AFFILIATION FACTORS IN ALCOHOLICS ANONYMOUS

by

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ABSTRACT

The thesis deals with the process of affiliating with Alcoholics Anonymous. By applying the principles of Balance theory an attempt is made to stipulate conditions under which prospective members will or will not join the Fellowship.

ACKNOWLEDGEMENTS

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CHAPTER I

Alcoholism has become a major problem in North America. It is estimated that there are almost 5 million alcoholics[1] in the U.S.A. Whilst it would appear that the problem is not quite so acute in Canada as it is in the U.S.A., its seriousness cannot be denied. There are an estimated 100,000 alcoholics in Ontario, 36,000 in Toronto alone, and 13,000 in the Hamilton region.[2]

Attempts are made to help alcoholics by various agencies, --guidance clinics, physicians, psychiatrists, clergyment. Some areas are fortunate enough, like Ontario, to have such agencies as the Alcohol and Drug Addiction Research Foundation of Ontario. Perhaps however one of the best known of these groups which seek to help alcoholics is the fellowship of Alcoholics Anonymous.

The existence of Alcoholics Anonymous is generally very well known, but few people know the mechanics of how A.A. works, what it does for those who join, or if there are limits to the kind of people A.A. can help. Surprisingly little research has been done in this area, though there are several studies done of a demographic nature. The majority of work that is available concerning the limitations of A.A. has been almost a "solo-effort" by Harrison M. Trice, who has published several studies and articles over the years all concerned with the fellowship and its members. Throughout this paper I shall refer frequently to Trice's work.

Why the concern with the limitations of A.A.? I noticed while at A.D.A.R.F. that many people were referred to A.A., and others came up at Case Conferences, when it was mentioned that they had tried A.A. unsuccessfully. I began to wonder if there were any special reasons for their failure to join, if certain kinds of people, i.e. people in particular sets of circumstances, would be more likely to join than others. And so I began to attend some A.A. group meetings.

Before going on to hypotheses and justification, I would like to present in this opening chapter an introduction to and a description of the A.A. fellowship.

Briefly then I shall try to answer the following questions.

1. How is A.A. organized?
2. How does it get its members?
3. What form does its therapy take?

I also hope to show in answering these questions what A.A.'s view of alcoholism is, which will prove significant later on, and in conclusion, what those who work in the field of alcoholism think of the fellowship.

A.A. came into existence in 1934. The story of its almost accidental foundation is well documented as are the histories of its co-founders Dr. Bob and Bill W.[3] It was in fact based on the idea that one alcoholic by talking to another at a time when the latter wanted very badly to drink, was able

to prevent him from doing so. Since that time, though the fellowship had obviously expanded and the therapy has become more complicated the basic idea has remained the same--a group of alcoholics helping to keep each other sober.

This is the creed of A.A.

> Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions. A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

A.A. is organized into autonomous local groups, i.e. although there is a format for the meetings, and a meeting with one group is very like one with another, at least in content, there is no overall command or bureaucracy. Hence the difficulty of obtaining accurate figures of membership or demographic data except on a local basis. The membership in the U.S.A. is estimated by A.A. to be 300,000.[4] What records are kept, are the concern of each individual branch. In some larger areas, like metropolitan areas or cities, Central Offices have been set up, which are manned day and night to receive calls for help and co-ordinate aid, and to give out information (for instance Hamilton has one which advertises in local papers) but they do not interfere with the running of individual groups.

Groups, of course can vary in size. Thirty to fifty seems to cover the numbers in city groups, I am told by a local group organiser. Larger groups than that begin to suffer the drawbacks of size. Urban groups meet mainly in churches, other groups are set up in hospitals and prisons.

Differences in the composition of the membership of groups have been noted by several observers, i.e. some groups may be classified with ease as predominantly middle class or lower class. This will be discussed in greater detail in Chapter II. A.A. as a whole has the reputation of being a middle-class organization.

Meetings of each group are held on a regular weekly basis. The chair at the meeting is held in rotation by various members of the group who must qualify themselves to be chairmen. This sounds very much more formal than it in fact is. Qualification means that they must declare themselves to be an alcoholic.

At the beginning of the meeting the Twelve Steps are read out followed by the Twelve Traditions. The Serenity Prayer is said.

> Lord, grant me the serenity, to accept the things I cannot change, to change those that I can and the wisdom to know the difference.

Then a guest speaker is introduced usually from another group or another city. He talks about his drinking history, what happened to him because of alcoholism, how he came to A.A. and what has happened to him since. After a speech of

thanks, a voluntary collection is taken and the Lord's Prayer is said. After the official close of the meeting coffee and cookies are served by the women members or, since these are few in number, by the wives of the members.

Where do these members come from? How are they introduced to A.A.? Many are told to try A.A. by other agencies to which they have gone for help. These include alcoholism clinics, like those run by the Addiction Research Foundation of Ontario, psychiatrists who treat alcoholics, clergymen, social work agencies, like family guidance clinics. A surprisingly high number as will be shown in Chapter II, are referred by a friend or relative already in A.A. These are possibly taken to the first meeting by their 'sponsor' as A.A. calls them.

Others come to A.A. also with sponsors, whom they have met as a result of 'Twelfth Step calls'. This occurs when an alcoholic desperate for either a drink or help, calls A.A. (Central Office), or a friend. Two A.A. members are sent out to talk to him. If he wants to, he is encouraged to attend an A.A. meeting and he choses one of the two initial visitors to be his sponsor. This sponsor acts as a guide and a mentor during the first months of contact and after, if necessary. All new members are encouraged to have a sponsor.

Some members do join by walking into a meeting but I suspect these are few in number. In New York City Study

56.5% of the participants were referred by agencies or friends and relatives. Whilst 29.7% were self-referred.[5] Unfortunately this figure does not distinguish those who arrived with a sponsor after a Twelfth Step call from those who walked into a meeting.

What is the kind of therapy that A.A. offers? As I have said earlier, it is essentially treatment of alcoholism by alcoholics, stopping the alcoholic drinking by offering advice, friendship, companionship, encouragement at any time it is wanted, day or night.

An A.A. member will tell you that success in the fellowship depends on the member "getting the program". This consists of the following Twelve Steps:

1. We admitted we were powerless over alcohol --that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being, the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.

> 9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
>
> 10. Continued to take personal inventory and when we were wrong promptly admitted it.
>
> 11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
>
> 12. Having had a spiritual experience as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Thus the member must acknowledge that he is an alcoholic, and alone is helpless, and begin to shoulder some responsibility. Twelfth Step calls are seen as a vital form of reinforcement of the desire to remain sober, as are meetings when the alcoholic can relive the unpleasant details of the past with the speaker.

Also such events have the function of occupying the mind and taking up time. In areas like Hamilton it is possible to attend an A.A. meeting every night of the week all year round.

As I have mentioned, people are recommended to A.A. by several agencies and it would seem that A.A. is held in high regard. Nevertheless some workers and physicians have expressed certain doubts and misgivings over the fellowship and particularly about the views put forward by A.A.

A.A. themselves have said

> It has been our experience that professional people are not too happy reading many of the A.A. publications.[6]

The statements they seem to object to are these like

> Most of us were relieved when it was explained to us that alcoholism was an illness. It was emphasized to us from the beginning that no one but we ourselves could determine whether or not we were alcoholics. The admission had to be sincere and based on our own judgement--not that of a doctor, husband, wife or spiritual advisor.[7]

The latter needs no explanation of why it should cause concern among physicians and social workers. A.A. has also been criticised for its tendency to consider alcoholism as the whole problem and not perhaps, the symptom or result of others. People like Arthur Cain have criticised its refusal to attempt different forms of treatment for alcoholism, and suggests it may in fact prevent some alcoholics from being c cured, by insisting that alcoholism is an incurable disease. "Once an alcoholic always an alcoholic" is A.A.'s idea. This may yet prove to be so but A.A. encourages no attempts to prove otherwise. But perhaps the most potent criticism of A.A. and from my point of view the most valid is that of Dr. E. M. Jellinek that "A.A. has created alcoholism in its own image",[8] i.e. that the fellowship recognizes only one type of alcoholism and thus excludes others, thereby feasibly shutting its doors to many other genuine alcoholics. I will not discuss this in detail now as it will be dealt with in Chapter II.

Finally there are the vague misgivings, difficult to express in writing like those I discussed with a member of A.D.A.R.F. staff. That A.A. replaces alcohol--the member

becomes an A.A. addict--this may be better than suffering the horrors of alcoholism, but is it the only answer?

FOOTNOTES

CHAPTER I

1) 4,712,000 Aspects of Alcoholism. Lippincott & Co. Phila (1963).

2) Figures obtained through A.D.A.R.F.

3) Alcoholics Anonymous - The Big Book

4) A.A. Pamphlet. Birds of a Feather

5) Bailey, M. & Leach, B. Alcoholics Anonymous: Pathway to Recovery. The National Council on Alcoholism, Inc., New York, 1965, p.26.

6) A.D.A.R.F. Pamphlet on A.A.

7) Ibid.

8) Jellinek, E.M. The Disease Concept of Alcoholism. New Haven College and University Press, 1960, p.38.

CHAPTER II

From the preceeding chapter it can be demonstrated that A.A. is held in high esteem by those people who work in the field of alcoholism treatment. Family doctors, psychiatrists, social workers and clergymen all recommend persons with a drinking problem to try A.A. Nevertheless A.A. obviously does not treat all alcoholics, nor even all of these who approach the fellowship with a view to becoming a member. Exactly what percentage of these who approach do not affiliate has not been accurately documented. Hence no figures, other than inspired and not-so-inspired guesses, are available. However, regardless of these number such people are fairly easily found.

> Many problem drinkers cannot voluntarily align themselves with an A.A. group despite the fact that one is available and they are exposed to it.[1]

The problem with which I am concerned is - what, if anything, differentiates those who affiliate from who do not? the possible factors fall into two groups,

a) those involving the individuals themselves;

b) those involving the circumstances in which the individuals find themselves.

It will be my contention that the affiliation is a result of certain combinations of these two groups of factors.

Trice is concerned with what he perceives as "a selectivity that acts to exclude.[2] This selectivity is on the part of the group which can either encourage the prospective member to join by

introducing him to the rest of the members, making him part of the after-meeting cliques over coffee and cookies, and generally being friendly, or they can discourage him by taking little notice of him once they have heard his initial story. They are using the selection process to determine "readiness"[3] to join. (What it meant by readiness and the factors involved in it, will be discussed in detail later, and hence I would like to leave it unexplained for the moment.) This selectivity will be a dual process, since the group's perception of the prospective affiliate will be partially a result of his own attitudes, story and appearance.

This statement can be justified by looking at Fritz Heiders Theory of Structural Balance,[4] or more specifically, by looking at T. M. Newcomb's[5] adaption of Heider.

From Newcomb;[6]

1) Individuals achieve perceptual constancy with regard to persons by attributing stable orientations to them.

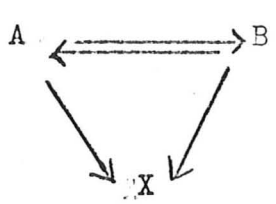
2) Such attributed orientations are governed by principles of balance.

In Newcomb's systems there are two types of relationships

1) attraction - to members

2) attitudes - to non-person objects

Newcomb's system may be drawn like this



This system is positively balanced. Because A & B are attracted to each other and share the same attitude towards X.

But relationships within a system are functions of the perceived orientations of others.

i.e. the way B thinks A perceives X affects B's relationship with A. Thus perceived orientations may not be actual orientations but the individual B will act and indeed even act only on the perception he perceives from A's behaviour and expressions.

How does all this fit in with the affiliation process in an A.A. group? To go back to Newcomb's diagram.

Fig. 1.

This may be used to illustrate the situation of the prospective A.A. member.

If we label him, the prospective member, as A, the A.A. group as B and the goal sobriety as X, the relationship should become clearer. According to Heider and Newcomb, people tend to prefer positively balanced systems, and there is a tendency towards balance in relationships.[7] The above system is positively balanced (Fig.1).

A and B are mutually attracted.

A and B share the same attitude towards X.

Hence I believe that before A takes the step of joining A.A. he should be in the above situation, i.e. be attracted to the group and/or have a strong positive attitude towards X, sobriety.

I use the term and/or, above, for specific reasons, since I believe that either relationship may be the determining factor in joining, depending on the situation of A. This will become clearer in a moment. Heider, refers to a 'tendency towards balance', Newcomb to a 'strain towards symmetry', which results in the balancing of a system either negatively or positively. This occurs in the following situations.

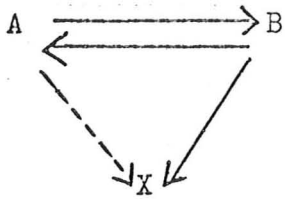


Fig. 2

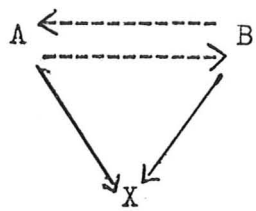


Fig. 3

Actually in the A.A. situation the diagrams would more accurately look like this

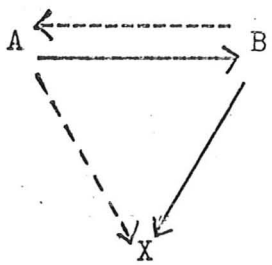


Fig. 4

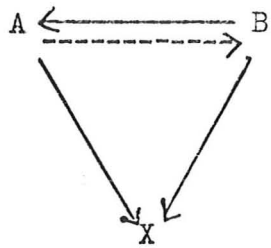
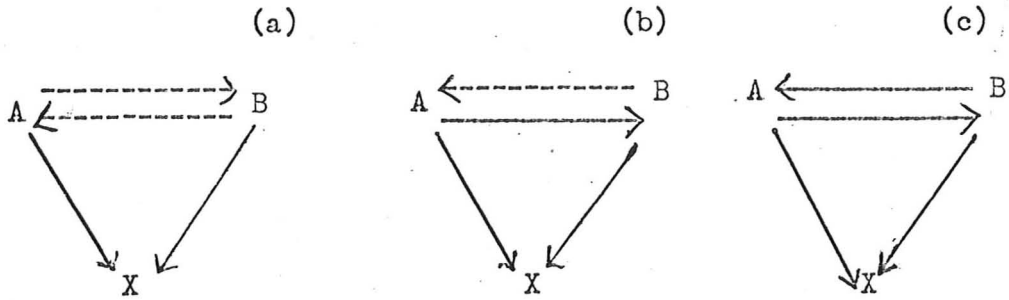


Fig. 5

since the A.A. group B is not very likely to have a positive attitude to a prospective member who does not want to be sober. Indeed it seems unlikely that A would be thinking of joining the group if he did not want to be sober. However, how badly he wants sobriety is a different matter and I believe very significant in affiliation especially in the following situation.



Here even if A does like B and B does not like A for various reasons, if A wants to be sober desperately enough he may overcome the difficulties and join, finding something to attract him in A.A. Fig.(b) and forching B to change his opinion of A. Fig.(c)

I therefore believe that there are two main sets of factors involved in deciding whether or not an individual joins A.A. They will be these factors which influence A's.,

a) attraction to the group

b) attitude to sobriety

We must not forget B's part in all this but in part I think B's attraction to A is affected by similar factors to those that affect A's attraction to B. i.e. B will be influenced by A's background, his attitudes towards sobriety particularly. This is the main way I believe A.A. judges the 'readiness' of a particular member. (See later on Jellinek discussion of the A.A. view of alcoholism).

I think we must accept that B's attitude to X is a positive one, since he or they are members of A.A. (In passing, I feel I should mention that I think Trice's selection process on the part of the members occurs when the relationships are not immediately balanced, e.g. if A does not display an attitude to sobriety sufficiently similar to that of the rest of the members, or is not 'attractive' to the group for other reasons, there will

be little encouragement given to him to join.)

To help pin down the factors involved in the AB, AX relationships I would like to digress for a moment and look at factors which affect group affiliation generally.

Cartwright and Zander[8] state attraction to the group will depend upon two sets of conditions:

a) such properties of the group as its goals, programs, size, type of organization and position in the community, and

b) the needs of the person for affiliation, recognition, security, and other things which can be mediated by groups.

If these sets of conditions are related to the two types of relationships which Newcomb propounds, we can see the types of variables which might be involved in formulating attraction to members and attitude to the goals of the group.

Cartwright and Zander also refer to two major sources of attraction to explain why people join or remain in a group:

a) the group itself is the object of the need;

b) the group is a means for satisfying needs outside the group.[9]

When considering A.A. it is difficult to decide which one of the two foregoing reasons would be the major sources of attraction. I cannot see it being just one.

In the first case people join because they like the people in the group and/or because they are in agreement with the goals and activities of the group. This would obviously be one reason for joining an A.A. group. But membership can also give

benefits outside the group e.g. in relationship with family friends, at work. It may be a source of self-confidence and increased prestige in the community. Hence I believe both factors are involved.

Briefly, other relevant factors promoting attraction and affiliation with a group - factors which can be applied to the A.A. situation include anxiety and severity of initiation. The former was discovered in a study of bomber crews. Schachter[10] studied the effects of experimentally induced states of anxiety on the desire to be with other people. His studies conclude that "a state of anxiety leads to the arousal of affiliative tendencies" ..."it appears theoretically rewarding to formulate this body of findings as a manifestation of needs for anxiety reduction and of the need for self-evaluation; that is ambiguous situations or feelings lead to a desire to be with others as a means of socially evaluating and determining the appropriate and proper reaction."

Here Schachter seems to be entering the field which is popularly known as Reference Group Theory and it is perhaps at this point appropriate to return to my main concern i.e. affiliation with A.A., and the variable and factors which promote this.

Now I would like to discuss the factors which affect A's attraction to B, i.e. the prospective member's attention to the group. These I think will fall into two sections:

a) those concerned with the prospective affiliate's present circumstances;

b) those concerned with his past history.

In the first group are factors such as, loss of other group support, family factors, sex, age, occupation, knowledge of A.A. and members. In the second such factors as previous history of group membership, ethnic, religious and educational background. Dealing with them in turn in the order above.

Loss of group support

Initially here it is necessary to digress once more and return to the subject of reference groups.

Merton discusses two types of reference group:

1) Normative type which sets and maintains standards for the individual.

2) Comparison type which provides a "frame of comparison relative to which the individual evaluates himself and others."[11]

Thus reference groups provide "a frame of reference for self-evaluation and attitude formation - a function which Schachter[12] found important during situations of anxiety. Shibutani[13] has added a third group.

3) Groups to which men aspire.

A man, then, measures himself and formulates his attitudes against the background of the groups to which he belongs, those he uses for comparisons and ones of which he would like to become a member.

To appreciate how important groups and membership in them are to man we have only to look at the many studies in sociological literature e.g. the Hawthorn Experiment,[14] the work of Bales,[15]

Whyte's Street Corner Society,[16] Homans' The Human Group[17] to select only a few of the many.

> From infancy onwards we are members of families, childhood gangs, school and college cliques, clubs and teams - all small groups. When as grownups we get jobs, we still find ourselves working with a few persons and not with the whole firm, association or government department....The group is the commonest as it is the most familiar of social units ...Sociology might have begun here.[18]

Men obtain their norms from the group to which they belong and seek group approval for their actions. To the sociologist these are elementary principles and need no further elaboration.

The influence of the group to which an individual belongs will be important in the first instance in determining whether or not he begins to drink at all. Studies of drinking among teenagers and young people have shown the importance of the group's influence. They begin drinking in order to conform to the group's expectations - to belong.

"Drinking has become so much a part of our culture and society that it is an accepted procedure."[19] It is also well known that "cultural patterns in particular areas have a tremendous effect upon drinking habits. There are cultures where, although drinking is an accepted procedure, excessive drinking or drunkenness is absolutely forbidden" e.g. Orthodox Jews. Whereas in other cultures e.g. France, the level of alcohol in the blood of the French man is considerably higher than in North America, but not all Frenchmen are defined as alcoholics.

This is used only to illustrate the importance of the group

for the definition of alcoholism. Excessive or abnormal drinking is a relative phenomenon. What is accepted as normal among one group may be defined as deviant by another. To join A.A. the individual must admit that he is an alcoholic, that he can no longer control his consumption of alcohol - it has "gotten out of hand"... But referring to the previous statements one person's definition of alcoholism will be different from another's. This does not really matter, since A.A. is concerned with a self-definition of alcoholism. Actually, these self-definitions are not so diverse really. Most of the members of A.A. are probably alcoholics in anyone's terminology. Occasionally one can find on the files of A.A. and treatment agencies such as the Alcoholism and Drug Addiction Research Foundation of Ontario, self-referred cases who drink perhaps only 2 bottles of beer each night without ill-effects but who worry about what they perceive to be compulsive drinking and alcoholism. However these are few and far between.

I perceive that the importance of the group, in the definition of alcoholism and perhaps eventually in affiliation with A.A., lies in the amount and type of drinking it tolerates before defining it as abnormal. Some people may thus be defined as alcoholics and may be made to seek help fairly early in the course of the disease if the group does not as a whole approve of heavy drinking, while others may be financially and physically in a very bad way before they realize something is wrong and seek help. Why is the group so important? Because it is very much more

difficult for an individual to convince himself that his drinking is not abnormal, when he has lost the support and presence of his friends than when he is still a member of his former social network. He can clearly perceive himself as being out of step once he is no longer a member of the group. He knows that he no longer conforms to their expectations. This alone may not be sufficient to make him seek help or, even if he does so, to approach A.A., but it does help him realize that there is a problem there.[20]

The loss of group support may be important in other ways. 'Lone drinking' has long been considered a very grave and obvious sign of alcoholism.[21] This view may not be quite so unfounded or as melodramatic as some people have since thought.

Note also the particular existence mentioned by Schachter[22] of affiliation tendencies in situations surrounded with anxiety. Anxiety may indeed be one reason for the excessive drinking in the first place.[23]

Also, though there is no conclusive evidence that any one type of person is more likely to become an alcoholic than another[24] it does seem that alcoholics do have certain tendencies. Alcohol can be, and frequently is, the means that people use when they can no longer cope with the problems of life.[25] Drinking becomes an escape and lets them avoid having to make decisions - even when these are of the minor type. In fact one of the things that A.A. seems to ignore is that alcoholism is frequently a symptom of some underlying problem although there is some evidence that the Fellowship unwittingly treats these too.[26]

In listening to the psychiatric assessments of alcoholics given during the Case Conferences at the Hamilton branch of A.D.A.R.F. I could not help but notice the numerous occasions on which an alcoholic was described as a "passive-dependent" personality. In the sociological literature a parallel can be found if we look at David Riesman's 'other-directed man'.[27] He is a man incapable of thinking or making decisions for himself. He takes all his cues for behaviour from others and reacts like a puppet. The alcoholic seems to fit the first part of this description but not the last - for his 'others' have become alcohol.

Nevertheless, like all men, the alcoholic needs group support - perhaps to such a dependent person group support is even more important and thus the loss of such support will be a tremendous blow to him. Joining A.A. would make him once more the member of a group. This is what I mean by saying that membership in A.A. is the result of particular sets of circumstances. An alcoholic who has lost group support is more likely to define himself as alcoholic and is potentially an A.A. affiliate, or a potential affiliate with some other group of that type - if and only if other factors also are found. But I believe other factors must also be present.

Having just discussed loss of group membership, it seems logical here to discuss past group membership; even though I have placed it in the second group of factors.

Past Group Membership

This is not really one variable but has several factors

associated with it. Some of these are not strictly sociological but are concerned with the personality characteristics of the prospective affiliate. Thus one would expect to find it easier for a person who enjoys being a part of a group, who is used to associating with voluntary groups and is generally a more outgoing person to associate with the new group.

One of the methods which Trice used to cover this rather indefinite subject was to ask his respondents to agree or disagree with the following statement:

Before I went to any A.A.meetings at all, I often shared my troubles with others.[28]

He found that 73.6% of those who agreed with this statement were affiliates compared with 30.7% of affiliates who disagreed. He also found that just over half 51.9% had had experience as voluntary group members before joining A.A. This percentage may not be as high as I would expect to find because Trice specified the groups as fraternal orders and excluded other groups.[29]

I would expect the joiners to be emotionally outgoing, easy to associate with and to like being with other people. The problem is of course to find questions and measurements for these rather vague variables.

This collection of variables and others might be labelled - like Schachter's 'affiliative tendencies'. Another variable in this group might be the power of verbalization. This variable was suggested to me by Dr. Wolfgang Schwartz of A.D.A.R.F. Toronto, based on his own observations and work with A.A. groups. He

suggested that A.A. members might score higher than non-affiliates on verbal tests and have greater powers of articulation even before joining. Certainly verbal capacity plays an important part if one is to become an active member of the fellowship, since standing up and telling one's story is a vital part of the A.A. therapy.

Family

This is really associated with the first major variable, that of loss of group support. Does his family encourage or discourage him from going to A.A.? One would expect affiliation to be easier with the support of wife and family. Wives and husbands can attend A.A. meetings with the alcoholic and are in fact encouraged to do so. Affiliation may also be more likely if the spouse is absent altogether, than if he or she disapproves of, and provides no encouragement for the alcoholic to try and persevere in A.A. The wife can be harmful in such a situation for she may be competing with A.A. for her husband and her husband's time. Time is one reason why family encouragement is necessary since initially new members are encouraged to attend A.A. meetings as frequently as possible, and in cities, there is a meeting every night. For example, a Hamilton female member with whom I was associated had been sober in A.A. for six months when I met her. During that time she had missed only 3 nights at a meeting in the whole of that time including Sundays - and she had missed those three nights through illness! Thus lack of competition from the

family and other groups or individuals is probably initially very important and I expect to find that members of A.A. did not have family competition when they joined, i.e. the families may not have been very happy but they did not actively oppose affiliation.

Sex

Sex itself may be a factor affecting affiliation, or rather influencing other variables promoting or inhibiting affiliation. In New York the ratio of women to men was 1:2.2[30] Looking at Hamilton this would seem fairly high. I have no figures for Hamilton but in the groups which I attended men very obviously outnumbered women by a much higher ratio. This is true of recorded female alcoholics in general. Women alcoholics seem to be in worse condition generally than their male counterparts when they seek help. This may be for two reasons:

a) alcoholism is more of a stigma in a woman and hence to be concealed.

b) women have more opportunities of concealing their alcoholism even from their husbands, e.g. they can drink at home while husband and children are out, they have more opportunity to conceal liquor and less likelihood of it being found. (They do the housework)

Thus when it does become known, it is discovered and recognized later than it might be in a man. Also when recognized action may not be taken until a long while after for the first reason mentioned.

Thus I would expect women members to be older than the men generally at time of affiliation and to have drinking histories qualitatively worse, i.e. to be in the later stages of the disease.

Age

Trice in his study does not look at demographic variables such as this but I believe these types of variables can be not only interesting but indeed significant. The New York City Study reported 65.4% of its male respondents, and 67.4% of its female respondents over 40 years of age. 11.9% of the men and 7.5% of the women did not report their age. Only 4.1% of the men and 5.4% of the women were under thirty.[31] It would therefore seem that one can expect to find few young people within the A.A. fellowship. This is hardly a startling fact and could have several explanations.

In the first place, if, as it seems likely, A.A. members are mainly Gamma alcoholics, this is the progressive type of alcoholism known as a disease and it may take some time to develop to the point where disillusionment occurs, the 'bottom' is hit and people are 'ready' for A.A. If one couples this with the fact that often there is a period of social drinking before onset of alcoholism (average of 8.8 years in New York City Study)[32] it is not unreasonable that a number of years should elapse before A.A. needs to be contacted. There is also no reason to believe that those who later become alcoholics begin drinking any earlier than drinkers who experience no difficulties. None of the studies show this. The New York Study fixed the average age of the first

drink of its participants at 17.6 for males, 18.6 for females aged under 18 in 1933.[33] This is an attempt to counteract the effect of Prohibition, which may have prevented earlier drinking among those over 18 in 1933 - their average age of the first drink was 19.1 years for males and 19.7 for females.[34]

There is also, from this study evidence of a gap between the self-diagnosis of alcoholism and affiliation with A.A. This gap in fact is of quite considerable duration. 66.7 per cent of the New York City respondents reported over ten years elapsing between the onset of alcoholism and first attendance at A.A.[35]

In addition to this, considering some of the factors discussed previously, young people may be less likely to affiliate for other reasons, particularly because of competition from other groups. Their drinking patterns may fit in with the groups to which they belong e.g. college groups, university residence cliques, work gangs, etc. where indeed heavy drinking may confer prestige and be part of expected group behaviour. There may be less likelihood to diagnose alcoholism because of the individual's youth - dismissing it as a phase which everyone goes through and which will pass - the "it's just his age" syndrome.

A.A. will suffer competition from all the social voluntary groups which offer membership to the young and also from the norms of this society which define drinking as normal

and excessive drinking in youth as transitory.

Thus there is no reason to expect A.A. members to be predominately young and some justification to expect them to be reasonably old i.e. over 40.

Occupation

This is one of a cluster of variables which I believe to be associated with my first major variable, the loss of group support.

Occupation can be important for determining style of life and the kind of people one associates with socially. It is a strong determinant of class. Is drinking and certain styles of drinking more accepted by certain social and occupational groups than others? For example, what styles and amounts of drinking can be expected from an advertising executive a steelworker, and a Baptist minister? I have discussed earlier the influence and importance of the group in the diagnosis of abnormal drinking and the possible effects of withdrawal of group support on the likelihood of affiliation with A.A. so I do not think it necessary to reiterate them here. Occupation will be, I believe, one of the component parts of this group assessment, along with the following two variables - ethnicity and religiosity.

But before going on to these, it is first necessary to consider another possible aspect of the importance of occupation, particularly in its role as an indicator of class.

It could be that a certain class may be attracted to A.A. and to the type of therapy that A.A. provides. I have no real evidence for saying this, except the general notion that A.A. is a middle class organization. I do not know if this can even be substantiated. It may be however that these people find it easier to verbalize and will be attracted to that type of therapy. Or it could simply be that the members are already middle class and new affiliates join because the members are like themselves. Lofland[36] testing this class variable, with predominately working class and predominately middle class groups found that they did not discourage affiliates of different class, rather they actively encouraged them - working class groups liked middle class members because they conferred prestige on the group and middle class welcomed lower class members because they felt they would not otherwise be living up to A.A. traditions.

I would however like to see if there are any occupational 'clusters' among A.A. members. Closely associated with this variable is education. 24.8% were college graduates in the New York City Study.[37]

Ethnicity

This is another of the variables significant in formulating group assessment and the alcoholic's assessment of himself, in the same way that occupational groups are. Thus it seems likely that a Jew will become more worried about excessive drinking earlier than perhaps an Irishman because of the

difference in each ethnic group's view of drinking. However this alone may not be sufficient to bring about an approach and affiliation with A.A. In the case of the Jew, religion may preclude affiliation with the fellowship. But certain ethnic groups, e.g. staunch Methodists, may withdraw support earlier than others - before in the eyes of A.A. the alcoholic is 'ready' i.e. especially here with reference to the second variable suffering. Where group support is withdrawn earlier the alcoholic may not run the full downward course of the disease and hence may not be an attractive prospect to A.A. Where, however drinking is tolerated, by the time the group withdraws support, the alcoholic may be in a later stage and this loss of support may thus become the precipitating factor in the affiliation process, since the alcoholic's history will be 'right' for A.A. - he has probably been disillusioned by the rejection of the group.

Religiosity

This factor may work similarly to the two above i.e. different religions take different views of drinking and will differ in the stage at which they define drinking as abnormal - for some any alcoholic beverage consumption may be abnormal.

There is however another facet to the significance of religion. Because of the nature of the A.A. fellowship I believe it is more likely that those who have a fairly strong religious belief and background will affiliate rather than

those who do not. Robert Bales has looked at some of the similarities between A.A. and a religious sect[38] and an even greater comparison can be made using Troelsch's church/sect typology.

Also to get the A.A. program one must come to believe in 'a power greater than ourselves'.[39] A.A. stages that this power can be anything one interprets it to be. It is not necessarily God, however the religious aspects, e.g. the reliance on the Book,[40] the Twelve Steps and the Twelve Traditions, the Serenity Prayer, the fact that the Lord's Prayer is said at the conclusion of the meetings might make affiliation more difficult for an atheist or an agnostic, unless he is really determined to enter and remain in the Fellowship. In Trice's study, 58.3% of affiliates said they accepted the spiritual ideas of A.A. but 40.4 per cent said they had not.[41] From supplementary data however, not published, Trice established that affiliates were more regular church goers than non-affiliates in childhood and in the five years prior to A.A. attendance.[42]

I would also expect to find indications of this, and at least a belief in the Christian God.

Introduction to A.A. Previous knowledge of A.A.

I shall consider these two variables together since they are closely associated.

Over half of Trice's participants, 51.9 percent, had

two friends in A.A. and 51.1 percent had a relative who had attained sobriety through A.A. In addition to this 60.9 had heard favourable reports of A.A.[43] The previous figures are extremely high. In relation to my hypotheses, it would seem likely that the presence of a friend or relative, already in the fellowship, will be one of the factors which will increase the attraction of the group for the new member. It is obviously easier to affiliate with a group when one knows someone in it, than it is to walk in and join one when one knows no other member. It can also facilitate matters if one is taken to the meeting, i.e. accompanied by a sponsor whose duty it is to look after the new member. Hence I would expect a high percentage of members to have been introduced to A.A. by a friend or through a sponsor, those who do not affiliate are more likely to have gone alone.

On this point evidence from the New York Study is not a great deal of help. Though 38% were introduced by a friend or a family member, the survey has the figure of 29.7 self-referred.[44] The writers however do not state in which way they were self-referred. Referring back to Chapter I - sponsored are self-referred - they call A.A. for help, the person who goes to help them then becomes their sponsor but so are those who walk into a meeting. The New York City researchers did not ask about sponsorship.

With regard to previous knowledge of A.A., though favourable hearsay evidence is advantageous, Trice suggests

that having heard nothing unfavourable is important in promoting affiliation,[45] i.e. those who do not affiliate have heard unfavourable reports about A.A. whilst those who do affiliate may have heard favourable reports or nothing about A.A. but are not likely to have heard anything unfavourable.

Some of the foregoing variables may also be associated with the attitude to sobriety, e.g. occupation, family factors, etc. The ways in which they may play a part will be seen from the following discussion of the major factor here - suffering through alcoholism.

Suffering through alcoholism

This, is one of those other factors needed in combination with those above. Suppose a man belongs to a particular church group which condemns his fairly excessive drinking and ostracizes him, but this does not interfere with his position as a business executive or unduly with his family life, nor does it damage greatly his standing in the community. In such a situation the man is hardly likely to seek help or to have a vested interest, at that time at least, in giving up drinking. He has not yet "hit bottom". 'Hitting bottom' means being disillusioned and losing hope. Maxwell[46] reports that when he asked what had happened to some members before joining A.A. he received the following replies. "Complete feeling of being 'licked'. Dejected and remorseful. Down and Out".

"The feeling I was just in a sort of whirl-pool which was slowly taking me beyond hope"

"A beaten hopeless person, my back to the wall."

"At the end of the rope."

Others mentioned some "jolting event which gave a disillusioning crisis definition to their use of alcohol."[47]

These events included, loss of job, wife or husband, arrest or accident while drunk and being turned down for a life insurance application. In all out of 150 interviewed 88[48] per cent mentioned one of the above as happening prior to their joining A.A.

In a study of 1058 A.A. members in New York City the question was asked "Did any special event or state of affairs cause you to go to A.A. for help?" The choices were very similar to the factors mentioned above and 62.3% of the respondents mentioned one of them as a precipitating factor in their application with the fellowship.[49]

Of Trice's respondents, though he did not ask any questions specifically about this sort of situation 56.3% of them had "decided they were licked."[50]

This idea of the necessity for suffering in order to join and achieve success in A.A. may be tied in with a psychiatric assessment of the therapy provided by A.A. put forward by Tiebaut.[51]

Tiebout says the alcoholic must 1) hit bottom before he can be helped; 2) must develop and maintain humility. He must be in despair before he genuinely wants to be helped. (This sounds like a very A.A. - like statement - those who do

not succeed are considered to have not 'really wanted help' - i.e. they weren't really ready). Humility must be maintained so that the newly sober alcoholic will not become over confident and lapse. Tiebout divides the therapy into two parts:

a) Surrender

b) Ego-reduction

Surrender is the recognition that his drinking is out of control and that he cannot 'go it alone'. Therefore he puts himself entirely in the hands of A.A.

His ego is reduced because he has no confidence in himself any longer. The past is a source of pain to him. He needs to be free from all traces of his former self. A.A. takes him over. His old norms are replaced with those of A.A. Once more we can see the importance of the loss of previous group support. The alcoholic obviously cannot reach such a state unless he has in some way suffered.

A.A. talks about high and low bottoms, i.e. some individuals may become disillusioned quite early in the course of the disease and be ready to surrender; while others may go on for years. Again the reasons for this may be partially found in the environment and social background of the alcoholics, depending on the group view of drinking and alcoholism.

This concept of the A.A. member being an alcoholic who has suffered would fit in with the type of alcoholism which

predominates among A.A. members, using the Jellinek Classification;[52] this is Gamma alcoholism which also happens to be the predominate form of alcoholism on the North American continent.[53] Jellinek says this is the only type of alcoholism that A.A. recognizes.

> It is what members of Alcoholics Anonymous recognize as alcoholism to the exclusion of all other species....Alcoholics Anonymous have naturally created the picture of alcoholism in their own image.[54]

Thus it would seem that only people with the characteristics of Gamma alcoholism would be perceived by the members as 'ready' or as likely members or indeed as alcoholics at all. Jellinek points out also that persons with other types of alcoholism are probably less likely to approach A.A. in the first place.[55] In fact he says some members of A.A. are not Gamma alcoholics but are in fact Alpha alcoholics, i.e. they do not lose control. 13% out of his sample of 2000 were Alphas but these "conform in their language to the A.A.standards",[56] i.e. they have painted a picture of their alcoholism as being of the Gamma species.

The characteristics of Gamma alcoholism are as follows:

1. acquired increased tissue tolerance to alcohol;
2. adaptive cell metabolism (signs of physical addiction which cause Jellinek to label this and two other types of alcoholism a disease;
3. withdrawal symptoms and "chewing" i.e. physical dependence, and
4. loss of control

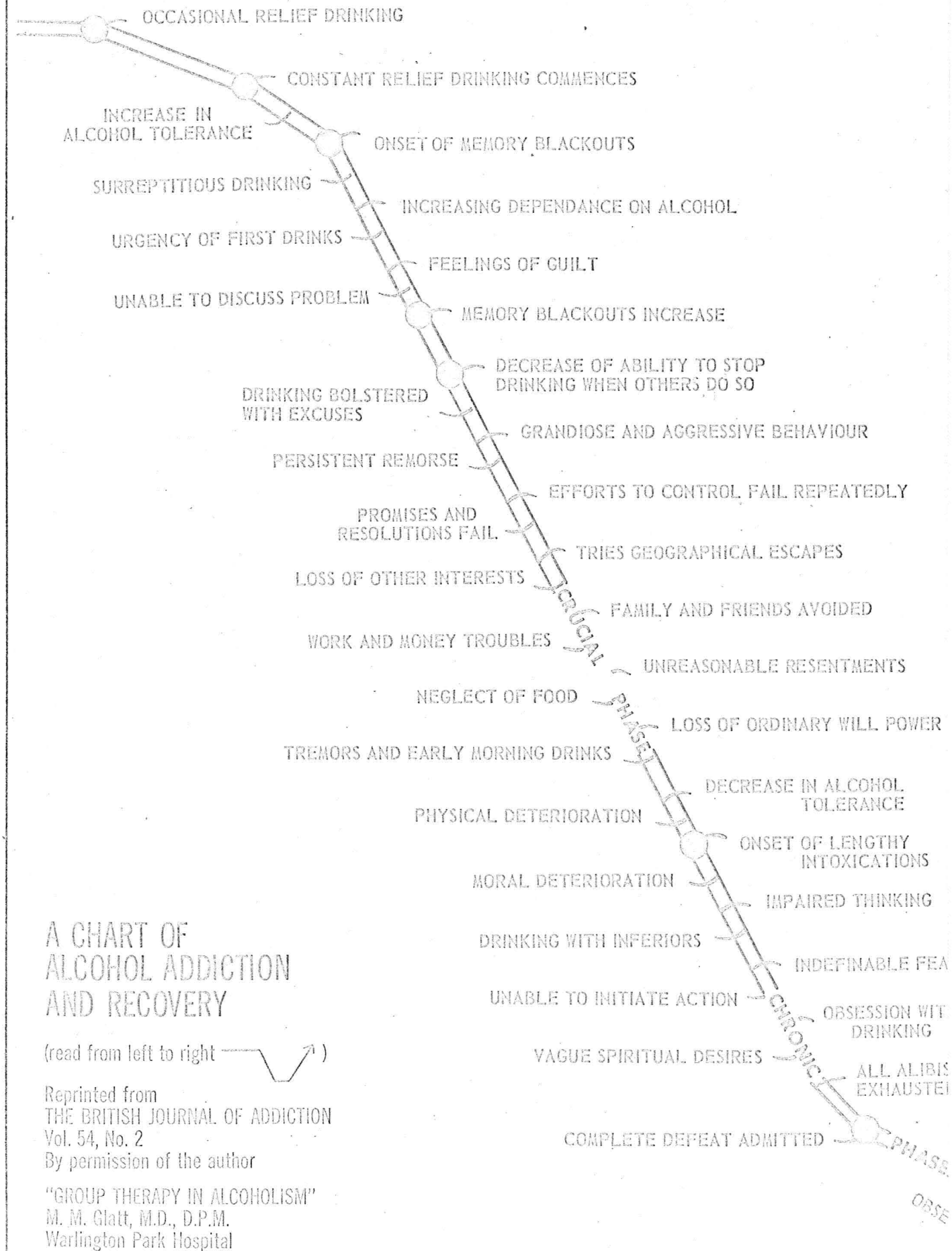
also it is characterized by "marked behavioural changes".

> This species produces the greatest and most serious kinds of damage. The loss of control, of course impairs inter-personal relations to the highest degree. The damage to health in general and to financial and social standing are also more prominent than in other species of alcoholism.[57]

Thus this is the species of alcoholism which disrupts life the most and does the most serious damage without complete physical breakdown of Beta alcoholism. And it is this type that A.A. means when it refers to alcoholism. Hence we can expect the people who approach and join to have undergone some of the experiences associated with the'progressive disease' concept of Gamma alcoholism, in order to be attracted to and to be encouraged by the members who are also mainly Gamma alcoholics. They are more likely to perceive the members as more like them, and having had a similar history, be encouraged by the fact that "if they did it, so can I".

To see the typical progression and drinking history of a Gamma alcoholic see the chart by M.N. Glatt included and his article.[58]

I must however point out that this concept of suffering is relative not absolute, associated with A.A.'s idea of 'high' and 'low' bottoms. It is a very individual thing. Some may reach their breaking point much earlier than others, or some sudden single crisis may be the last straw rather than a long



A CHART OF ALCOHOL ADDICTION AND RECOVERY

(read from left to right ↗)

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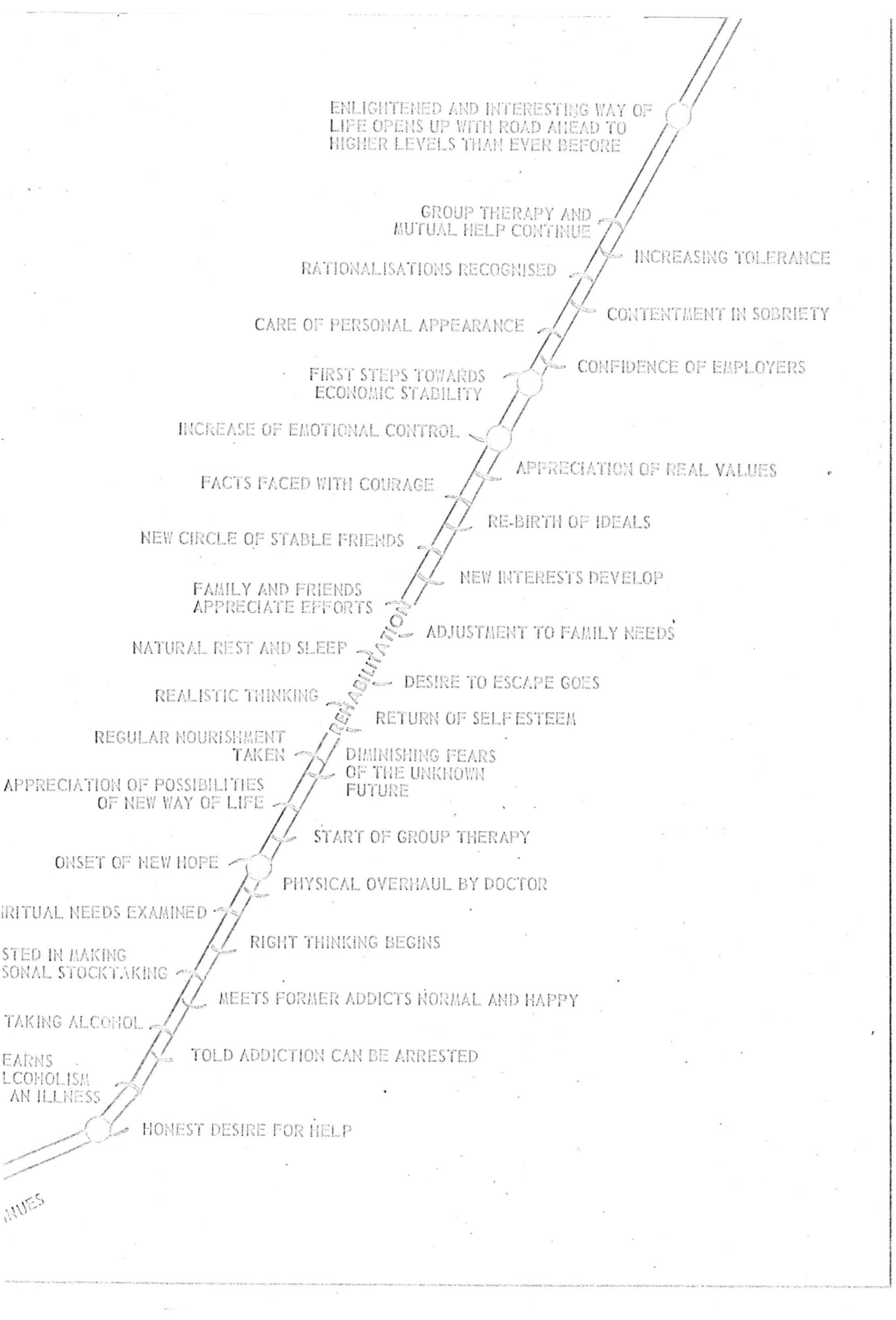
"GROUP THERAPY IN ALCOHOLISM"
M. M. Glatt, M.D., D.P.M.
Warlington Park Hospital


ENLIGHTENED AND INTERESTING WAY OF LIFE OPENS UP WITH ROAD AHEAD TO HIGHER LEVELS THAN EVER BEFORE
GROUP THERAPY AND MUTUAL HELP CONTINUE
INCREASING TOLERANCE
RATIONALISATIONS RECOGNISED
CONTENTMENT IN SOBRIETY
CARE OF PERSONAL APPEARANCE
CONFIDENCE OF EMPLOYERS
FIRST STEPS TOWARDS ECONOMIC STABILITY
INCREASE OF EMOTIONAL CONTROL
APPRECIATION OF REAL VALUES
FACTS FACED WITH COURAGE
RE-BIRTH OF IDEALS
NEW CIRCLE OF STABLE FRIENDS
NEW INTERESTS DEVELOP
FAMILY AND FRIENDS APPRECIATE EFFORTS
REHABILITATION
ADJUSTMENT TO FAMILY NEEDS
NATURAL REST AND SLEEP
DESIRE TO ESCAPE GOES
REALISTIC THINKING
RETURN OF SELF ESTEEM
REGULAR NOURISHMENT TAKEN
DIMINISHING FEARS OF THE UNKNOWN FUTURE
APPRECIATION OF POSSIBILITIES OF NEW WAY OF LIFE
START OF GROUP THERAPY
ONSET OF NEW HOPE
PHYSICAL OVERHAUL BY DOCTOR
IRITUAL NEEDS EXAMINED
RIGHT THINKING BEGINS
STED IN MAKING SONAL STOCKTAKING
MEETS FORMER ADDICTS NORMAL AND HAPPY
TAKING ALCOHOL
TOLD ADDICTION CAN BE ARRESTED
EARNS LCOHOLISM AN ILLNESS
HONEST DESIRE FOR HELP
NUES

series of disasters. I am not trying to show, nor do I expect to find that all those who join A.A. have experienced a similar progression from bad to worse, but that they themselves can point to the crisis or say "That's when I gave up and knew I was beaten."

Maxwell[59] points out that A.A. claims to now be getting more members in the early and middle stages of alcoholism than they did previously. However I do expect that the majority will still have lost a great deal and been in a very dire position physically and mentally before joining A.A.

Again I do not think the factor of suffering alone will prove sufficient to persuade an alcoholic to join A.A. otherwise why are there not more 'Skid Row' types of alcoholics in A.A.? In the New York City Study the members were found to be middle to upper middle in class, only 7.3% of the men and 2.2% of the women were unskilled. 44.8% of each sex were in the professional or managerial category.[60] Though these figures may not be completely typical of A.A. there is no reason to suppose that the general A.A.membership is grossly different from this and indeed the overall impression is that A.A. is extremely middle-class in composition - though actual groups vary considerably and seem to be formed predominately by one class.

Skid Row types seem rarely to be found in the fellowship. May be then other factors are lacking. For example, my

first major variable may play a part here. Drinking is an accepted part of the Skid Row culture, it is not perceived as abnormal. The down and out may still have strong group contracts with others on Skid Row but nevertheless forming a group. Or he may be where he is because he dislikes associating with others, i.e. there is an element of under-socialization involved here and he has always lacked affiliative tendencies.[61]

Thus a person who has been ostracised by his social group for heavy drinking, has lost his job, and is having financial and marital difficulties because of his alcoholism, and who has also belonged to other voluntary associations e.g. Elks, Masons, Kiwanis, etc. in the past is extremely likely to join Alcoholics Anonymous. I therefore expect that these characteristics will apply to A.A. members, i.e. they will display the variables discussed above.

These then are the hypotheses I would hope to test and the variables which I believe will prove significant. They were considered because I believe that these are the variables which are significant in the process of affiliation with A.A. not necessarily with success afterwards, though it seems that a high proportion of those who affiliate do succeed in becoming sober. Thus some data relating to the past drinking habits of alcoholics, previous treatments has been omitted.

In summary I expect to find that those who affiliate with A.A. will have

a) lost support of social groups - drinking friends, etc.

b) have suffered through alcoholism, i.e. lost work, health, prestige, etc.

c) have more affiliative tendencies than non-affiliates, e.g. emotionally outgoing, belonged to other groups in the past.

d) will be older, i.e. over 40.

e) will have attended church, taken a more active part in religious organizations frequently in the past.

f) will have been introduced by friend or relative already in A.A. or sponsored.

g) will have heard nothing unfavourable about A.A.

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CHAPTER III

The procedures used to implement the foregoing proposal for research will be, of course, limited by the amount of time and money available, as well as by considerations for using the best available techniques. It is for the former reason that I am in fact submitting two alternative methodologies. The first of these is ideally what I would like to do, the second, what I would probably have to do because, chiefly of lack of time. The proposals differ in the method of data collection. Ideally I would like to obtain the information which I require in an interview but because of the number of interviews necessary to make results relevant, I believe this method will prove impractical, at least in my situation. Hence I also submit an outline of a questionnaire which would have to substitute for the interview.

To deal first of all with the project if it were to be done by an interview I estimate that I would need about three hundred people in all to make any significant comparisons. This amount will be necessary in order to insure that the results found, are not namely the result of chance, when drawing the sample from the population.

This means in fact a minimum of 150 persons in each of two groups.

a) those who are members of A.A.

b) those who have tried A.A. but who have not affiliated with the fellowship.

This number is necessary in order to provide an adequate sample for certain questions particularly those concerned with ethnicity and religiosity. The tables for analyzing these questions will have up to 21 possible categories. To interview three hundred people, with even a fairly concise schedule, would take up a great deal of time, if done by one person, and the costs of paying assistants may prohibit their use. The size of the group needed to be interviewed is the main factor which might prohibit the interview.

The major reasons why I would prefer an interview to a questionnaire are four given by Selltiz, et al.[1] In summary these are, likelihood of greater co-operation, greater flexibility, it can lead to better support with the respondent and greater probing with emotionally laden subject.

I will be dealing with people who have several serious problems. In fact, the A.A. group itself may not be the main source of difficulty, provided they are convinced that their anonymity has been safeguarded. I anticipate that they will not be shy of telling me their histories, since they have had practice in A.A. meetings. Instead, I expect the major difficulties with the group of non-affiliates. I hope that these fears may prove to be unfounded or exaggerated, but this group may have even more difficulties than the A.A. group and may be less willing to co-operate. This is a further reason for using the interview. I feel it would be easier to overcome their doubts in an

interview, rather than with a mailed questionnaire, and hence the response should be higher.

The questionsto be asked are not very personal or probing but in most cases can be answered with a factual answer (see questionnaire). but I feel that because the people with whom I will be dealing are alcoholics, rapport would be useful in eliciting truthful responses, and this can only be done by winning their confidence. The interview schedule would be very similar to the proposed questionnaire (see Appendix).

The sample of the first group will be taken from a list of all Hamilton A.A. group members. Compiling this list will involve co-operation from individual group organizers since each group is autonomous. They will be interviewed after their A.A. meeting or if they preferred, by appointment elsewhere. One of the local organizers, Jim M. offered his store as an office and rendezvous for this purpose, in the hope that it would encourage members to take part.

There are two feasible sampling sources for the second group. Again one is ideal, the other is what I am prepared to work with if necessary. Ideally then, I would like to obtain names and addresses of all those new people who attend an A.A. meeting but do not come back more than twice. A.A.'s co-operation would be necessary in this, of course. When there were a sufficient number assembled, to make sampling practical, I would then approach 150 of these.

This may be a difficult and lengthy process. I do not know the rate at which new people approach A.A. or how many join and do not join.

If this proves impractical the sample could be drawn from the files of the Dundurn Clinic. However this may introduce some undesirable factors. I want, for validity's sake to compare affiliates and non-affiliates who are as similar as possible in other aspects, e.g. by controlling for factors like class. Using the Dundurn sample may point to differences between people who prefer a medical to a non-medical approach, rather than to the differences contained in my hypotheses.

If interviewing proves too expensive and time-consuming then the study could be done in questionnaire form, using the same samples described above, but with an increase in group size partially to allow for an anticipated higher rate of non-returns with a questionnaire, but also to, hopefully, increase the significance of the reulsts,because the number mentioned with regard to the interview, is the bare minimum and the use of a questionnaire would allow for a larger sample, since time and money are not factors in this case. For the sake of simplicity and standardization of response, the questions will be pre-coded rather than open-ended.

To prevent spurious correlations in both methods, interview and question with other group membership, it will be necessary to control for social class.

Finally a word about the questionnaires. Wherever possible,

I have kept the questions the same on both, with the necessary adjustment for each group.

After the first few questions which are demographic, 6 - 12 on the Questionnaire (Q.I) are concerned with factors affecting attraction to the group, as are 15, and 16. The corresponding numbers on the non-A.A. questionnaire (Q.II) are 6 - 11 and 14 and 15.

13 and 14 on Q.I, 12 and 13 on Q.II, are concerned with the respondent's attitude to sobriety; 17 to 26 (10 - 23 on Q.II) relate to previous and current group memberships. The next four questions deal with the religious background and beliefs of members and non-members, in the expectation that this is a significant factor in forming both the attitude to sobriety and the attraction of the group. Reasons for this are given in Chapter II.

The remaining few questions again refer to the attraction to the group.

NOTES

1) Selltiz, Jahoda, Deutsch and Cook. Research Methods in Social Relations . (New York: Holt, 1966) pp.241-243.

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APPENDIX

QUESTIONNAIRE I. A.A. SAMPLE

1) Sex

2) Age

3) Marital Status

   Single

   Married

   Widowed or Divorced

4) Number of children

5) Which A.A. group do you belong to? e.g. Midtown, Sanford, etc.,

6) How old were you when you first started to drink alcohol?

7) Age at which you first sought help for alcoholism?

8) How long have you been a member of A.A.?

9) How were you referred to A.A.?

   a) Social work agency

   b) Psychiatrist

   c) Other physician

   d) Clergyman

   e) Relative

   f) Friend

   g) Self-referred - Twelfth Step Call

   h) Self-referred - Walked into meeting

10) Did you go to your first meeting with a sponsor?

11) Did you already have a relative or friend in A.A.?

a) Relative

b) Friend

c) None

12) Before you approached A.A., was what you had heard about it, on the whole

a) favourable

b) unfavourable

c) had heard nothing

13) Did any particular event cause you to go to A.A.?

a) loss of jobs

b) separation from wife

c) financial crisis

d) involvement with law

e) illness

f) emotional crisis

g) other - specify

14) Have you, because of your drinking habits, lost?

a) work

b) family

c) friend(s)

d) money

Indicate as many as apply

15) What is your occupation?

16) What education have you had?

a) elementary

b) some high school

c) high school graduation

d) some above high school

e) college graduate

17) Did you drink mainly with a group?

18) Did you engage in other social activities, e.g. golf, bowling, etc., with the same group that you drank with?

19) Were you still a member of such groups at the time you joined A.A.?

20) Do you still associate with them?

21) Have you ever belonged to clubs, associations, fraternities, etc., such as Masons, Kiwanis?

22) If so, did you play an active part in the group?

23) Do you enjoy taking part in group activities?

24) Are you an active member of A.A.? i.e., do you speak at meetings, go on Twelfth Step Calls?

25) Do you still belong to other social groups?

26) Would you say that the following statement applied to you?

"Before joining A.A., I often shared my trouble with others."

27) What is your religious preference?

a) Protestant
b) Catholic
c) Jewish
d) Other
e) None

28) Are you an active church-goer?

a) regular - every week
b) once a month
c) 3 or 4 times a year
d) rarely at all
e) never

29) Did you attend church regularly in your youth?

30) Did you find the spiritual part of the A.A. program easy to accept?

31) What is your ethnic background?

a) English
b) French
c) Irish
d) Italian and South European
e) German or East European
f) Other

32) Had you approached any other agency or person for help with alcoholism before A.A.?

a) Social Work Agency
b) Psychiatrist
c) Other Physician
d) Clergyman
e) Other
f) None

33) If so, did you feel that their treatment helped you?

34) If you are married, does your wife/husband approve of A.A. and encourage you to go?

35) Does he or she take part in any A.A. activities?

QUESTIONNAIRE II - NON-A.A.SAMPLE

1) Sex

2) Age

3) Marital Status

4) Number of children, if any

5) How old were you when you first started to drink alcohol?

6) Age at which you first sought help for alcoholism?

7) How old were you when you first tried A.A.?

8) How were you referred to A.A.?
   a) Social work agency
   b) Psychiatrist
   c) Other physician
   d) Clergyman
   e) Relative
   f) Friend
   g) Self-referred - Twelfth Step Call
   h) Self-referred - Walked into meeting

9) Did you go to your first meeting with a sponsor?

10) Did you already have a relative or friend in A.A.?

Relative Friend Neither

11) Before you approached A.A. was what you had heard about it?

Favourable Unfavourable Had heard nothing

12) Did any particular event cause you to go to A.A.?

a) loss of job
b) separation from wife
c) financial crisis
d) involvement with law
e) illness
f) emotional crisis
g) other - specify

13) Have you because of your drinking habits lost?

a) work
b) family
c) friend(s)
d) money

Indicate as many as apply

14) What is your occupation?

15) What education have you had?

a) elementary
b) some high school
c) high school graduation
d) some above high school
e) college graduate

16) Did you drink mainly with a group?

17) Did you engage in other social activities with the same group that you drank with?

18) Were you still a member of such groups at the time you tried A.A.?

19) Do you still associate with them?

20) Have you ever belonged to clubs, associations, fraternities, etc., such as Masons, Kiwanis?

21) If so, did you play an active part in the group, e.g., on committees, help with activities?

22) Do you enjoy taking part in group activities?

23) Do you still belong to such groups?

24) Would you say the following statement applies to you?
"I often share my troubles with others."

25) What is your religious preference?

a) Protestant

b) Catholic

c) Jew

d) Other

e) None

26) Are you an active church-goes?

a) regular - every week

b) once a month

c) 3 or 4 times a year

d) rarely at all

e) never

27) Did you attend church regularly in your youth?

28) Do you think you could have come to accept the spiritual part of the A.A.Program?

29) What is your ethnic background?

a) English

b) French

c) Irish

d) Italian and South European

e) German or East European

f) Other

30) Had you before trying A.A. approached any other person of agency for help with alcoholism?

31) If so, did you feel that their treatment helped you?