

**What we would Most Like to Know**

**Does A.A. Really Work?**

**Frederick B. Glasser, M.D., F.R.C.P. (C) and  
Alan C. Ogborne, Ph.D.**

Consider for a moment your immediate reaction to the above question. If you felt it to be natural and reasonable at the present stage of development of our field, then our initial remarks need not detain you, and you may omit the first section of this paper. If, however, your reaction was one of surprise, annoyance, anger, exasperation, shock, or perhaps even rage, we most earnestly solicit your sustained attention. We believe that the title question, though to be sure not framed in so simplistic a form, needs very much to be asked; and we believe it is also susceptible of being (at least partly) answered. If you are willing to suspend your disbelief momentarily and read on, we propose to show you why the question needs to be asked and how it might be answered.

**Why Does the Question Need to be Asked?**

First, because of the preeminent position of Alcoholics Anonymous in the overall effort to treat persons with alcohol-related problems. There are A.A. chapters in 90 countries, and its total active membership is estimated at one-half million (1). Since the organization is fast approaching its fiftieth birthday, the total number of individuals who have been actively and directly involved must conservatively be numbered in the tens of millions. No other self-sufficient method of treatment for alcohol-related problems can credibly claim such massive dimensions. Nor do even these figures begin to be an adequate measure of the real importance of A.A.; many independent treatment programmes draw heavily upon its principles and often incorporate it into their programme structure (2). It is beyond doubt the dominant treatment initiative in the field. Asking about the effectiveness of A.A., therefore, is exactly the opposite of an attempt to diminish its stature; it is rather a reflection of that stature. It would be trivial to ask such a question of a treatment approach not significantly in use.

Second, it is important to ask the question because it has, regrettably, not been answered. Saying so will inevitably raise the hackles of many, who will snort: 'Of courses A.A. works; we all know that.' To cut through an often endless and frequently acrimonious debate, let us say straightaway that we agree in general with such an assertion. Indeed, if we did not, we would see little value in pursuing the matter further. There is no point in flogging a dead horse. However, there are levels of 'knowing'; and although we 'know' at some level that A.A. does work, we find that

painstaking reviews of all the available literature lead to the inescapable conclusion that the efficacy of A.A. has not been proven; that A.A. has not been demonstrated to be effective beyond what might be expected by chance, and in a manner sufficiently direct and powerful to convince the most sceptical. Thus, for example, Leach and Norris, who hardly take a negative position with respect to A.A., state flatly in their comprehensive review that 'No valid claim to a "success rate" can be established for A.A...' (1,p.459).

A third reason for asking this question is to refine it. Zen masters were in the habit of responding 'MU!' to questions of the sort raised in the title, which demand sharp, dichotomous answers. Their unexpected use of this nonsense syllable was a dramatic and pedagogically effective way of asserting that, in order to be meaningful, such questions had always to be restructured. By the same token, we believe that the question of the title, as it stands, cannot be meaningfully answered. Rather we need to pose a series of more carefully phrased questions, and to recognize that most of these will require more than one-word answers.

Thus, particular aspects of what is implied by the word "work" need to be spelled out, as does the context and time frame within which particular effects are of interest. One does not cogently ask whether or not penicillin works, but whether it is effective in eliminating specific infective organisms in particular individuals over specific time intervals. Likewise, the question of whether psychotherapy works or not is equally simplistic. One needs instead to ask about the specific effects specific types of psychotherapy can induce in specific types of people in specific situations (3). A.A. clearly does very little for some problem drinkers, but for others involvement with A.A. impacts both their drinking and other aspects of their lives. For others still, A.A. seems to be the answer for the control of drinking yet it does little for their depression or lack of social skills. Though we will further refine the question below, it is readily apparent that we must at minimum ask for whom A.A. works and in what ways.

Our fourth and fifth reasons for asking the question emerge from these considerations. If we may learn, by asking the question, when to use A.A. to optimum therapeutic advantage, then we will learn at the same time when not to use it. One may consider it axiomatic that any treatment method powerful enough to effect a good result can also effect harm if not appropriately employed. Penicillin not only does not work in certain kinds of infections, but (for example) allergic reactions to it may be very serious in particular individuals; therefore, it must be used with care. Likewise, it is a common clinical experience to encounter individuals whose alcohol-related problems have been intensified by exposure to A.A. - if only because of their belief that, if they cannot be helped by A.A., there is no help for them. Like any powerful intervention, A.A. must be used with care.

Finally, the precise delineation of that subgroup in the overall population individuals with alcohol-related problems for whom A.A. is effective may have a positive effect on future research. It may indicate that, if a subgroup can be successfully selected for this specific treatment, other subgroups can be

selected for other specific treatments. In a word, such work may hearten those who seek to learn how to match specific individuals to treatments which can be reasonably expected to be of the greatest value to them (4,5). Of course, the effort to delineate this subgroup may not succeed, and the effect may, therefore, not be heartening. On balance, however, we favour going ahead. Failure is always a possibility, but is less disheartening than abject surrender in the face of uncertainty.

### **How Could the Question be Answered?**

First, of course, the question needs to be replaced by a series of more specific enquiries, as previously indicated. Dimensions along which A.A. might affect those who become involved (both positively or negatively) need to be specified, as do the characteristics of those who might be variously affected. Circumstances within which particular effects might occur should also be detailed, and the time periods within which effects might occur and persist should be specified. Only then would one arrive at questions which had some chance of being answered in a straightforward manner.

In the past few years considerable progress has been made toward delineating factors to be considered when assessing the outcome of any interventions for problem drinkers. Also the advantages and drawbacks of alternative means of assessing these factors are becoming clearer (6,7). Among professionals the consensus is that, in studies of the effectiveness of any intervention, multiple outcomes should be considered and that, where possible, each outcome should be assessed by two or more methods. Thus both self and collateral reports, backed by record searches and medical tests, should be used to assess drinking and drug use. Further, multiple information sources should, if possible, be used to assess psychological, social and economic functioning. Finally, outcome measures should be quantifiable, operationally defined and, whenever possible, continuous rather than categorical. It is thus not sufficient to be concerned only with self-reports of sobriety after attending A.A. Rather additional information sources must be used to gather more detailed data (e.g. days drinking specific amounts).

Every effort should be made to obtain valid indicators of the ways in which other problematic behaviors covary with A.A. involvement. Particular attention should, for example, be paid to the use of tranquilizers, possibly to the drinking of coffee, and certainly to cigarette smoking (8). Studies of the efficacy of A.A. should also consider how involvement with the movement contributes to psychological growth and the development of social skills particularly among (e.g.) depressed and/or socially incompetent individuals. As A.A. members themselves say, there is a big difference between sobriety and contented sobriety. Clearly, therefore, while a precise knowledge of the impact of A.A. upon the individual's consumption of alcohol and other drugs is an essential ingredient of any precise outcome study, it is nevertheless not a sufficiently broad measure to permit an adequate evaluation of the overall effect of affiliation.

Characteristics of problem drinkers who might be best suited

to A.A. have been suggested by the present authors (9). There is, however, a clear need to define these characteristics further and to determine the specific effects that A.A. involvement might have on problem drinkers with these and other characteristics. But as important as individual characteristics might be, they may not in themselves completely determine outcome. Situations which lead problem drinkers to seek help, and the general 'ebb and flow' of social support and life events surrounding and coming after help seeking, are increasingly being recognized as affecting the impact of any help which is given (10). Environmental factors conducive to A.A. affiliation and optimal benefit (e.g. support from spouse) need, therefore, to be explored and specified in any further enquiries into the efficacy of the movement.

Because treatment outcomes are less stable than many have imagined (11,12) the time intervals within which particular effects are sought, or may reasonably be expected to last, need also to be considered in studies of the outcomes of A.A. involvement. The effects of exposure to A.A. may take a long time to manifest themselves and there are good reasons to suspect that, as A.A. members say, some problem drinkers are perpetually 'one drink away from being a drunk.' Long term follow-up studies are, therefore, clearly needed.

Research on the efficacy of A.A. is, of course, severely hampered by the voluntary and informal nature of the movement, the absence of membership lists, and of the routine documentation of referral sources, membership characteristics and frequency of attendance. These problems have, in fact, raised serious doubts about the possibility that questions of A.A.'s efficacy could ever be convincingly answered (13,14,15). We do not subscribe to such a pessimistic point of view. Rather we believe that with some ingenuity and effort several important inroads into understanding A.A.'s real effects on (at least some) problem drinkers can be made.

Not all the important questions can be answered by the means we propose but, at least, questions of relevance could be answered more convincingly than at present. Those who encourage problem drinkers to attend A.A., or to enter into any other form of help or treatment, should, after all, be vitally concerned about the appropriateness and outcomes of all available options and take pains to assess vigorously the results of any recommendations made. If A.A. really does 'work,' if it is sufficiently powerful to bring about the remarkable changes that are claimed, then referral to A.A. should not be the 'informal process' which some have condoned (15). Rather such a referral must be made responsibly, after vigorous assessment, and also carefully monitored. If A.A. 'works' it might, as noted above, also 'backfire.'

Research designs appropriate to studying the efficacy of A.A. from the point of view of referral agencies include the nonequivalent control group design, the multiple time series design and the randomized control group design (16). The first two designs use, as comparison groups for regular A.A. affiliates, those who fail to attend after being referred and those whose attendance is spasmodic. Statistical means (covariance analysis) are used to 'equate' these groups on pre-referral characteristics. While there

are several problems with both of these designs, they are infinitely preferable to designs which use different comparison groups. The multiple time series is, in fact, quite powerful because the availability of multiple data points before and after the intervention of interests allows for control of any differences in the regression characteristics of the experimental (i.e. A.A. affiliates) and comparison groups. Multiple data points could be obtained by taking a detailed history at assessment and monitoring relevant behaviours on (say) a monthly or even weekly basis for an extended follow-up period.

Several longitudinal studies of referrals to A.A. have approximated those designs, so there is no question of their feasibility. However, studies conducted to date have typically suffered from meagre baseline assessment, inadequate follow-up, and the use of univariate statistics (15). Replications of these studies which correct for these drawbacks would certainly be quite useful.

Randomized control group designs involving A.A. would use as controls for A.A. referrals problem drinkers selected from the same intake population but randomly assigned to some other, logically defensible, or at least established, alternative to A.A. (e.g. outpatient counselling, group therapy, community reinforcement) (17). Problems of attrition from A.A. and other treatments and self-selection into other programmes (including A.A.) would be handled as in any other controlled addiction treatment studies (18). Such randomized controlled studies are our preference. They could potentially be carried out by any agency with assessment, referral and follow-up resources. There would be no special ethical problems posed by random assignments provided the relative merits of A.A. over and against any other referral option were genuinely in doubt (as they surely are).

Lest the reader be sceptical that such studies could be conducted we call to witness two such studies which have been reported in the literature (19,20). In both studies potential subjects were selected by an external organization which carefully assessed the nature of their problems, their backgrounds, strengths, weaknesses, and so forth. Identified subjects were then randomly assigned to A.A., to a control condition, and to one or more alternative interventions. At the close of a designated period of time subjects were followed up to determine their status, and comparisons were made between the several groups in the experiment. Little in the way of fundamental difficulty can be found with this basic experimental design.

But we would add a further refinement. It reflects the importance of matching clients and treatments. In both of the above-mentioned studies, subjects were wholly or mainly selected from populations of municipal court offenders who were coerced into treatment. These particular populations, while eminently available for study, are extremely unlikely to contain high proportion of individuals possessing those characteristics which prior research suggests may be associated with affiliation to, and a positive outcome from, Alcoholics Anonymous (9). Accordingly, it is not surprising that the results in both of these studies were negative. They did not constitute a fair test of the general efficacy of A.A.

As elucidated by the authors of one of the studies (20, p.84), their results prove, not that A.A. is ineffective, but that 'it is not effective as a coerced treatment with municipal court offenders.' This is a notoriously difficult group of individuals to treat successfully, and no intervention need feel unduly abashed that it has not done so.

Our preferred method would be to conduct a fairer trial. We would select that group of individuals whom we had reason to believe were most likely to achieve a positive result from affiliation with A.A. We would then randomly assign them to A.A., to one or more alternative interventions, and to a control condition. We would introduce those assigned to A.A. to staff members of our organization who are A.A. members, and who would assist them in becoming affiliated. We would follow all subject carefully for a prolonged period of time (a minimum of 18 months), requiring that they keep careful track of their A.A. attendance, utilizing diaries provided for that purpose. At periodic intervals both their involvement in A.A. and their general progress with respect to amount and type of alcohol consumption and its consequences, as well as other crucial parameters of their functioning (work status, legal involvements, status of family and extra-familial relationships, mental and physical health) would be evaluated. By comparing the several groups in the study, we would be able to judge the relative efficacy of A.A. as compared with a control condition and alternative interventions. An added dimension might follow the converse of this strategy: we might in addition select another group of clients not having the characteristics we expect to predict success in A.A., assign them randomly to all conditions of the experiment, and follow them up in the same manner. This addition would increase the power of the experiment, and it would cast a more searching light upon the criteria selected for matching.

Would such a study answer our question? MU! again. There are many problems with even the most carefully designed experiment (21). Also, because the venue of A.A. is so broad, and alcohol related problems are so diverse and so variable, a series of studies of this kind in multiple settings and with multiple populations, not just one study, will have to be done. It might well be that the client characteristics predictive of success in one setting will not hold for other settings, though for purposes of generalizing it would be desirable to find at least some commonalities. But our overall plea is not based upon achieving success; it is based upon making the investigative attempt. Not making any attempt to answer important questions, however challenging they may be, is the beginning of the end for any field which aspires to be based upon science. Science continually makes the investigative attempt; initially, it may fail; but it often ultimately succeeds.

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