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Alcoholics Anonymous: One Treatment Program to Rule Them All?

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Abstract

Treatment programs like Alcoholics Anonymous (AA) are essential in aiding individuals who feel as though they cannot face their substance abuse problems on their own. However, this article will discuss the notion that AA style programs are not a one-size-fits-all medium of treatment. It will do this by exploring the concept that factors such as an individual's personality, social capabilities, mental health, or physical problems, can all negatively impact on a small percentage of the population who seek assistance from AA style programs. Therefore, it is crucial that those who do not complete the programs are not left by the wayside. Finally, this article will explore the importance that programs akin to AA have made and the sustained efforts to further aid those individuals who do not find the AA program suitable.

Keywords: Alcoholics anonymous; Mental health; Psychosocial; Alcohol

Introduction

The use of alcohol is highly prevalent in the majority of western cultures [1]. Amongst adults in the United States, approximately 66% to 90% of individuals have consumed alcohol in their lifetime [1]. Inevitably, numbers such as these result in a population of individuals who feel as though they have become addicted to the substance, and as a result, need assistance to reduce or prevent their intake. Alcoholics Anonymous (AA) provides the latter of those two options. This article will examine the effectiveness of AA programs and explore whether it is a treatment program that is suitable for all individuals who want to prevent their consumption of alcohol. By examining the AA program on a theoretical level, as well as potential factors (e.g., personality, social skills, mental health and physical problems) that may mitigate the effectiveness of AA, this article will discuss whether AA truly is a one-size-fits-all option.

Alcoholics Anonymous is a treatment program that places emphasis on goals and activities that are completed via a 12-step sequence. It is a self-help program that is normally conducted within a group setting, and aims to assist people in realising that they are powerless over the substance [2]. By following the creed and tenants of the program, the individual can come to terms with their 'weakness' and eventually be able to stop drinking completely [2]. While this broad summation of the AA program does not cover all aspects of it in its entirety, for the purposes of this article, two aspects of the program will be discussed in detail. Firstly, the individual steps of the program itself will be discussed. Secondly, the underlying theoretical model that the program is based on will be explored. This will better enable the analysis of the AA principles and in detail explore the psychological personality traits of individuals to help determine whether or not AA is a suitable program for all who attempt to utilise it.

In brief, the 12 steps of the AA program are as follows:

- Admitting that the individual's life is unmanageable and that they are powerless over alcohol
- Believing that a higher power could bring them back to sanity
- Relinquishing their will and lives to the care of God
- Making a fearless moral inventory of themselves
- Admitting to God, themself, and other human beings, the nature of their wrongs
- Being prepared for God to remove these defects of character
- Asking God to remove said personal shortcomings
- Creating a list of all the people that they had harmed and being willing to make amends with them
- Making amends with said people where possible and safe
- Continuing to take a personal inventory and when in the wrong, promptly admit it

Using prayer and meditation to improve contact with God, and praying for the knowledge and the will to maintain personal strength.

Having a spiritual awakening as a result of the completed steps; carry out the messages of the program to other alcoholics, and practicing the principles of the program in all of the individual's affairs [3].

The concept of AA being an effective substance abuse intervention program lies within its ability to develop and maintain abstinence. However, what is often left by the wayside as a result of this assumption is the theoretical underpinning that accompanies the treatment program. A major factor that supports the success of AA programs (be it intentional or not) is the substantive psychosocial form of treatment that it provides [4]. This treatment acts as a method of delivery that confronts certain psychological vulnerabilities that individuals with alcohol problems commonly share in relation to self-regulation [4]. The idea of self-regulation and fixing character defects and weakness, centres on confronting attitudes about the self and others. For example, individuals learn to share and express their personal turmoil via a group therapy process that advocates accepting surrender to a higher

power or altering selfish behaviour to more altruistic ends. In-turn, this provides a safety net that, for many participants, shelters and cocoons them.

The debate surrounding the effectiveness of AA treatment programs contains a myriad of arguments. However, information relating to the efficacy of AA is difficult to ascertain as the program is voluntary by nature and strongly promotes anonymity [5]. Furthermore, a common issue that AA related studies have is difficulty following up on participants that have opted not to continue the AA program. Additionally, when contact was made after discontinuation of the AA program, participants often did not adequately explore the deeper reasons regarding why they withdrew [6]. Although, for the participants that choose to remain, evidence suggests that they do find the AA program of benefit.

Most prominently, there are two arguments that promote that AA is effective [7] (McKellar, Stewart & Humphreys 2003). The first is that by attending AA treatment, members consume less alcohol and have fewer health and social related concerns [7]. The second is that individuals who do not relapse feel more comfortable attending meetings and therefore continue attending, promoting a positive cycle of abstinence and support to other members [7]. In support of this, Timko et al. [8] found that individuals who attended AA had more positive substance related outcomes than those who did not. Also, individuals who attended more AA meetings were more likely to be able to maintain their abstinence and had less alcohol related concerns at the one-year follow-up point.

Furthermore, a study conducted by Moos and Moos [9] examined the role of both duration and frequency of participation with individuals attending AA treatment programs. Their longitudinal study, which used 473 participants who had alcohol use disorders, measured the outcomes of two time periods. The first was after one year and the second after eight years, with a focus being specifically on the effects of level of participation. Their results found that participants who associated with AA swiftly and participated longer had better one year and eight year substance use outcomes compared to those individuals that chose not to participate. Additionally, individuals who delayed participation and frequency in the AA programs appeared to have no better substance use outcomes compared to those that never participated. This indicates that to a certain extent, there could be a strong personal desire and comfort in engaging with the AA process; otherwise little to no effect may be elicited.

However, substantively negating the impact of AA treatment programs is the systematic literature review conducted by Ferri et al. [10]. The review examined eight trials in detail and came to the conclusion that none of the experimental studies unequivocally supported the effectiveness of AA (or a 12-step approach program). While a strong statement, the studies reviewed were limited to randomised trials that were exploring the comparison of AA to other psychosocial interventions. Also, multiple hypothesis and interventions were in some studies explored at the same time which may have impacted upon the validity of the findings. As such, this 'hard-science' approach may not be as appropriate when considering personal and social factors alongside the desire to maintain attendance in the program.

The actual decision itself to maintain attendance and participate in AA meetings is one that warrants greater attention. For example, Tonigan et al. [11] explored whether the perceived social dynamics of three AA groups impacted on the group's perception of the 12 steps in the program and the subsequent completion of the 12 steps. After the members in the AA groups completed questionnaires, a profile analysis found that all three groups differed in perceived group independence, cohesiveness, aggressiveness, and expressiveness. Additionally, the three groups also varied in how often the members discussed the 12 steps in the meetings with the group that was highest in aggressiveness being lowest in step discussion. These findings indicated that AA groups vary not only in individual characteristics within members, but also in relation to overall discussion and completion of the 12 steps. Therefore, caution needs to be taken not to regard all AA groups as homogeneous bodies. Furthermore, that the personal characteristics of participants should be considered to match individuals to AA treatment groups.

Personality Traits and Personal Characteristics

Personality traits are identifiable, stable qualities that characterise how an individual differs from other individuals [12]. While multiple theories exist in regards to trait-based models of personality, the Five-Factor (or Big Five) model is one that is widely agreed upon as an accurate measurement of a person's personality. McCrae et al. [13] stipulate that five overarching traits exist within the model. The first is the continuum between neuroticism and stability, which measures the extent that individuals are nervous or at ease, insecure or secure, or worried or calm. The second is extraversion and introversion, which measures the extent that individuals are affectionate or reserved, talkative or quite, or social or unsocial. The third measures openness to experience, which determines the extent that an individual is open or closed to experience, creative or uncreative, daring or timid, or independent or conforming. The fourth is agreeableness and antagonism, which measures the extent to which an individual is courteous or rude, flexible or stubborn, good-natured or irritable, or lenient or critical. The final trait continuum is between conscientiousness and undirectedness, which measures the extent that an individual is careful or careless, reliable or unreliable, or organised or disorganised.

Given these descriptions of individual traits, it stands to reason that certain individuals may be more or less aligned with the practices and processes of the AA program [14]. For example, an individual who is highly extroverted, agreeable, and open to new experience may be more suited and engaged with AA treatment programs. Conversely, an individual who is highly introverted and antagonizing may find the group discussion aspect of AA difficult to participate in. Studies such as the one conducted by Tonigan et al. [11], indicate that personality traits of participating members do influence the cohesion of the group dynamic. Furthermore, the level of engagement elicited by the participant on an individual level may also widely vary. This notion is supported by Hurlburt et al. [15] who stipulate from their findings that AA members were, to a significant level, extraverted and less tough-minded and emotional than non-members. Furthermore, more contemporary research [16] indicates that longer attendance at AA sessions can aid in the reduction of impulsivity (a common trait of extraverts). However, that does not extend to those who score highly in neuroticism.

As AA is an internal and reflective process, individuals who are highly neurotic may have trouble with certain practices and processes. For example, steps four and ten (moral inventory), as well as step 11 (meditation), in particular could be highly distressing to individuals who score highly in neuroticism. In support of this claim, Giluk [17] conducted meta-analyses of 29 studies and measured correlations

between the Big Five personality traits and trait mindfulness (used in meditation practices). The findings of the 29 studies in the meta-analysis demonstrated that that the strongest correlation was a negative correlation between mindfulness and neuroticism, r=-0.45, 95% CI [-0.65, -0.51]. The remaining four personality traits achieved the following results: extraversion, r=0.12, 95% CI [0.08, 0.22], openness to experience, r=0.15, 95% CI [0.15, 0.25], agreeableness, r=0.22, 95% CI [0.15, 0.45] and conscientiousness, r=0.32, 95% CI [0.34, 0.54].

These findings indicate that the engagement of meditation for individuals who are highly neurotic is not only ineffective, but that it can actually have a distressing impact on the individual. As such, it is not surprising that these participants may form some of the population that ceases their association with AA programs. Conversely, the results suggest that the traits of conscientiousness and agreeableness (and to a lesser extent, extraversion, and openness to experience) play a more positive role in the acceptance of meditation practice. In-turn, this could suggest a more positive response to the AA program which not only utilises mediation, but also a heavy focus on self-actualization and development.

Additionally, the focus on catharsis (or the breaking down of psychological defences) [18] is another roadblock that many individuals with certain personality traits may struggle with. Individuals, who are highly neurotic, introverted and not open to new experiences, may not want to release their emotional tensions in a group setting. Furthermore, they may struggle with being told that their justifications towards alcohol use are nothing more than denial. As such, the experience of AA for those who do not find it as an effective intervention, may find that it has done more harm than good. This is especially the case if they perceive their discontinuation as a personal failure, rather than the fact that it was not a suitable method of addressing their substance use problems.

Social Networks and Effectiveness of AA

The role of social networks is another dominant factor when considering the effectiveness of AA treatment programs [19]. A longitudinal study conducted by Humphreys et al. [20] examined the role of social networks as a link in the nexus between being affiliated with AA and the improved reduction of substance abuse. The findings of the study concluded that a positive relationship existed between involvement in the AA programs and less frequent substance use. Additionally, the findings stipulated that two aspects of friendship (general friendship and support for abstinence) had a moderating impact on these results. However, the study used 2337 male inpatients that were in the U.S. Veterans Affairs programs. This makes it difficult to generalise the findings to the rest of the public due to the focus on one sex, advance age, and possibly unique combat experiences. Another factor to consider is the role of other social influences that would exist in a non-inpatient environment (i.e., greater access to social facilities, greater degrees of freedom of choice).

Alternative alcohol reduction programs, such as Project MATCH, that model their treatment programs on a step-based style of intervention also found evidence of the impact of social networks [21]. Their findings indicated that the steps within the program appeared to suppress the engagement of involvement with other peers who are frequent and heavy drinkers. In-turn, this appeared to reduce the temptation of individuals to succumb to the social pressures of drinking within their social groups. Conversely, Kaskutas L et al. [19] found that positive social influences and networks provided by AA, such as role modelling, 24-hour availability of sponsors, and experience based advice on staying sober, had a significant moderating role on the positive outcomes of reduced substance use. Their overall findings indicated that AA involvement was a significant predictor of lower alcohol use and related problems.

However, more specifically, the size of this effect was reduced by 36% when social network size and support for sobriety issues were included as moderating factors [19]. Furthermore, the findings also provide support that abstinence was predicted by not having pro-drinking influences in the individual's social network, but rather by having the support from individuals met in the AA program. However, having abstinence support from people who were not in the AA program was not found to be a significant predictor of abstinence. This indicates that the positive outcomes of AA may not only be a result of the programs tenants, but rather the specific peer networks that it provides (i.e., acceptance from peers who have had similar experiences).

Whilst these findings were explained partially by a greater degree of affiliation and participation within the AA style of programs and activities, they clearly are not the only factors that need consideration. As discussed earlier, this desire to participate and make certain lifestyle changes requires a degree of openness to change, agreeableness, and social confidence. As such, a section of the population may again exist who are not finding this style of intervention (i.e., goal development, meditation, new social networks) helpful and as such may also be being neglected much needed assistance.

Alcoholism & Comorbidity with Other Conditions

As previously discussed, AA treatment programs are designed to promote abstinence and focus on providing a network that encourages group therapy via 'surrender' and 'self-improvement'. However, all members of AA groups are volunteers and not necessarily mental health practitioners or general practitioners. As such, a certain care needs to be taken to appreciate that the substance use may not be the only psychopathy affecting the individual. In support of this, a number of studies have found that individuals with high motivation and lower psychopathology can predict greater AA engagement and/or less alcohol abuse [22-25]. Therefore, if this rationale of 'high motivation, low psychopathology' substantially accounts for many of the members who remain in the AA programs, the implication can be made that AA may only look as though it is effective because the individuals who remain may be the ones with fewer or less serious problems to address [7].

A number of psychopathies share a high co-morbidity with substance abuse. One example is apparent from research conducted by Swendsen et al. [26], which found evidence of specific patterns of comorbidity between alcohol abuse or dependence and increased risk of depressive and anxiety related symptoms. Individuals who did have alcohol abusive or dependency problems would generally experience a two-to-threefold increase in depressive or anxiety symptoms. Similarly, a study in the United States that examined, in part, the prevalence of comorbid alcohol abuse and mental health disorders found that 37% of participants with an alcohol disorder also had a comorbid mental health related disorder [27].

More specifically, Hesselbrock et al. [28] found that specific gender differences exist in differentiating the likely comorbid mental health disorder. They found that male alcoholism was generally more likely to be related to antisocial personality disorders, whereas female

alcoholism was more likely to be related to eating disorders and depression. However, certain mental disorders such as depression or antisocial personality disorder can be noted in both genders, especially when the alcoholism has been prolonged and substantive [28]. Furthermore, the individual may be compensating for a mental disorder by self-medicating via alcohol abuse [26]. As such, the drinking may not be the root of the individual's problem. These types of mental disorders, subsequent symptoms and behaviours are not necessarily accounted for to a professional standard in AA meetings. As a result, the individual may need a more specific and tailored treatment, rather than just a social network and group therapy environment. In this sense, AA can again be seen as only effective to a certain demographic of the population, and that population may likely be those individuals who do not have a coinciding mental disorder [22-25].

The mental health aspects are not the only aspects that need to be considered when examining the effectiveness of AA treatment programs. By the time an individual determines that they need help to confront their drinking habits, they may already have a dependence on the substance. Alcohol dependency affects the brain on a physical level and the repeated ingestion of alcohol can lead to an increased tolerance towards the substance [29]. This means that more of the substance is required to achieve a similar effect [29]. Furthermore, a common feature of alcohol dependency is that an individual will experience alcohol withdrawal if they attempt to cease their intake of alcohol. Typically the physical symptoms include: nausea and vomiting, headaches, tremors, and in extreme cases, seizures [1]. Due to the seriousness of the withdrawal process, individuals who consume on average more than eight standard drinks a day are recommended to seek medical advice before initiating their reduced alcohol intake [29].

Therefore, from a medical and biological perspective the concept of AA has a fundamental flaw. The concepts of surrender and faith can only go so far, and aside from not only possibly being unhelpful to the individual, the withdrawal process can be potentially dangerous, especially if they force themselves through the AA step-process to violently purge their body after years of heavy alcohol abuse. In short, for many individuals alcohol abuse may not be something that can just be 'thought through'. By not including a medical based approach, the effectiveness of AA, once again, is potentially limited to those who do not have a strong biological need or psychological disorder.

Implications, Recommendations and Conclusion

The arguments presented in this piece may appear to paint a bleak picture of the effectiveness of AA treatment programs; however, this is neither true nor accurate. As discussed towards the beginning of the paper, AA is effective and useful for a majority of people [8,9]. What this paper has aimed to demonstrate is that AA is not a one-size-fits-all concept or program. More specifically, individuals with certain personality types, social inadequacies, mental conditions, or physical requirements, may not be suitable for, or find beneficial, the tenants of the AA program. As such, one primary recommendation is offered: when any new member contacts or attends an AA meeting they could be provided with an 'in case of emergency' briefing pack. This dossier of information could highlight some of the aforementioned points that openly state that AA is not suitable for everyone, and as such, that discontinuation of the program should not be seen as failure. Instead of allowing the individual to become reclusive about their drinking once more, the pack could provide both psychological and medical contacts or centres that can enable the individual to seek alternative types of help.

Another alternative is the adaptation of AA programs to new and evolving perspectives of psychology. Galanter [30] argues that by drawing on currently available research it is possible to include social network support and positive psychology into the AA spiritually-orientated approach. Positive psychology is a field that aims to promote positive aspects of the human experience, rather than just focusing on how to retrospectively diagnose and treat [31]. This more contemporary psychological approach supports the findings of Kelly et al. [32] who indicate that AA programs are at least as helpful as other intervention approaches. Again, though the 'how' remains un-properly researched. This leaves some to speculate that rather than the exact process or content, it may be the free and long-term support that exposes clients to therapeutic elements [32]. Regardless, future research into how positive psychology can integrate, expand and encompass more individuals within AA programs is essential.

It is a truism to say that service-oriented organisations envision themselves at being the best provider of their particular service. However, when it comes to mental health and physical well-being, there can be no one-stop shop. Alcoholics Anonymous, while effective for many individuals who access it, is not for everyone. The troubling part is that individuals who attempt to better themselves and who do have incompatible personality traits, poor social skills, or other mental health or physical conditions, may risk falling to the wayside. It is the responsibility of self-help services, such as AA, to recognise that what they have to offer may not be for every individual, and as such, provide further advice to those who seek assistance or appear to be at risk of failure.

References

1. American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders (4thedn), Washington, DC.
2. http://www.aa.org.au/members/twelve-steps.php
3. http://www.aa.org.au/new-to-aa/what-is-aa.php
4. Khantzian EJ, Mack JE (1989) Alcoholics Anonymous and contemporary psychodynamic theory. Recent Dev Alcohol 7: 67-89.
5. Khantzian EJ, Mack JE (1994) How AA works and why it's important for clinicians to understand. J Subst Abuse Treat 11: 77-92.
6. Emrick CD (1989) Alcoholics Anonymous: membership characteristics and effectiveness as treatment. Recent Dev Alcohol 7: 37-53.
7. McKellar J, Stewart E, Humphreys K (2003)Alcoholics anonymous involvement and positive alcohol-related outcomes: cause, consequence, or just a correlate? A prospective 2-year study of 2,319 alcohol-dependent men. J Consult Clin Psychol 71: 302-308.
8. Timko C, Moos R, Finney J, Moos B (1994) Outcome of treatment for alcohol abuse and involvement in AA among previously untreated problem drinkers. J Ment Health Adm 21: 145-160.
9. Moos RH, Moos BS (2004) Long-term influence of duration and frequency of participation in alcoholics anonymous on individuals with alcohol use disorders. J Consult Clin Psychol 72: 81-90.
10. Ferri M, Amato L, Davoli M (2006) Alcoholics Anonymous and other 12-step programmes for alcohol dependence (Review). Cochrane Database Syst Rev 19.
11. Tonigan JS, Ashcroft F, Miller WR (1995) AA group dynamics and 12-step activity. J Stud Alcohol 56: 616-621.
12. Lefton L, Brannon L (2006) Psychology (9th edn), Pearson, New York.
13. McCrae R Costa P (1999) A five-factor theory of personality. In: Pervin L, John O (eds) Handbook of Personality theory and Research (3rdedn), Guilford Press, New York.

14. Kaskutas L (2009) Alcoholics Anonymous effectiveness: Faith meets science. J Addict Dis 28:145-157.
15. Hurlburt G, Gade E, Fuqua D (1984) Personality differences between alcoholics anonymous members and nonmembers. J Stud Alcohol 45: 170-171.
16. Blonigen DM, Timko C, Moos RH (2013) Alcoholics Anonymous and reduced impulsivity: a novel mechanism of change. Subst Abus 34: 4-12.
17. Giluk TL (2009) Mindfulness, big five personality, and affect: A meta-analysis. Personality and Individual Differences 47: 805-811.
18. Bushman B (2002) Does venting anger feed or extinguish the flame? Catharsis, rumination, distraction, anger, and aggressive responding, Personality and Social Psychology Bulletin 28: 724-731.
19. Kaskutas LA, Bond J, Humphreys K (2002) Social networks as mediators of the effect of Alcoholics Anonymous. Addiction 97: 891-900.
20. Humphreys K, Noke J (1997) The influence of post treatment mutual help group participation on the friendship networks of substance abuse patients. Am J Community Psychol 25: 1-16.
21. (1998) Matching alcoholism treatments to client heterogeneity: Project match three-year drinking outcomes. Alcohol Clin Exp Res 22: 1300-1311.
22. Isenhart CE (1997) Pretreatment readiness for change in male alcohol dependent subjects: predictors of one-year follow-up status. J Stud Alcohol 58: 351-357.
23. McLellan AT, Luborsky L, Woody GE, O'Brien CP, Druley KA (1983) Predicting response to alcohol and drug abuse treatments. Role of psychiatric severity. Arch Gen Psychiatry 40: 620-625.
24. Morgenstern J, Labouvie E, McCrady B, Kahler C, Frey R (1997) Affiliation with alcoholics anonymous after treatment: A study of its therapeutic effects and mechanisms of action. J Consult Clin Psychol 65:768-777.
25. Stoffelmayr B, Benishek L, Humphreys K, Lee J, Mavis B (1989) Substance abuse prognosis with an additional psychiatric diagnosis: Understanding the relationship. J Psychoactive Drugs 21:145-152.
26. Swendsen J, Merikangas K, Canino G, Kessler R, Rubio-Stipec M, et al. (1998) The comorbidity of alcoholism with anxiety and depressive disorders in four geographic communities. Compr Psychiatry 39: 176-184.
27. Regier DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, et al. (1990) Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study. JAMA 264: 2511-2518.
28. Hesselbrock M, Hesselbrock V (1997) Gender, alcoholism, and psychiatric comorbidity. In: Wilsnack R, Wilsnack S (eds) Gender and Alcohol: Individual and Social Perspectives, Rutgers Centre of Alcohol Studies, New Jersey.
29. http://www.dassa.sa.gov.au/site/page.cfm?u=125
30. Galanter M (2007) Spirituality and recovery in 12-step programs: an empirical model. J Subst Abuse Treat 33: 265-272.
31. Seligman ME (2002) Positive psychology, positive prevention, and positive therapy. Handbook of positive psychology, Oxford University Press, USA.
32. Kelly J, Magill M, Stout L (2009) How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behaviour change in Alcoholics Anonymous'. Addiction Research and Theory 17: 236-259.