British Journal of Addiction, Vol. 75, 65-71, 1980

A.A. Ideology among Alcohol Treatment Directors

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Summary
Mail-return questionnaires were used to test the hypothesis that Alcohol Treatment Center (ATC) directors who scored high on A.A. ideology would evaluate A.A. more favourably, would recommend that a broader range of problem-drinker types affiliate with A.A., and would come from institutions which afford more A.A. activities. Analysis of the data confirmed all aspects of this hypothesis. Implications are suggested.

Alcohol Treatment Centers (ATCs) offer a wide range of treatment services for the alcoholic patient. At a broad level, these services can be classified into diagnosis, referral, and treatment. The types of treatments found in these settings include such things as individual psychotherapy, group therapy, family counselling, behavior modification, and chemotherapy. One of the most common types of treatment services offered by these facilities is the activities of Alcoholics Anonymous.* In 1978 A.A. claimed an estimated membership of about 1,000,000 worldwide in 30,000 groups. Of this, about 670,000 members were in the U.S. in 20,000 groups, including 1,400 groups in hospitals and 1,250 in correctional institutions (2).

The ubiquity of A.A. activities in ATCs has also been confirmed by other research (3). This latter study discovered that 96 per cent of all ATCs surveyed reported the use of some type of A.A. activity. The kinds of A.A. activities used by these facilities were: having A.A. meetings on the premises (64%); having outside A.A. speakers coming in (48%); having patients attend outside A.A. meetings while patients at facility (66%); recommending families attend Al-Anon or Al-Ateen meetings (8%); having 'A.A. counselors' coming in (50%); and other A.A. activities (16%). In addition, 73 per cent of these ATCs recommended that 75 per cent or more of their patient population attend A.A. while patients or after they left the facility. It appears reasonable to assert, therefore, that A.A. is a major treatment modality employed in ATCs for the treatment of alcoholic patients. It is also reasonable to expect, because of the widespread use of A.A. activities in these facilities, that A.A. philosophy has a major influence in these facilities.

* This fact is evidenced by the Alcoholism Treatment Directory:1976(1), which reports the types of treatment services offered in most of the ATCs in the U.S.

With this in mind, the remainder of this article will examine several concomitants of A.A. ideology among ATC directors. In particular, it will examine the relationship between A.A. ideology, evaluation of A.A. effectiveness, amount of A.A. activities offered by ATCs, and specific diagnostic patterns displayed by ATC directors. It is hypothesized that directors who score high on A.A. ideology will come from facilities which offer more A.A. activities, they will have a more favourable evaluation of A.A., and they will recommend A.A. for a broader range problem-drinker types.

Method

To test this hypothesis, analysis was conducted with data collected by mail-return questionnaires sent out to ATC directors in two states. This study had been part of a broader study (3) which focused on the analysis of the 'alcohol career' patterns of A.A. members. Altogether 100 questionnaires were sent to all the ATC directors in one state and a 60 per cent random sample of another. Six questionnaires were returned as undeliverable because the directors had either left the institution or treatment services had been terminated. Out of the remaining 94 questionnaires, 57 were returned in time for processing. This represented a return rate of 61 per cent. There were no follow-up mailings used to increase this rare of return. (This questionnaire was intended to be part of a pilot study.) The questionnaire asked ATC directors a number of questions including such things as available bed space, sources of patient referrals, the demographics of their patient populations, evaluation of A.A. effectiveness, opinion about 'controlled drinking' among former alcoholics, and evaluation of patient types.

It is estimated that the 57 ATCs involved in the study provide treatment and referral for at least 20,000 patients a year. These ATCs represent one-third of the facilities in the two-state area studies. The states, from which the questionnaires were collected, are located in the industrial North-eastern part of the U.S. and have a combined population of about 25 million. According to figures supplied by Keller (4) this size catchment area would yield approximately 900,000 serious problem drinkers diagnosable as 'alcoholic' in a one-year period.

The questionnaire data were qualitatively supplemented by participant observations conducted at several ATCs and approximately 20 'focused interviews' with ATC directors and other alcohol treatment personnel. These latter data were processed and analyzed according to some of the strategies suggested by Schatzman and Strauss (5), Lofland (6), and Becker and Geer (7). These results were then compared to the questionnaire data, when applicable, and used to guide the analysis presented here. The work of Frank (8) also provided theoretical insight, which was helpful in both questionnaire construction and in analysis.

Results

The analysis of the data presented in Table 1, reveals the relationship between three variables constructed from this ATC questionnaire. The three variables are *'A.A. Treatment Ideology,' 'Evaluation of A.A.,' and 'Amount of A.A. Activities.'* A.A. treatment ideology is an additive index of six Likert-type items which was based on questions dealing with total abstinence, the 'Rand Report', the 'loss of control' theory of alcoholism, the 'disease' concept of alcoholism, etc. The questions making up this index were selected because they were known to be associated with an A.A. oriented-philosophy. Evaluation of A.A. is a score derived from two ordinal-scaled questions ascertaining the respondent's evaluation of the 'quality' and 'effectiveness' of A.A. Amount of A.A. activities is an additive index of the total amount of A.A.-type services offered by the ATC. A more detailed discussion of these scores can be found elsewhere (3).

Table 1. The relationship between A.A. treatment ideology, evaluation of A.A., and amount of A.A. activities (in per cent)[1]

		Low	High	N
A.A. treatment ideology				
Evaluation	Low	77	37	(23)
of A.A.	High	23	63	(24)
		100%	100%	(47)
X^2 (Yates' corrected) = 5.86, 1 df, $p < .05$. Yule's Q = .70				
Amount of A.A.	Low	71	28	(27)
Activities	High	29	72	(26)
		100%	100%	(53)
X^2 (Yates' corrected) = 8.30, 1 df, $p < .005$, Yule's Q = .73				
Evaluation of A.A.				
Amount of A.A.	Low	68	19	(21)
Activities	High	32	81	(25)
		100%	100%	(46)
X^2 (Yates' corrected) = 9.13, 1 df, $p < .005$, Yule's Q = .80				

[1] The number of responses throughout the tables varies because not all the directors answered all the questions.

As can be discerned from Table 1, ATC directors who score high on A.A. ideology, tend to score high on evaluation of A.A. It is also clear from the table that those ATCs which are high in A.A. activities also have directors who score high on A.A. ideology. Finally, the last part of Table 1 shows that those ATCs which are high in A.A. activities, have directors who score high on evaluation of A.A.*

While the causal direction cannot be definitely ascertained here, it is clear that all three of these variables are *positively* intercorrelated. This suggests that where one finds an ATC high in

*The cutoff point for defining 'high' and 'low' scores on these three notables was set so that about 50 per cent of the cases would fall into each group.

A.A. activities, one is likely to find a director high on the other two variables. What this may mean for the patients at these ATCs is suggested in Table 2. In an attempt to discern the relationship between A.A. ideology, evaluation of A.A., and the directors' evaluation of different type problem drinkers, ATC directors were asked to evaluate 16 types of problem drinkers in terms of suitability for A.A. affiliation. The evaluation was based on a five-point scale which ranged from '0' (Would never recommend A.A. affiliation) to '4' (would always recommend A.A. affiliation). The problem-drinker types ranged from skid-row alcoholics, middle-class alcoholics 'willing' to give A.A. a try, male alcoholics, female alcoholics, to black alcoholics. Although these categories are not mutually exclusive, they provide a general idea about how ATC directors react diagnostically to different types of problem drinkers in terms of A.A. affiliation. Table 2 presents the total mean treatment evaluation scores for those directors classified as high or low on both A.A. ideology and evaluation of A.A. From this table it can be seen that those directors who were either high on A.A. treatment ideology or evaluation of A.A., were also in favour of sending more types of problem drinkers to A.A. (they gave higher scores). This finding seems to suggest that those higher scores on A.A. ideology and evaluation also feel that A.A. would be helpful for a wider range of problem drinkers, in comparison to those who are not high on these variables.

Table 2. The relationship between A.A. treatment ideology, evaluation of A.A., and judgement of alcoholic types

Variables		Total mean treatment score	N	t (one-tail)
A.A. treatment ideology	Low	47.6	(19)	$t = -1.98$, 38 df,
	High	54.0	(21)	$p < .05$
Evaluation of A.A.	Low	45.3	(20)	$t = -4.75$, 35 df,
	High	58.2	(17)	$p < .001$

An interesting finding here can be seen in Table 3, which presents the individual mean scores for all 16 types of problem drinkers. These are dichotomized by those high or low on both A.A. ideology and evaluation of A.A. The first thing that should be noticed is that those high on either of these two variables tend to rate all 16 problem-drinker types as more suitable for A.A. affiliation. But, ATC directors high on A.A. ideology gave only seven of these types significantly higher scores. They were skid-row alcoholics, criminal offenders who are alcoholics, female alcoholics, multiple drug users who have a strong alcoholic dependence, moderate psychiatric cases with alcoholic tendencies, alcoholics who are 'unwilling' to give A.A. a try, and black alcoholics. The interesting thing here is that these problem drinkers are the types (with the exception of women) which one would expect to do poorly in A.A. In fact, available research indicates that A.A. affiliates who are more generally impaired tend to do worse in A.A. (9,10). This has also been found to be true of other kinds of alcoholism treatment as well (11,12,13). Thus, optimism about A.A. effectiveness with these type affiliates is at odds with available research.

The other part of Table 3, which shows the evaluation of the 16 types by high or low evaluation of A.A., indicates that the high evaluators of A.A. feel that it is more suitable for all types of problem drinkers. In fact, they gave all 16 types significantly higher scores. This is more or less expected. Those high in their general evaluation of A.A. also feel that it is more effective for all types of problem drinkers, than those who evaluate A.A. as generally lower. Thus, ATC directors' evaluation of A.A. and individual problem-drinker types appear to be redundant because they tap the same dimension.

Table 3. The relationship between A.A. treatment ideology, evaluation of A.A. and judgement of alcoholic types*

Evaluation of alcoholic types	A.A. treatment ideology	Ind. mean treat. score	Evaluation of A.A.	Ind. mean treat. score
Skid row alcoholics	Low	2.67	Low	2.59
	High	3.43[1]	High	3.82[3]
Criminal offenders who are acoholics	Low	2.62	Low	2.45
	High	3.38[2]	High	3.82[3]
Lower-class alcoholics	Low	3.30	Low	3.05
	High	3.52	High	3.88[3]
Middle-class alcoholics	Low	3.24	Low	3.09
	High	3.57	High	3.83[3]
Upper-class alcoholics	Low	3.15	Low	3.00
	High	3.52	High	3.78[3]
Male alcoholics	Low	3.37	Low	3.29
	High	3.64	High	3.82[2]
Female alcoholics	Low	3.15	Low	3.09
	High	3.64[1]	High	3.82[3]
Multiple drug users with strong alcohol dependence	Low	2.30	Low	2.19
	High	3.10[2]	High	3.35[3]
Moderate psychiatric cases with alcoholic tendencies	Low	2.25	Low	2.33
	High	3.00[2]	High	3.06[1]
Alcoholics willing to give A.A. a try	Low	3.73	Low	3.58
	High	3.74	High	3.94[1]
Alcoholics unwilling to give A.A. a try	Low	1.77	Low	1.86
	High	2.73[2]	High	2.88[2]
Alcoholics who refuse to admit a drinking problem	Low	2.60	Low	2.41
	High	2.82	High	3.12[1]
Younger alcoholics (16–21 years old)	Low	3.05	Low	2.73
	High	3.18	High	3.59[2]
Older alcoholics (over 50 years old)	Low	3.45	Low	3.18
	High	3.55	High	3.88[3]
Black alcoholics	Low	3.15	Low	3.05
	High	3.59[1]	High	3.82[3]
White alcoholics	Low	3.35	Low	3.23
	High	3.59	High	3.82[3]

* One-tail t-test, with group Ns ranging from 17–24.
[1] $p < .05$.
[2] $p < .01$.
[3] $p < .001$.

Discussion

Data presented here suggest that ATC directors who score high on A.A. ideology, score high on A.A. evaluation, and are from institutions which offer more A.A. activities. Furthermore, ATC directors who are higher on A.A. ideology tend to feel that all types of problem drinkers would benefit from such an affiliation. In spite of a lack of evidence for such beliefs, these directors tend to feel that A.A. affiliation would also benefit those types of problem drinkers usually considered more difficult to treat (Skid-rowers, criminal offenders, multiple drug users, etc.). One explanation for this is that directors who are higher on A.A. ideology are, naturally, more optimistic about its results. Therefore, they tend to recommend a broader range of problem-drinker types affiliate with A.A. But there may be another less direct explanation, equally applicable. This explanation is rooted more in the underlying tenets of A.A. philosophy, rather than with optimism of A.A. generally. If one reads the basic textbook of A.A. (14), Chapter 5 starts off as follows:

Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves (p.58).

This suggests that the effectiveness of A.A. is tied to 'will' and 'constitutional capability.' Placed in this system of thinking, such variables as personality, psychiatric symptomatology, sex, age, race, ethnicity, socioeconomic status, etc. have little bearing with respect to how the individual may fare in an A.A. milieu. Indeed, according to A.A. philosophy, the reason the potential affiliate may fail to well in A.A. is not due to such background variables, but rather to will and constitutional capability. This tendency, it is suggested, may have been reflected by those higher on A.A. ideology. Those low on this variable, on the other hand, may have felt that such background variables could affect eventual outcome. This tendency could have been reflected in their more cautious judgement about recommending A.A. for all types of problem drinkers.

IN conclusion, it can be said that although these findings should be interpreted with caution, they are significant for our understanding of A.A. ideology and the A.A. affiliation process. A.A. is one of the major forms of 'treatment' offered those with drinking problems today. The findings reported here suggest that where a high amount of A.A. activities are offered in ATCs, there tend to be directors who are higher on A.A. treatment ideology and evaluation of A.A. ATC directors high on these two latter variables tend to recommend a wider range of more serious problem drinkers for A.A. affiliation. As was noted, research on A.A., as well as other treatment organizations, does not support this optimism with respect to A.A. or more conventional treatment.*

* The role of the ATC in actually encouraging post-institutional affiliation

with A.A. should not be underemphasized today. As was pointed out, most ATCs offer some form of A.A. services for patients, as well as encourage affiliation after release. In one study (3,p.123), for example, approximately 25 per cent of the 155 A.A. members studied claimed that 'hospitals' had influenced them in seeking A.A. for help with their alcohol problems.

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