed the program. These areas of literature are more directed at outcome and skim the reasons, or factors of why participants were, or were not successful in the program as well as success with in the area of relapsing. Although the research on AA inadvertently may touch on reasons for success, or unsuccessfulness in the program, the research for singling out what characteristics determine success in a group setting such as AA stems from the literature based in group therapy. While factors in group work have proven merit, the only area that really uses an established characteristic as a predictive factor in AA centers around adolescence in alcohol treatment programs. That one characteristic studied pertains to age appropriateness for the program, not participants' other basic characteristics such as race, education or gender.

Another research area that has been studied by both academic and theological researchers is the religious underlying aspect of AA. Literature produced by both of the aforementioned parties has cited successes and failures in the program based on the religiosity of AA. Theologians insert the religious reference to a higher power holds participants accountable for their success, while academic researchers note no significant

contribution to success. Academic researcher also found that reference to a higher power to being a barrier to participation (Hillhouse & Fiorentine, 2001). Theological research found that age combined with religiosity show a link to success in AA (Zemore, 2007). Academic research shows no relation or combination of demographics with religiosity as being linked to successfully completing AA. Neither academic research nor theological research could connect religiosity with any other demographic of participants in AA as being a significant factor fostering retention in the program.

The purpose of this study was to investigate the similarities and differences in the various stages of participants of a sample attending an AA program and identify variables that contribute to retention in the program. Additionally the purpose of this study was to use traditional Glaser and Strauss Grounded Theory to develop a profile of Endurers in the program.

The research questions that formed the framework for the study were:

4. What variable, or combination of variables as measured by the Duke University Religion Index (DUREL), the Group Selection Questionnaire (GSQ) and demographics contribute to long term attendance in an AA program?
5. What are the similarities and differences for participants in three stages of recovery; (Newcomers, Chronic Relapsers, and Endurers) of a sample attending an Alcohol Anonymous program?
6. What combination of test scores and participant characteristics for Newcomers and Chronic Relapsers can be used to identify the potential to become Endurers?

Due to the anonymity of the participants, it was important to use a non-identifying instrument that collected data on participants attending the last meeting of the 12 step cycle. The research design for the study was a single measure that combined the Duke Religious Index, Group Selection Questionnaire and a demographic selection. Quantitative methods were used for data analysis.

Participants and Procedures

Participants consisted of members from 4 different groups of AA programs sponsored by Recovery for Life (N=210) with the average size of the groups ranging from 20 to 80 participants per collection. Participants were from two sites in Chesapeake (n=181) and two in Norfolk (n=29) from six different completed cycles. The two Chesapeake sites completed one cycle in October and one in January. Both Norfolk sites completed their cycles in December. All the meetings were held in church locations.

A notification letter of anonymity was attached to each instrument as well as read out loud by researcher for clarification purposes. After the letter was read aloud, participants were instructed what to do upon completion of instrument, meaning fold the instrument in half and place it in one of three instrument collection boxes stationed in the back, middle isle and front of the room.

Data Analysis

Descriptive statistics for the demographic data were reported as frequencies with accompanying percentage of respondents for each possible response. Descriptive statistics for the DUREL, total and subscales, and the GSQ, total and subscales, consisted of means and standard deviations. Demographic data including religious affiliation and having identified negative demeanor traits were analyzed to determine if a statistical

significance existed between the three attending groups of AA, Newcomers, Chronic Relapsers, and Endurers using cross tabulation resulting in a Pearson's Chi Square statistic. A Discriminant Analysis was used to establish like attributes of the participants in the three groups of Newcomers, Chronic Relapsers, and Endurers attending AA. Scores on the DUREL and GSQ and demographics for the three groups in AA of Newcomers, Chronic Relapsers, and Endurers were compared using multivariate analysis of variance (MANOVA). The results of these analyses were presented in both tabular and narrative form in Chapter 4.

Findings and Conclusions

Presented are the research questions, findings and conclusions for the measured demographics and responses on the DUREL which identified whether a participant was religious affiliated or non religious affiliated, and on the GSQ.

Research Question 1

1) What variable, or combination of variables, as measured by the Duke University Religion Index (DUREL), the Group Selection Questionnaire (GSQ) and demographics contribute to long term attendance in an AA program?

Findings: Results of the Discriminant Analysis indicated that the groups showed no significant homogeneity (Box's $M = 0.57$). The results also indicated the only two variables that were statistically significant were age ($F = 6.695, p < 0.002$) and identified negative demeanor ($F = 4.754, p < 0.010$). Therefore measurements on the GSQ of negative demeanor and the demographic of age were the established attributes that distinguished between participants in the three groups of Newcomers, Chronic Relapsers, and Endurers that attend AA.

Conclusion: The demographics of religious affiliation, marital status, gender, education and race were not statistically significant as attributes of the participants while age and negative group demeanor were statistically significant and found to contribute to long term attendance in an AA program.

Research Question 2

2) What are the similarities and differences for participants in three stages of recovery (Newcomers, Chronic Relapsers, and Endurers) of a sample attending an Alcohol Anonymous program?

Findings: Results of the MANOVA indicated there were no statistically significant effects for religious affiliation ($F_{(2)} = 0.466, p = 0.628$), race ($F_{(2)} = 0.961, p = 0.385$), marital status ($F_{(2)} = 1.367, p = 0.258$), gender ($F_{(2)} = 0.657, p = 0.520$), and education ($F_{(2)} = 0.082, p = 0.921$). This finding indicated that there were no statistically significant differences between attendance in AA and the demographics of race, marital status, gender, education and being identified as having a religious affiliation. Results indicated statistically significant results for the effects of negative demeanor ($F_{(2)} = 4.754, p = 0.010$) and age ($F_{(2)} = 6.695, p = 0.002$) indicating a main effect for age range and identified negative group social traits as measured by the GQS.

Conclusion: The two statistically significant differences between participants in the three groups of Newcomers, Chronic Relapsers, and Endurers, were age range and negative group demeanor, with Newcomers and Endurers indicating the more significant interaction. Participants in the three groups within AA of Newcomers, Chronic Relapsers, and Endurers responses on to whether they were identified religious affiliation and the

demographics of martial status, gender, age, education and race did not result in statistically significant differences.

Research Question 3

3) What test scores and participant characteristics of Newcomers and Chronic Relapsers can be used to identify the potential to become Endurers?

Findings: Based on the results from the Discriminant Analysis, age ($F = 6.695, p = 0.002$) and negative demeanor ($F = 4.754, p = 0.010$), and MANOVA, age ($F_{(2)} = 6.695, p = 0.002$) and negative demeanor $F_{(2)} = 4.754, p = 0.010$), both negative demeanor and age were the two characteristic to show significance between the three groups of Newcomers, Chronic Relapsers, and Endurers.

Conclusion: Age and negative group demeanor are inversely related to whether Newcomers and Chronic Relapsers have the potential to become Endurers.

Summary of Findings and Conclusions

Research questions 1 and 2 detailed how demographics and scores on the DUREL which indicated religious affiliation and on the GSQ which indicated negative group demeanor affected attendance in the three groups of Newcomers, Chronic Relapsers, and Endurers in AA. It was determined that there was no statistical significant found in the demographics of religious affiliation versus non religious affiliation, martial status, gender, age, education, and race and whether they contributed to long term attendance in an AA program. However, a statistical significant finding for the demographics of age and negative demeanor resulted. Group comparisons to identify similarities and differences did not find a statistical significant for the demographics of martial status,

gender, age, education, race and religious affiliation. The multivariate test indicated two main effects of similarities were age and negative demeanor.

Research question 3 sought to identify what scores on the measure of the DUREL and GSQ and participant characteristics of Newcomers and Chronic Relapsers could be used to in determining their potential to become Endurers. A pattern in the findings of both the Discriminant Analysis and MANOVA indicated that age and negative group demeanor were statistically significant in both analyses. Based on those statistically significant findings, age and negative group social behavior both would be useful in determining Newcomers' and Chronic Relapsers' potential for becoming Endurers.

Findings Related to Previous Literature

There are three reasons why this study contributes to the existing literature. First, it adds to the body of knowledge about AA. Second, the outcome can establish if there is a combination of demographics of the sample population in AA that can contribute to success in the program. Third, to generate a theory on whether Newcomers and Chronic Relapsers in AA can be retained to become Endurers based on the research outcomes.

Age

Across the three groups of Newcomers, Chronic Relapsers, and Endurers which attended a local AA program, age was a significant factor which shared some limited similarity to previous research concerning AA and age. Kelly, Myers and Rodolico (2008) conducted research on AA and participants under 18, in which no significant success was found in that age group and AA because some aspects of AA did not appeal to the maturity level of the age group. This study did not include any participants under 18, thus concerning participants in the study; age was a found to be a significant factor in

attendance in this sample of AA. This supports the pre existing literature concerning the appeal of AA to an adult population.

Negative Demeanor Group Social Behavior

The Group Selection Questionnaire or GSQ can be useful in group selection and in generating predictive factors in group outcomes. The GSQ has three subscales: expectancy which measures attitudes and expectations about being in a group, participation which measures the belief about participate in the group process, and demeanor, which measures possible group deviant behaviors. Group deviant or negative demeanor behaviors may cause members to become outcast or bullies in the group setting. MaNair-Semends (2002) studied attendance and interpersonal factors as measured by and instrument similar to the GQS, the Group Therapy Questionnaire. Her study found a statistical significance between attendance in group therapy and the interpersonal factors of Social Phobia/Inhibition and Angry Hostility. In group, hostility is expressed through actions and indirect expressions of anger that may be a pattern for these members identified with that interpersonal factor. Such anger not only is perceived as bullying behavior to other group members but also as difficulty engaging in the group process.

The current study found a similar trait by using the Group Selection Questionnaire in the subscale of demeanor. A negative demeanor can be problematic in group settings (e.g., arguing for argument's sake, talking over others,) leading a member to be viewed as a "deviant" by others in the group; thus the current study found that group deviancy was a factor in all three groups of Newcomers, Chronic Relapsers, and Endurers which attended the AA sample. This group deviancy or negative group demeanor was a commonality

among all three groups as well as an identified factor that affected attendance. The finding adds to the current research that negative interpersonal traits that can lead to bullying not only affect a person's ability to participate in the group process which is the basis for AA, but also can affect the group process for others as well.

Religiosity or Religious Affiliation

There has been much research done in the areas of AA and religiosity. Atkins and Hawdon (2007) investigated the effects of religiosity on participation in AA and found that participants with a non religious affiliation were less likely to participate in 12-step groups such as AA. Though the study made a point to separate religiosity from spirituality, there were minimal differences in participation. A significant difference in participation in individuals who had a religious affiliation, claimed attachment to established religions and membership to particular sects, and those who had no religious affiliation, professed atheism or had no association with any spirituality.

The currently study used the Duke University Religion Index (DUREL) to identify religious affiliation and non religious affiliation. The DUREL measures multiple dimensions of religion in the areas of the organizational, non-organizational and intrinsic dimension of religiousness. This study found that religious affiliation was not a significant factor in that affected attendance of the three groups of Newcomers, Chronic Relapsers, and Endurers of the AA sample. This study found that a participant being identified as being religious affiliated or non religious affiliated had no bearing on predicted whether a newcomer in AA would become a chronic relapser or an endurer and therefore could not be useful in developing the profile of an endurer in AA.

Implication for Practitioners

This study has implication for practitioners in practical research, traditional treatment and mental health community settings.

Practical Research

This study contributes to the current literature in AA by supporting the research concerning types of personality traits that may contribute to members being unsuccessfully retained in AA. This has significance for researchers continuing to investigate the effectiveness of the AA model as viable treatment for alcohol issues with measurable outcomes. The study also lends to assisting researchers interested in AA to target populations to study not based on general demographics but instead a personality type. In studying more specific personality types in open group setting such AA, researcher are presented with another aspect of the group process that may affective measured outcome.

Traditional Treatment

For practitioners seeking treatment for clients in conjunction with or beyond traditional methods of inpatient residential and outpatient therapy for alcohol abuse and dependency issues compatibility of add-on services is a necessity. However, screening clients for certain traits that would not work well in a group setting should be considered before referring some clients to AA. AA is an open group that accepts every one, even those with negative group behaviors. Therefore, clients with identified negative group behaviors may participate in AA, but the chances of that participant engaging in AA with any longevity is questionable. This study offers support for the ideal that clients

exhibiting more aggressive behaviors to be better suited for treatments in a one to one setting where the therapist controls the session.

The study added to the current research by investigating the similarities and difference in three groups attending AA and used the information obtained to generate a theory on what variables or combination of variables can describe participants who successfully complete the AA treatment program and return for more than one cycle. When practitioners are reviewing demographics, none of the following can be useful in predicting whether a client would be successful in completing more than one cycle of AA: race, gender, marital status, education level, and a religious affiliation or non affiliation. However, whether a client has identified negative group behaviors and is over the age of 18 but not older than 59, can be useful in predicting whether a client has the potential to complete more than more one cycle of AA and have some longevity in the program.

Community Mental Health

For practitioners in the mental health community setting, this study lends credence to which client with certain diagnoses would do well in AA and which client would not. Many clients in community mental health services have a dual diagnosis which is a diagnosis of a serious mental health illness coupled with a substance abuse problems. Research shows that these dual diagnosis clients benefit from attending AA meetings, especially one tailored to accommodating the mentally ill (Bogenschutz et al, 2006). The Bogenschutz study referenced research subjects with an Axis I diagnosis, such as schizophrenia and the use of alcohol and drugs and that AA was found beneficial along with the factor of outpatient and/or inpatient treatments. However, there was not a

discussion of single factors such as Axis II diagnosis and incidents of alcohol, no drug use.

The study found that persons with negative group behaviors such as aggression or attention seeking behaviors would not be successful as some others in AA. In mental health, individuals with an Axis I or Axis II diagnosis can have those types of behaviors manifested as psychiatric symptoms. While AA is an open group setting, even those diagnosed individuals without aggressive behaviors may struggle with the setting and the concepts. These factors should be weighted as mental health providers seek treatment option for clients. For example, clients with borderline personality disorders that experience unstable and dysfunctional relationships may not be best suited for AA which fosters stability and support. AA also provides sponsors and the behaviors from some types of mental illness diagnosis impede developing functionally and healthy bonding relationships.

So in seeking additional substance abuse treatment options for the dual diagnosis population, community mental health practitioners need to screen clients for an AA program based on diagnosis and compatibility. It should also be considered whether the setting of open semi structured group versus closed psychodynamic group is appropriate for the client. Finally the type of AA meeting should be explored. There are AA meetings where mental illness is common place and the group facilitator has some background or training in dealing with mentally ill individuals. However, that said, is specific to individual groups and not the AA program as a whole. For community mental health practitioners, the best interest of the client population would be to consider AA groups with group facilitators that have experience with dual diagnosis members or AA

groups with a multiple dual diagnosis and substance abuse base or MDD-SUD. This might be instrumental in helping the clients with dual diagnosis get the maximum benefits that AA has to offer.

Future Research Implications

There are areas of weakness that are noticeable with the current study that would benefit from being changed in future studies of this topic in AA. Some potential methodological changes include: 1) modify the instrument; 2) widen and increase the population of the sample; and 3) additional analysis of the data. A more detailed description of the changes is as follows.

Modify the instruments

The instrument used was comprised of two different questionnaires, Duke University Religion Index and the Group Selection Questionnaire and a demographic form. Together all three made forty two questions that needed to be completed in a short amount of time. A potential way to address the problem in future research is to eliminate questions on the demographic form that are not used in the analyses. Though helpful to the program's administrator, some of the demographic questions were not of any use to the study. Also the Group Selection Questionnaire has a different format in which participants may check boxes for their answers. For future research, that format is a quicker way to respond to the GSQ yields the same results and would be ideal for a population in which some are still struggling with sobriety even during the AA meetings.

Widen and increase the population of the sample

Another area of limitation in the current study is the localness of the study. Recovery for Life is a local AA program that services certain cities in the Tidewater

region. The cities in the southern and western parts of the Tidewater region were under-represented because Recovery for Life no longer held meeting in those areas. Therefore, the results may only be generalized to certain geographical areas. For future research, the sample population should include participants from AA meetings in those areas such as Williamsburg, Portsmouth, Hampton and Suffolk and include other AA meetings along with the AA meetings of Recovery for Life. In addition the sample in different geographic regions, future research should also include different types of AA meetings. All of the meetings were held in Baptist churches in Chesapeake and Norfolk. Different types of AA meetings in future research should include meetings such as all women's AA programs or military AA programs.

Additional analysis of the data

The analyses used addressed the research question was used to find any statistical significance. However once that statistical significance was found the degree in which the variables were a factor was not apparent. Though the analyses addressed the specific research questions, more in depth analysis for the age variable could have been useful. For future research, a logic regression could be used to determine which subcategories or age bracket in variable of age were more influential as factors than others.

Summary

The purpose of this study was to investigate the similarities and differences in the various stages of participants of a sample attending an AA program, identify variables that contribute to retention in the program, and to use Grounded Theory to develop a profile of Endurers in the program. Data was collected through an instrument that combining a demographics section, the DUREL and the GQS, and was administered to

two different geographical groups over six ending cycles across a four month time. The results of this study add to the literature available on retention in AA and factors that affect long term success in AA. Results of this study also extend to the literature on the Group Selection Questionnaire and how effective it is at predicting participants for the group process. The results of this study extend to the currently literature on the Duke Religious Index and its effectiveness in measuring religiosity or in this case religious affiliation. The combined contributions of the results of this study indicates that no one demographic or combination of demographics, a religious affiliation or certain group traits necessary for positive participant in the group process can be associated with success in AA. However, certain demographics and identified traits can be useful in predicting whether participants have the potential for retention in AA to become Endurers. Finally the results indicate a pattern the can prove useful in Grounded Theory to generate a profile of Endurers.

Chapter VI
MANUSCRIPT

Investigating Similarities and Differences as Measured by the DUREL and GSQ Between
Three Subgroups Attending a Local AA Meeting to Develop a Profile of Long Term
Attendees.

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ABSTRACT

Alcoholics Anonymous groups are growing in popularity due to their cost effectiveness and history of dependability. Although the program clearly has the numbers to support its popularity, skeptics continually analyze its claims of effectiveness through research. While research pertaining to AA is diverse, very little is presented concerning factors that contribute to retention in the program. The primary purpose for this quantitative study was to investigate the similarities and differences in the various stages of participants of a sample attending a local AA program, identify variables that contribute to retention in the AA sample, and to use Grounded Theory to develop a profile of long term attendees in the local AA program. This study analyzed the answers from an instrument that combined a demographics form used by the program Recovery for the Life, the Duke University Religion Index, and the Group Selection Questionnaire to determine the variables and characteristics of participants who attended and were retained in AA. Results indicated age and negative group demeanor were significant similarities for participants in the three groups of Newcomers, Chronic Relapsers, and Endurers and contributed to long term attendance in the local AA program. Results also indicated that age and negative group demeanor are inversely related to whether Newcomers and Chronic Relapsers have the potential to become Endurers. Discussion of the results and how they relate to the literature, implications for practitioners and recommendations for future research are also included.

Investigating Similarities and Differences as Measured by the DUREL and GSQ Between Three Subgroups Attending a Local AA Meeting to Develop a Profile of Long Term Attendees

According to the Substance Abuse and Mental Health Administration, more than five million people attend AA or its sister program NA every year (The NSDUH Report, 2008). Although the program clearly has the numbers to support its popularity, skeptics continually analyze its claims of effectiveness through research. The research pertaining to AA is very diverse, covering everything from attendance to demographics to outcomes (Krentzman et al., 2011). Even with diverse areas, there is still little research on whether there are factors that can predict if participants will complete the course of AA. Some qualitative studies may accidentally find out personal motivation for entering AA; however, the factors past motivation are not investigated. There has been no research establishing a connection between those beyond motivation factors and retention in the AA program. This study sought to add to the body of knowledge by developing profiles of three groups of attendees that complete a group based AA program.

According to the DSM-IV TR, alcohol is considered a substance and substance-related disorders fall into two groups: substance use and substance induced. The substance use group includes dependence and abuse. The substance-induced group includes intoxication, withdrawal, delirium, dementia, amnesia, psychosis, mood disorder, anxiety, sexual dysfunction and sleep disorders (DSM, American Psychiatric Association, 2000). Upon further reading, the DSM-IV TR distinguishes the difference between use and induced to be that induced is a change in behavior due to the use of

substance; while use is a pattern of maladaptive behavior occurring over a twelve month period of time.

SAMHSA or Substance Abuse and Mental Health Administration is a branch of the United States government dedicated to improving the quality and availability of substance abuse prevention, alcohol and drug addiction, treatment, and mental health services. SAMHSA uses the DSM-IV's definition of substance abuse as well as its definition of dependency.

The treatment for substance abuse disorders is to change the pattern of behavior. This can be done by use of individual therapy which includes outpatient and inpatient therapy, group therapy, or a combination of both. The more traditional alcohol addiction treatment methods range from individual and family counseling to use of medical models. Counseling and therapy models include behavior modification such as Cognitive Behavioral Therapy and Motivation Enhancement Therapy. Cognitive Behavioral Therapy works at changing the thoughts, beliefs, and action while Motivation Enhancement Therapy uses motivational strategies to activate a personal change mechanism. (Longabaugh et. al., 1998) The medical model of treatment, such as Detoxification therapeutic medications, is always under the direct supervision of a physician. In detoxification there is a protocol for purging the body of alcohol while dealing with the withdrawal symptom in a controlled environment. Therapeutic medications such as ReViaT and Antabuse are used to produce unpleasant physical reactions like vomiting when alcohol is ingested while the medications are in the body's system (Mark et. al., 2003) The medical model of alcohol treatment is often used in inpatient therapy as well.

The AA Model

One of the most common group treatments does not involve therapy, but employs a self-help approach. The self help approach is a 12 step self help program called Alcoholics Anonymous (AA). AA has a 75 year history of treating individuals with alcohol use and abuse issues (Gross, 2010). AA is one of the more traditional ways of treating individuals with alcohol dependence issues. Alcoholics Anonymous was founded in Akron, Ohio by surgeon Dr. Bob Smith and New York stockbroker Bill Wilson on June 10, 1935 (Gross, 2010). The vision of AA was to be a fellowship of alcoholics dedicated to helping each another stay sober through spirituality, recognizing no specific denomination, and open to all religious or beliefs persuasion including atheists(Stafford, 1991).

They developed a twelve step model that is in current use today. The twelve steps of AA are as follows.

13. We admit we are powerless over alcohol-that our lives had become unmanageable.
14. Came to believe that a Power greater than ourselves could restore us to sanity.
15. Made a decision to turn our will and our lives over to the care of God as we understood Him.
16. Made a searching and fearless moral inventory of ourselves.
17. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
18. Were entirely ready to have God remove all these defects of character.
19. Humbly asked Him to remove our shortcomings.

20. Made a list of all persons we had harmed, and became willing to make amends to them all.
21. Made direct amends to such people wherever possible, except when to do so would injure them or others.
22. Continued to take personal inventory and when we were wrong promptly admitted it.
23. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
24. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Five of the twelve steps involve the use of God directly and four of the steps involve moral inventory with personal improvement. One step requires admitting powerlessness to alcohol while another acknowledges a higher power, not necessarily God. It does specify “God as we know Him” which leaves room for various religious and belief persuasions to interpret God to their own means. The last step sums up all the previous steps as it fosters a spiritual experience or awakening and sharing this spirituality with other alcoholics while reflecting in daily life. The history of AA not only explains the basic principles behind self help groups, but also lends to the understanding of the alcohol recovery; add to the traditional methods used by clinicians.

Within AA there are three subgroups: Newcomers, Chronic Relapsers, and Endurers in the program. Newcomers are individuals that have been clean and sober for less than two years and/or are participating in their first 12 step cycle of the 12 step program.

Chronic relapsers or recidivist are a individual that complete a drug rehabilitation or treatment program, becomes clean and sober for an amount of time, then goes back to using. Endurers, commonly knows as lifers, are individuals that continuously attend AA meetings through numerous cycles and numerous years.

Introduction to the Literature Review

The primary purpose for this study was to investigate the similarities and differences in the various stages of participants of a sample attending an AA program, identify variables that contribute to retention in the program, and to use traditional Glaser and Strauss Grounded Theory to develop a profile of Endurers in the program. The literature review will cover many of the current topics in AA research relevant to this study. The topics range from outcomes and attendance to barriers and dropping out. The literature review in this chapter will also briefly highlight self help 12 step treatment groups. The history and validity of both the DUREL and GQS will be discussed in this chapter. Finally closing out the chapter will be a section on the qualitative research method base.

The literature dealing with 12-step programs, AA, self-help groups and the group therapy process is endless, exploring everything from outcomes to spiritual relationships. While studies on group therapy date back to the 1930s, studies on 12-step programs began in the 1980 as momentum began for self help programs. One reason there was little research in the area of AA and 12-step programs initially is the historical use of outpatient group therapy to treat additions (Humphreys, 1999). The literature on outpatient group therapy outnumbers literature on 12-step programs nearly 10 to 1, inclusive of both quantitative and qualitative studies (Gross, 2010).

Literature concerning AA is abundant; however, literature on characteristics of participants in AA is limited. The literature focuses on dropout and factors that cause dropout and encourage attendance of participants in AA and other self help programs. Another area of focus in the literature explores barriers to participation and completing the program. Beyond the 12-step self help literature is the literature concerning factors in group selection for various types of therapy groups.

Perception and outcomes related to participation is another area of focused research. Most qualitative research in the field deals with interviews some time after the participants have completed the program. This was done to study the effectiveness over a period of time, in some studies ranging from one year up to five years (Vederhus, Laudet, et. al., 2010). Again, these areas of literature are more directed at outcome only. In reporting the results, these studies also include reasons or factors of why their participants were or were not successful in the program as well as success with not relapsing.

Although the research on AA inadvertently may touch on reasons for successful or unsuccessfulness, the research for singling out what characteristics determine success in a group setting lies in part in the literature based in therapy groups. While factors in group work has been proven numerous times, the only area that really uses an established characteristic as predictive in AA centers around adolescent in alcohol treatment programs. Again that is one characteristic studied pertaining to age appropriateness, not other characteristics such as race or education.

Another research area that has been studied by both academic researchers and theological scholars is the religious underlying aspect of AA. Literature produced by both of the aforementioned parties has cited successes and failures based on the religious

aspect. Theologians insert the religious reference to a higher power holds participants accountable for their success while academic researchers note no significant contribution to success but was significant to being a barrier (Hillhouse & Fiorentine, 2001).

Theological research found that age combined with religiosity show a link to success in AA (Zemore, 2007). Academic research shows no link with other demographics as contributing to religiosity as being a barrier. Neither area of the research could connect religiosity with any other factors.

Purpose

The previous research in the field of AA discusses participation in twelve step programs for various outcomes for participants. The primary purpose for this study was to investigate the similarities and differences in the various stages of participants of a sample attending an AA program, identify variables that contribute to retention in the program, and to use traditional Glaser and Strauss Grounded Theory to develop a profile of Endurers in the program. Some studies have indicated the spiritual component of the AA program can contribute to a life long commitment; but the same studies do not identify the participants' characteristics beyond motivation that are related to completing the program more than one cycle and continuing limitless attendance. This study investigated this possible connection between those factors of comparability between three distinct groups and generated a predictive hypothesis about the participants in the short term two groups as it relates membership in the long term group.

Research Questions

The research questions were:

7. What variable or combination of variables as measured by the Duke University Religion Index (DUREL), the Group Selection Questionnaire (GSQ) and demographics contribute to long term attendance in an AA program?
8. What are the similarities and differences for participants in three stages of recovery; (Newcomers, Chronic Relapsers, and Endurers) of a sample attending an Alcohol Anonymous program?
9. What combination of test scores and participant characteristics for Newcomers and Chronic Relapsers can be used to identify the potential to become Endurers?

Participants

Participants consist of members from 4 different groups of AA programs sponsored by Recovery for Life (N=210). The average sizes of the groups ranged from 20 to 80 participants per night. Participants were from two sites in Chesapeake (n=181) and two in Norfolk (n=29) from six different completed cycles. The two Chesapeake sites completed one cycle in October and one in January. Both Norfolk sites completed their cycles in December. All the meetings were held in church locations.

Each of the groups had members of the three target subgroups- Newcomers, Chronic Relapsers and Endurers. Newcomers will often come with misconception of sobriety. Most Newcomers have been clean and sober: physically and emotionally, for six months or more (aa.org, 2011). Newcomers were classified as participants that have

completed their first cycle of their first ever AA meeting. Chronic Relapsers are individuals that have numerous failed attempts to stay sober. Chronic Relapsers have attending previous AA meetings and completed several cycles. Chronic Relapsers were classified as participants that have completed several cycles of AA meetings inconsistently with spells of relapse (Smith, 2011). Endurers are individuals that have years of prolong sobriety. Endurers have attended AA meetings continuously for years. Endurers were classified as participants that have completed several cycles of AA meetings over the course of 10 years or more.

Participants in the programs varied in characteristics depending on the location of the facility holding the meeting. The areas that are in a more suburban location had participants that drove to the meeting. Thus the participants were diverse in age, education, income levels, and social class. The locations that were more urban and close to public transportation had a similar make up to the suburban group and included participants from the lowest economic quartile. The more urban location will also be accessible to foot traffic.

In addition to the location, one other factor determined participants in the meetings: whether the AA meeting offers child care assistance and meals. Those locations included parents and added more variation to the participant sample. Regardless of the location, each meeting offered an assortment of participants both voluntary and court ordered; educated and uneducated; atheist, agnostic, and denominational; married and single; wealthy and low income; and finally striving to get clean and those who have been clean and sober for years.

Instruments

Duke University Religion Index, the Group Selection Questionnaire and Demographic Form

The instruments that were used are the Duke University Religion Index (DUREL) and the Group Selection Questionnaire (GSQ). The DUREL measures organizational, non-organizational and intrinsic dimensions of religiousness while the GSQ is used to manage group selection and composition, but has been useful in generating predictive factors in group. The two instruments were incorporated into in the Recovery for Life exit demographic data form which investigates barriers to treatment, years of alcohol use, use of other services, and composition of participants attending.

The DUREL was created to assess multiple dimensions of religious beliefs in a comprehensive format. The DUREL is a five item self-reporting scale that assesses religion in terms organizational, non-organizational, and intrinsic dimensions. The items have six possible answers rating from 1=more than once a day to 6=rarely or never. The scoring guidelines range from one to twenty five with the higher score indicating higher levels of religious involvement in a person's life. The DUREL is the questionnaire thus far that has proven creditability as a validated measure of religious beliefs and/or involvement (Storch et. al., 2004).

The Group Selection Questionnaire is used to manage group selection and composition, but has been useful in generating predictive factors in group outcomes. Its reliability was tested in two phases on two different levels. In both phases, the GSQ was successful in predicting group process and outcomes. The proven reliability of the GSQ makes it a valid instrument for evidence base practices in both group work and research.

The three subscales of expectancy, deviant social behavior, and ability to participate utilize Likert-type items. The expectancy questions measures attitudes and expectations about participating in the group. The participation questions relate to the participant belief that they can participate in the group. The deviant social behavior, also called demeanor, investigates the clients' insight into the possibility of abnormal behaviors that cause them to become outcast or bullies (Burlingame et. al., 2010). The nature of the GSQ proves it to be an appropriate instrument for predicting group outcomes such as individuals who improved during group psychotherapy, participated and felt as though they were part of the group and displayed retention in the group (Krogel et. al, 2009).

To create an instrument to meet the needs of this study, it needed be completely anonymous yet provide information through a combination of questions to generate general information on the sample's participants. Questions in this section included areas pertaining to race, gender, education, age, marital status, substance abuse in years prior to attending meetings, number of meetings attended, previous level of behavior, and perceived effectiveness of program. The human services questions included any social services, legal or incarceration involvement. The substance abuse questions allowed participants to include other substances such as prescription and club drugs.

The demographic questions concerning marital status, previous level of behavior and education will only have four responses. A question on program expectation was answered on a scale of 1 to 10. The questions on whether participants ever attended and completed a previous AA program cycle; how many times, if any, there was a relapse and return to an AA program and how many cycles of AA attendance without relapse were added as participant identifiers for categorization in one of the three groups. Questions

pertaining to gender, age, years of alcohol use, barriers to treatment, attitude toward treatment were included. A section with the DUREL and GSQ questions was added at the end of the program's instrument. All the questions in each section were grouped together on the instrument for ease of coding.

Procedure

The need of confidentiality and anonymity and how it will be addressed

The subject of addiction recovering is a very sensitive area. Due to the anonymous make up of the group, informed consent was waived. To obtain informed consent required participants' signatures and that would negate the anonymity of group. This loss of anonymity would jeopardize the employability and reputations of participants in the group which could, in turn, causes harm to some participants. The purpose of the study was to use information gathered to help participants thus, names and any other identifying information need to be waived to comply with the rules of anonymity.

That fact that the research is completely anonymous and participation is voluntary was emphasized. A notification letter of anonymity was attached to each instrument as well as read out loud by researcher for clarification purposes. After the letter was read aloud, participants were instructed what to do upon completion of instrument, meaning fold the instrument in half and place it in one of three instrument collection boxes stationed in the back, middle isle and front of the room. If a member of the group does not want to take the instrument, then that action was be taken as refusal to participate. Otherwise, filling out the instrument was understood as giving consent. An additional sheet explaining the purpose of the study and the definition of waiver of signing was

attached to the front of the instrument. The information on the waiver of signing was presented and read aloud to the group before starting the instrument in addition to the oral explanation of the study. No one under the age of 18 was allowed to participate in the study. Participants were allowed to tear the cover sheet off and keep it to ensure anonymity.

Data Analysis

Descriptive statistics for the demographic data were reported as frequencies with accompanying percentage of respondents for each possible response. Descriptive statistics for the DUREL, total and subscales, and the GSQ, total and subscales, consisted of means and standard deviations. Demographic data including religious affiliation and having identified negative demeanor traits were analyzed to determine if a statistical significance existed between the three attending groups of AA, Newcomers, Chronic Relapsers, and Endurers using cross tabulation resulting in a Pearson's Chi Square statistic. A Discriminant Analysis was used to establish like attributes of the participants in the three groups of Newcomers, Chronic Relapsers, and Endurers attending AA. Scores on the DUREL and GSQ and demographics for the three groups in AA of Newcomers, Chronic Relapsers, and Endurers were compared using multivariate analysis of variance (MANOVA).

Findings and Conclusions

Presented are the research questions, findings and conclusions for the measured demographics and responses on the DUREL which identified whether a participant was religious affiliated or non religious affiliated, and on the GSQ.

Research Question 1

1) What variable, or combination of variables, as measured by the Duke University Religion Index (DUREL), the Group Selection Questionnaire (GSQ) and demographics contribute to long term attendance in an AA program?

Findings: Results of the Discriminant Analysis indicated that the groups showed no significant homogeneity (Box's $M = 0.57$). The results also indicated the only two variables that were statistically significant were age ($F = 6.695, p < 0.002$) and identified negative demeanor ($F = 4.754, p < 0.010$). Therefore measurements on the GSQ of negative demeanor and the demographic of age were the established attributes that distinguished between participants in the three groups of Newcomers, Chronic Relapsers, and Endurers that attend AA.

Conclusion: The demographics of religious affiliation, marital status, gender, education and race were not statistically significant as attributes of the participants while age and negative group demeanor were statistically significant and found to contribute to long term attendance in an AA program.

Research Question 2

2) What are the similarities and differences for participants in three stages of recovery (Newcomers, Chronic Relapsers, and Endurers) of a sample attending an Alcohol Anonymous program?

Findings: Results of the MANOVA indicated there were no statistically significant effects for religious affiliation ($F_{(2)} = 0.466, p = 0.628$), race ($F_{(2)} = 0.961, p = 0.385$), marital status ($F_{(2)} = 1.367, p = 0.258$), gender ($F_{(2)} = 0.657, p = 0.520$), and education ($F_{(2)} = 0.082, p = 0.921$). This finding indicated that there were no statistically significant

differences between attendance in AA and the demographics of race, marital status, gender, education and being identified as having a religious affiliation. Results indicated statistically significant results for the effects of negative demeanor ($F_{(2)} = 4.754, p = 0.010$) and age ($F_{(2)} = 6.695, p = 0.002$) indicating a main effect for age range and identified negative group social traits as measured by the GQS.

Conclusion: The two statistically significant differences between participants in the three groups of Newcomers, Chronic Relapsers, and Endurers, were age range and negative group demeanor, with Newcomers and Endurers indicating the more significant interaction. Participants in the three groups within AA of Newcomers, Chronic Relapsers, and Endurers responses on to whether they were identified religious affiliation and the demographics of marital status, gender, age, education and race did not result in statistically significant differences.

Research Question 3

3) What test scores and participant characteristics of Newcomers and Chronic Relapsers can be used to identify the potential to become Endurers?

Findings: Based on the results from the Discriminant Analysis, age ($F = 6.695, p = 0.002$) and negative demeanor ($F = 4.754, p = 0.010$), and MANOVA, age ($F_{(2)} = 6.695, p = 0.002$) and negative demeanor $F_{(2)} = 4.754, p = 0.010$), both negative demeanor and age were the two characteristic to show significance between the three groups of Newcomers, Chronic Relapsers, and Endurers.

Conclusion: Age and negative group demeanor are inversely related to whether Newcomers and Chronic Relapsers have the potential to become Endurers.

Summary of Findings and Conclusions

Research questions 1 and 2 detailed how demographics and scores on the DUREL which indicated religious affiliation and on the GSQ which indicated negative group demeanor affected attendance in the three groups of Newcomers, Chronic Relapsers, and Endurers in AA. It was determined that there was no statistical significant found in the demographics of religious affiliation versus non religious affiliation, martial status, gender, age, education, and race and whether they contributed to long term attendance in an AA program. However, a statistical significant finding for the demographics of age and negative demeanor resulted. Group comparisons to identify similarities and differences did not find a statistical significant for the demographics of martial status, gender, age, education, race and religious affiliation. The multivariate test indicated two main effects of similarities were age and negative demeanor.

Research question 3 sought to identify what scores on the measure of the DUREL and GSQ and participant characteristics of Newcomers and Chronic Relapsers could be used to in determining their potential to become Endurers. A pattern in the findings of both the Discriminant Analysis and MANOVA indicated that age and negative group demeanor were statistically significant in both analyses. Based on those statistically significant findings, age and negative group social behavior both would be useful in determining Newcomers' and Chronic Relapsers' potential for becoming Endurers.

Findings Related to Previous Literature

There are three reasons why this study contributes to the existing literature. First, it adds to the body of knowledge about AA. Second, the outcome can establish if there is a combination of demographics of the sample population in AA that can contribute to

success in the program. Third, to generate a theory on whether Newcomers and Chronic Relapsers in AA can be retained to become Endurers based on the research outcomes.

Age

Across the three groups of Newcomers, Chronic Relapsers, and Endurers which attended a local AA program, age was a significant factor which shared some limited similarity to previous research concerning AA and age. Kelly, Myers and Rodolico (2008) conducted research on AA and participants under 18, in which no significant success was found in that age group and AA because some aspects of AA did not appeal to the maturity level of the age group. This study did not include any participants under 18, thus concerning participants in the study; age was a found to be a significant factor in attendance in this sample of AA. This supports the pre existing literature concerning the appeal of AA to an adult population.

Negative Demeanor Group Social Behavior

The Group Selection Questionnaire or GSQ can be useful in group selection and in generating predictive factors in group outcomes. The GSQ has three subscales: expectancy which measures attitudes and expectations about being in a group, participation which measures the belief about participate in the group process, and demeanor, which measures possible group deviant behaviors. Group deviant or negative demeanor behaviors may cause members to become outcast or bullies in the group setting. MaNair-Semends (2002) studied attendance and interpersonal factors as measured by and instrument similar to the GQS, the Group Therapy Questionnaire. Her study found a statistical significance between attendance in group therapy and the interpersonal factors of Social Phobia/Inhibition and Angry Hostility. In group, hostility

is expressed through actions and indirect expressions of anger that may be a pattern for these members identified with that interpersonal factor. Such anger not only is perceived as bullying behavior to other group members but also as difficulty engaging in the group process.

The current study found a similar trait by using the Group Selection Questionnaire in the subscale of demeanor. A negative demeanor can be problematic in group settings (e.g., arguing for argument's sake, talking over others,) leading a member to be viewed as a "deviant" by others in the group; thus the current study found that group deviancy was a factor in all three groups of Newcomers, Chronic Relapsers, and Endurers which attended the AA sample. This group deviancy or negative group demeanor was a commonality among all three groups as well as an identified factor that affected attendance. The finding adds to the current research that negative interpersonal traits that can lead to bullying not only affect a person's ability to participate in the group process which is the basis for AA, but also can affect the group process for others as well.

Religiosity or Religious Affiliation

There has been much research done in the areas of AA and religiosity. Atkins and Hawdon (2007) investigated the effects of religiosity on participation in AA and found that participants with a non religious affiliation were less likely to participate in 12-step groups such as AA. Though the study made a point to separate religiosity from spirituality, there were minimal differences in participation. A significant difference in participation in individuals who had a religious affiliation, claimed attachment to established religions and membership to particular sects, and those who had no religious affiliation, professed atheism or had no association with any spirituality.

The currently study used the Duke University Religion Index (DUREL) to identify religious affiliation and non religious affiliation. The DUREL measures multiple dimensions of religion in the areas of the organizational, non-organizational and intrinsic dimension of religiousness. This study found that religious affiliation was not a significant factor in that affected attendance of the three groups of Newcomers, Chronic Relapsers, and Endurers of the AA sample. This study found that a participant being identified as being religious affiliated or non religious affiliated had no bearing on predicted whether a newcomer in AA would become a chronic relapser or an endurer and therefore could not be useful in developing the profile of an endurer in AA.

Implication for Practitioners

This study has implication for practitioners in practical research, traditional treatment and mental health community settings.

Practical Research

This study contributes to the current literature in AA by supporting the research concerning types of personality traits that may contribute to members being unsuccessfully retained in AA. This has significance for researchers continuing to investigate the effectiveness of the AA model as viable treatment for alcohol issues with measurable outcomes. The study also lends to assisting researchers interested in AA to target populations to study not based on general demographics but instead a personality type. In studying more specific personality types in open group setting such AA, researcher are presented with another aspect of the group process that may affective measured outcome.

Traditional Treatment

For practitioners seeking treatment for clients in conjunction with or beyond traditional methods of inpatient residential and outpatient therapy for alcohol abuse and dependency issues compatibility of add-on services is a necessity. However, screening clients for certain traits that would not work well in a group setting should be considered before referring some clients to AA. AA is an open group that accepts every one, even those with negative group behaviors. Therefore, clients with identified negative group behaviors may participate in AA, but the chances of that participant engaging in AA with any longevity is questionable. This study offers support for the ideal that clients exhibiting more aggressive behaviors to be better suited for treatments in a one to one setting where the therapist controls the session.

The study added to the current research by investigating the similarities and difference in three groups attending AA and used the information obtained to generate a theory on what variables or combination of variables can describe participants who successfully complete the AA treatment program and return for more than one cycle. When practitioners are reviewing demographics, none of the following can be useful in predicting whether a client would be successful in completing more than one cycle of AA: race, gender, martial status, education level, and a religious affiliation or non affiliation. However, whether a client has identified negative group behaviors and is over the age of 18 but not older than 59, can be useful in predicting whether a client has the potential to complete more than more one cycle of AA and have some longevity in the program.

Community Mental Health

For practitioners in the mental health community setting, this study lends credence to which client with certain diagnoses would do well in AA and which client would not. Many clients in community mental health services have a dual diagnosis which is a diagnosis of a serious mental health illness coupled with a substance abuse problem. Research shows that dual diagnosis clients benefit from attending AA meetings, especially one tailored to accommodating the mentally ill (Bogenschutz et. al, 2006). The Bogenschutz study referenced research subjects with an Axis I diagnosis, such as schizophrenia and the use of alcohol and drugs and that AA was found beneficial along with the factor of outpatient and/or inpatient treatments. However, there was not a discussion of single factors such as Axis II diagnosis and incidents of alcohol, no drug use.

The study found that persons with negative group behaviors such as aggression or attention seeking behaviors would not be successful as some others in AA. In mental health, individuals with an Axis I or Axis II diagnosis can have those types of behaviors manifested as psychiatric symptoms. While AA is an open group setting, even those diagnosed individuals without aggressive behaviors may struggle with the setting and the concepts. These factors should be weighted as mental health providers seek treatment option for clients. For example, clients with borderline personality disorders that experience unstable and dysfunctional relationships may not be best suited for AA which fosters stability and support. AA also provides sponsors and the behaviors from some types of mental illness diagnosis impede developing functionally and healthy bonding relationships.

So in seeking additional substance abuse treatment options for the dual diagnosis population, community mental health practitioners need to screen clients for an AA program based on diagnosis and compatibility. It should also be considered whether the setting of open semi structured group versus closed psychodynamic group is appropriate for the client. Finally the type of AA meeting should be explored. There are AA meetings where mental illness is common place and the group facilitator has some background or training in dealing with mentally ill individuals. However, that said, is specific to individual groups and not the AA program as a whole. For community mental health practitioners, the best interest of the client population would be to consider AA groups with group facilitators that have experience with dual diagnosis members or AA groups with a multiple dual diagnosis and substance abuse base or MDD-SUD. This might be instrumental in helping the clients with dual diagnosis get the maximum benefits that AA has to offer.

Future Research Implications

There are areas of weakness that are noticeable with the current study that would benefit from being changed in future studies of this topic in AA. Some potential methodological changes include: 1) modify the instrument; 2) widen and increase the population of the sample; and 3) additional analysis of the data. A more detailed description of the changes is as follows.

Modify the instruments

The instrument used was comprised of two different questionnaires, Duke University Religion Index and the Group Selection Questionnaire and a demographic form. Together all three made forty two questions that needed to be completed in a short

amount of time. A potential way to address the problem in future research is to eliminate questions on the demographic form that are not used in the analyses. Though helpful to the program's administrator, some of the demographic questions were not of any use to the study. Also the Group Selection Questionnaire has a different format in which participants may check boxes for their answers. For future research, that format is a quicker way to respond to the GSQ yields the same results and would be ideal for a population in which some are still struggling with sobriety even during the AA meetings.

Widen and increase the population of the sample

Another area of limitation in the current study is the localness of the study. Recovery for Life is a local AA program that services certain cities in the Tidewater region. The cities in the southern and western parts of the Tidewater region were under-represented because Recovery for Life no longer held meeting in those areas. Therefore, the results may only be generalized to certain geographical areas. For future research, the sample population should include participants from AA meetings in those areas such as Williamsburg, Portsmouth, Hampton and Suffolk and include other AA meetings along with the AA meetings of Recovery for Life. In addition the sample in different geographic regions, future research should also include different types of AA meetings. All of the meetings were held in Baptist churches in Chesapeake and Norfolk. Different types of AA meetings in future research should include meetings such as all women's AA programs or military AA programs.

Additional analysis of the data

The analyses used addressed the research question was used to find any statistical significance. However once that statistical significance was found the degree in which

the variables were a factor was not apparent. Though the analyses addressed the specific research questions, more in depth analysis for the age variable could have been useful. For future research, a logic regression could be used to determine which subcategories or age bracket in variable of age were more influential as factors than others.

Summary

The purpose of this study was to investigate the similarities and differences in the various stages of participants of a sample attending an AA program, identify variables that contribute to retention in the program, and to use Grounded Theory to develop a profile of Endurers in the program. Data was collected through an instrument that combining a demographics section, the DUREL and the GQS, and was administered to two different geographical groups over six ending cycles across a four month time. The results of this study add to the literature available on retention in AA and factors that affect long term success in AA. Results of this study also extend to the literature on the Group Selection Questionnaire and how effective it is at predicting participants for the group process. The results of this study extend to the currently literature on the Duke Religious Index and its effectiveness in measuring religiosity or in this case religious affiliation. The combined contributions of the results of this study indicates that no one demographic or combination of demographics, a religious affiliation or certain group traits necessary for positive participant in the group process can be associated with success in AA. However, certain demographics and identified traits can be useful in predicting whether participants have the potential for retention in AA to become Endurers. Finally the results indicate a pattern the can prove useful in Grounded Theory to generate a profile of Endurers.

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APPENDICES

APPENDIX A

Research Question and Data Analysis Outline

Research Question and Data Analysis Outline

R e s e a r c h Q u e s t i o n	I n d e p e n d e n t V a r i a b l e	D e p e n d e n t V a r i a b l e	A n a l y s i s
1. What variable or combination or variables as measured by the Duke University Religion Index (DUREL), the Group Selection Questionnaire (GSQ) and demographics contribute to long term attendance in an AA program?	Items on the DUREL (average score per construct) that identified religious affiliation or non religious affiliation Items on the GQS subscales (expectancy, ability to participate & social skills) that identified group deviant traits Various identified demographics	Continuous attendance in multiple cycles of the AA program of the participants	Discriminant Analysis Measure will be used to establish like attributes of the participants
2 What are the similarities and differences for participants in three stages of recovery; (Newcomers, Chronic Relapsers, and Endurers) of a sample attending an Alcohol Anonymous program?	Attendance at various levels of the AA program of the participants	Items on the DUREL (average score per construct) that identified religious affiliation or non religious affiliation Items on the GQS subscales (expectancy, ability to participate & social skills) that identified group deviant traits Various identified demographics	One way MANOVA The predictor variables will be the common identified factors shared among the three groups that include religious affiliation or non religious affiliation and group deviant traits.
3. What test scores and participant characteristics of Newcomers and Chronic Relapsers can be used to identify the potential to become Endurers?	NA	NA	Grounded Theory The step of data collecting in Grounded theory will be the Discriminant rql. The step of analyzing the data to find concepts and patterns or will be the MANOVA from qs2. All lending to the step of developing a theory to explain the investigation.

APPENDIX B

Instrumentation

Progress Evaluation

Please fill out the following questions. Your responses will be kept anonymous, confidential and used for further program evaluation and educational purposes.

1. Race: ☐ Caucasian ☐ African American/Caribbean Islander ☐ American Indian ☐ Hispanic/Latino ☐ Asian/Pacific Islander ☐ Other

2. Are you married? ☐ Yes ☐ No

3. What is your gender? ☐ Male ☐ Female

4. What is your age group (circle)?
 1 2 3 4 5 6 7
 18-29 30-39 40-49 50-59 60-69 70-79 80 & older

5. What is your education level?
☐ High School/ High School Diploma ☐ Community College/ Certifications
☐ Some College/ Received a Degree ☐ Post Four Year Degree

6. How many years did you struggle with addiction before attending Recovery for the City meetings? (circle)

1 2 3 4 5 6 7
 0-5 5-10 10-19 20-29 30-39 40-49 50 or more

7. Define your addiction/behavior before you came to Recovery for the Life: (circle)

1 2 3 4 5 6 7 8 9 10
 Occasional Issues (use) Frequent Issues (use) Out of Control

8. Is this your first time attending a Recovery for the Life meetings? ☐ Yes ☐ No

9. How many years have you attended Recovery for the Life meetings? (circle)

1 2 3 4 5 6 7 8 9 10 or more

10. How many of the last 12 weeks did you attend? (circle)

1 2 3 4 5 6 7 8 9 10 11 12

11. On a scale of 1-10 please rate your emotional state at the start of the 12 weeks (circle).

1 2 3 4 5 6 7 8 9 10
 Defeated Discouraged Fair Good Whole

12. On a scale of 1-10 how much has the program helped you overall? (circle)

1 2 3 4 5 6 7 8 9 10
 Not much Somewhat A Great Deal

13. Have you been ☐ incarcerated ☐ hospitalized BEFORE coming to this program?

☐ No ☐ Yes

14. Have you been ☐ incarcerated ☐ hospitalized SINCE coming to this program?

☐ No ☐ Yes

15. To what degree has R4L KEPT you from returning to jail or the hospital (circle)? ☐ n/a

1 2 3 4 5 6 7 8 9 10
 Not much Somewhat A Great Deal

16. How many times did you relapse during your attended Recovery for the Life meetings?

1 2 3 4 5 6 7
 0-5 5-10 10-19 20-29 30-39 40-49 50 or more

17. How many AA meetings have you completed in the past at R4L or other places?

1 2 3 4 5 6 7
 0-5 5-10 10-19 20-29 30-39 40-49 50 or more

18. What has been your struggle with addiction? (please check any that apply)

☐ Substance Abuse (meth, heroin, cocaine) ☐ Food (overeating/eating disorder)
☐ Sexual Addiction (porn, etc.) ☐ Spouse's addiction
☐ Codependency/ATP ☐ Control (addicted to pleasing people)
☐ Club Drugs ☐ Nicotine (cigarettes)
☐ Prescription Drugs ☐ Inhalants
☐ Internet Addiction (Porn/Facebook/Poker) ☐ Gambling
☐ Anger (addicted to adrenaline and rage) ☐ Substance Abuse (alcohol)
☐ Self-mutilation (the rush of hurting myself) ☐ Other _____

19. Were you recommended or mandated to participate in this program?

☐ No ☐ Yes

20. How often do you spend time in private religious activities, such as prayer, meditation or Bible study?

1. More than once a day 2. Daily 3. Two or more times/week
 4. Once a week 5. A few times a month 6. Rarely or never

21. In my life, I experience the presence of the Divine (i.e., God). (circle)

1. Definitely true of me 2. Tends to be true 3. Unsure
 4. Tends *not* to be true 5. Definitely *not* true

22. My religious beliefs are what really lie behind my whole approach to life. (circle)

1. Definitely true of me 2. Tends to be true 3. Unsure
 4. Tends *not* to be true 5. Definitely *not* true

23. I try hard to carry my religion over into all other dealings in life.

1. Definitely true of me 2. Tends to be true 3. Unsure
 4. Tends *not* to be true 5. Definitely *not* true

24. Do you think group therapy will be helpful (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

25. Do you think participation in a group will be helpful (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

26. Do you think talking about feelings will be helpful (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

27. Do you talk much to others in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

28. Do you feel left out in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal 24.

29. Do you tend to be open to the group in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

30. Do you tend to share your feelings with others in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

31. Do you tend to avoid others in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

32. Do you feel others in a group look at you negatively (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

33. Do you share your opinion with others in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

34. Do you tend to talk about your feelings to the whole group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

35. Much often do you share your personal information with new people in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

36. Do you tend to take over the discussion in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

37. Do you tend to interrupt others when they are talking in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

38. Do you have any problem cutting across others if necessary in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal.

39. Do you tend to participate in group discussions (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

40. Are you open to participating in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

41. Do you tend to argue others in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

42. Do you like to be the center of attention in a group (circle)

1 2 3 4 5 6 7 8 9 10
Not much Somewhat A Great Deal

Progress Evaluation

APPENDIX C
Letter of Study Information and Anonymity

Good Afternoon,

My name is Keesha Kerns and I am a doctoral candidate in the Counselor Education & Human Services program at Old Dominion University. I am conducting an IRB approved research study for my dissertation, under the supervision of Dr. Nina Brown to fulfill the requirements for a doctorate degree. The purpose of the research study is to gather anonymous data about people who attend Alcohol Anonymous and their religious beliefs and group behaviors to determine if these have any influence on their long life in Alcohol Anonymous. The goal of this study is to promote awareness about three different groups of individuals that attend Alcohol Anonymous by developing a profile of each then compare the groups to predict if the two of the three can become individuals that attend Alcohol Anonymous for an extended period of time.

I would truly appreciate if you would consider participating in my study. Below is a brief description of my study:

I am inviting Recovery for the Life Attendees to participate in this study. Participants must attend the last meeting of the 12 step cycle for Recovery for the City. The most time needed to take the survey is **approximately 10 to 15 minutes**. This includes completing a short section with demographic questions, a section with a few religious questions, and a section with questions about behaviors in a group. Upon completion of study please fold in half and deposit in collection boxes. IF you choose not to participate, turn in a blank survey. All information gathered is **COMPLETELY ANONYMOUS**. No information given in this survey can cause the person answering to be identified in any way. At the end of the study the information will be destroyed.

If you have any questions or concerns, please do not hesitate to email me at kkern002@odu.edu or Dr. Nina Brown at nbrown@odu.edu.

Thank you in advance for your participation,

Nina Brown,
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Keesha Kerns,
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Doctoral Candidate in Counseling
Old Dominion University
Norfolk, VA 23529
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Good Afternoon,

My name is Keesha Kerns and I am a doctoral candidate in the Counselor Education & Human Services program at Old Dominion University. I am conducting an IRB approved research study for my dissertation, under the supervision of Dr. Nina Brown to fulfill the requirements for a doctorate degree. The purpose of the research study is to gather anonymous data about people who attend Alcohol Anonymous and their religious beliefs and group behaviors to determine if these have any influence on their long life in Alcohol Anonymous. The goal of this study is to promote awareness about three different groups of individuals that attend Alcohol Anonymous by developing a profile of each then compare the groups to predict if the two of the three can become individuals that attend Alcohol Anonymous for an extended period of time.

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If you have any questions or concerns, please do not hesitate to email me at kkern002@odu.edu or Dr. Nina Brown at nbrown@odu.edu.

Thank you in advance for your participation,

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APPENDIX D
DUREL Permission

From: **Harold Koenig, M.D.** <harold.koenig@duke.edu>
Date: Sun, Oct 21, 2012 at 6:59 AM
Subject: RE: Duke Religious Index
To: Keesha Kerns <kkern002@odu.edu>

Keesha – you have my permission. I'm attaching the scale and a paper about it here. HK

From: Keesha Kerns [mailto:kkern002@odu.edu]
Sent: Saturday, October 20, 2012 8:01 PM
To: Harold Koenig, M.D.
Subject: Duke Religious Index

Dear Dr. Koenig,

My name is Keesha Kerns and I am a doctoral candidate in Counseling at Old Dominion University. My committee chair, Dr. Nina Brown, introduced me to the Duke University Religion Index from a former student's study, David Richels. I am requesting permission to use the DUREL as part of my study in building a profile of three levels of participants completing a 12 step program. I am attaching a brief summary of the study for your information.

Thank you very much in advance for you time and attention to this matter.

Sincerely,

Keesha Kerns

APPENDIX E
Group Selection Questionnaire Permission

From: **Gary Burlingame** <gary_burlingame@byu.edu>
 Date: Tue, Oct 30, 2012 at 6:28 PM
 Subject: RE: Group Selection Questionnaire
 To: Keesha Kerns <kkern002@odu.edu>
 Cc: "Brown, Nina W. (nbrown@odu.edu)" <nbrown@odu.edu>

Sure...let me know what you find out...do you have a copy of the GRQ (we changed the name to group readiness questionnaire a year or two ago see attached manual)? I've attached a few files that might be useful...g

Gary M. Burlingame, Ph.D

University Professor

Professor of Psychology

Brigham Young University

238 TLRB, Provo, UT 84602

office [801-422-7557](tel:801-422-7557)

fax [801-422-0163](tel:801-422-0163)

sec [801-422-4050](tel:801-422-4050)

USH lab [801-344-4430](tel:801-344-4430)

From: Keesha Kerns [mailto:kkern002@odu.edu]
Sent: Saturday, October 20, 2012 5:56 PM
To: Gary Burlingame
Subject: Group Selection Questionnaire

Dear Dr. Burlingame,

My name is Keesha Kerns and I am a doctoral candidate in Counseling at Old Dominion University. My committee chair, Dr. Nina Brown, introduced me to the Group Selection Questionnaire and its purposes in predicting group therapy participation. I am requesting permission to use the GSQ as part of my study on the participants in the group setting of a 12 step program. I am attaching a brief summary of the study.

Thank you very much in advance for you time and attention to this matter.

Sincerely,

Keesha Kerns

(757) 478-3646

kkern002@odu.edu**Keesha Kerns****EDUCATION**

Ph.D. Counseling Education and Supervision

May 2013

Old Dominion University

Norfolk, VA

Dissertation: Investigating Similarities and Differences as Measured by the DUREL and GSQ Between Three Subgroups Attending a Local AA Meeting to Develop a Profile of Long Term Attendees.

Analyzed the answers from an instrument that combined a demographics form used by the program Recovery for the Life, the Duke University Religion Index, and the Group Selection Questionnaire to determine the variables and characteristics of participants who attended and were retained in AA.

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July 1993

East Carolina University,

Greenville, NC 27858

CERTIFICATION/LICENSURE

National Certified Counselor (NCC #65691)

Licensed Professional Counselor, North Carolina (under review)

AREAS OF INTEREST/RESEARCH

Substance Abuse

Factors that contribute to success in AA

July 2012-present

IRB approved research that explores religious affiliation, and group traits in relation to retain in Alcoholic Anonymous.

Narrative Therapy and Testimonials

July 2011-present

Research exploring the effectiveness of testimonials in narrative therapy

Therapeutic Day Treatment in Public Education

April 2012-June 2012

Qualitative research involving the parent of children in special education and their perceptions of therapeutic day treatment programs in public education

Male Recruitment and Retention Needs Assessment

August 2011-December 2011

Program evaluation of male recruitment and retention in Old Dominion University's graduate counseling program

TEACHING EXPERIENCE

COUN 633-Counseling and Psychotherapy Techniques Spring 2009
 (Graduate Assistant) This course featured a study of major theories of counseling and psychotherapy. The primary focus was on providing students with a theoretical foundation upon which to develop their own approach for providing counseling and psychotherapy.

COUN 680 Mental Health Counseling Spring and Fall 2011
 (Guest Lecturer) This course features a comprehensive approach to counseling targeting mental health in the community. The primary focus was on providing student with a foundation to develop their skills dealing with individuals with mental illness in the settings of inpatient, outpatient and community settings.

HMSV 341 Introduction to Human Services Summer 2013
 (Co Lecturer) This course is designed to teach students about human services, the helping process, and the role and function of the human service worker. The primary focus is to expose students to local and state human services facilities, different aspects of human services, foster critical thinking in the role of helping professional and to begin their development into human service professionals.

CLINICAL EXPERIENCE

Summary of Skills:

- | | |
|--|-------------------------|
| • Individual/ Therapist | • Case Management |
| • School Counselor | • MHCSS Intake Assessor |
| • Psycho-educational Group Facilitator | • Community Counselor |
| • Personal Growth Group Facilitator | • Functional Behavior |
| Assessor | |

Community Counselor II

National Counseling Group September 2009 to present
 Work with adults and children with various mental health diagnoses at home and in the community. Complete intake assessment for intensive in-home and mental health support community services, develop treatment plans, generate quarterly reports and correspond with outside agencies. Educate individuals on coping strategies and skills in area assessed as having a deficiency such as managing psychiatric symptoms and managing personal finances. Assist individuals in finding employment, develop skills needed to adjust to the work force and set up transportation to work and other appointments in the community. Participate in outpatient medication management meetings, special education meetings, court proceedings and therapy sessions. Provide support during substance abuse rehabilitation. Utilize community resources for the mental challenged population and provide in house training for fellow counselors on techniques for various populations that the agency serves.

Clinical Supervisor

Old Dominion University Counseling Program Spring 2009-Fall 2012
 Provided clinical supervision to Master's students completing their practicum and/or internship clinical training via individual, triadic, or group format. Supervised school counseling, college counseling, and clinical counseling students. Monitored students'

clinical skill development, provided feedback on taped counseling sessions and written case conceptualizations, and conducted student evaluations of progress. Linked with site supervisors to ensure maximum student support.

Certified School Counselor

Suffolk Public Schools,

March 2000 to October 2009

Shared a position with two elementary schools which duties included individual and group counseling session, behavior modification, special education committee, state and local testing coordinator, 504 chairperson, safe and drug free federal program on-site supervisor, students targeting outstanding performance club sponsor, student club day chairperson, career day coordinator and student intervention committee co-chairperson. Designed and implemented school wide guidance lesson in accordance to state curriculum. Member of citywide Functional Behavior Assessment team which assessed levels of extreme student behavior and developed strategies for the classroom. Responsibilities also included for school wide student recognition program and reception for both buildings. During summer months, screen candidates for four year old city wide program.

Certified School Counselor

Beaufort County Schools

January 1998 to June 1999

Counseled individuals and groups of students, interpreted test results, chaired student strategies committee, parent consultation, participated in administrative and special education meetings, and testing coordination. Provided services that included updating student files, orientation, placement, information, assessment and follow-up.

Certified School Counselor

Wilson County School

October 1996 to June 1997

Counseled individuals and groups of students with academic, social and personal needs, interpreted test results, parent consultation, participated in administrative meetings and updated student files. Provided services that included orientation, placement, information, assessment and follow-up.

Academic Support Counselor

East Carolina University Academic Support Center August 1995 to June 1996

Counseled individuals and groups of student on academic probation. Responsibilities also included designing and implement individual counseling plans, and administering and interpreting interest inventories to assist students in career planning. Held workshop on study skills on the college level, relaxation and advocating the student need.

OTHER PAID EXPERIENCE

Vision Therapist

Doctor's Vision Center

August 1997 to May 2000

Initially screened client referred by optometrist with various reading and vision difficulties. Designed and implemented treatment plans for clients with vision and reading insufficiencies. Assisted clients in developing strategies for their work environment based on vision deficiencies. Therapies included saccadic reading, computerized pursuits and tracking, attention and concentration, laterality integration,

visualization, and memory prompting. Also conduct initial program screening and sensory motor testing.

Special Education Teacher

Pitt County Schools
1996

August 1996 to December

In absence of teacher, taught behavioral and emotional handicap, classes. Designed lesson plans to maximize learning in students with mental and physical disabilities. Conducted special education meetings for students with individual education plans. Supplied parents with a daily communication log of various class room behaviors.

NONPROFIT AFFILIATIONS

Freelance Outreach Program

Atlanta, GA

Active Board of Directors Member

- Develop employment services plans for addicts at various stages of recovery
- Consult with outside agencies concerning potential employment in sites from Phillips Arena and Turner Field to Atlanta Motor Speedway and the Georgia Dome
- Provide community service opportunities in accordance with the judicial system
- Conduct annual program evaluation, produce data for members and volunteers
- Implement changes according to results of program evaluation

Youth Against Substance Abuse

Ft. Lauderdale, FL

Active Board of Directors Member

- Supervise grant writing team in submitting grants in accordance with the federal and state guidelines
- Set up community events, corresponding with local media and businesses for sponsorship
- Conduct annual program evaluation, produce data for members and volunteers
- Implement changes according to results of program evaluation

The New Me Inc.

Charlotte, NC

Active Board of Directors Member

- Consult on education significance of outreach program designed in improved quality of living for youths in greater downtown Charlotte area
- Monitor funds acquisition and adult education program development
- Consult with parents and community leaders on various summer education programs
- Conduct annual program evaluation, produce data for members and volunteers
- Implement changes according to results of program evaluation

PROFESSIONAL MEMBERSHIPS

*Western Tidewater Counseling Association

*Virginia Counseling Association

*Virginia Education Association