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A STUDY OF THE PERCEIVED ATTRIBUTES OF ALCOHOLICS IN SELF-HELP GROUPS REGARDING THEIR CURRENT STATES OF SOBRIETY

By

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ABSTRACT

A STUDY OF THE PERCEIVED ATTRIBUTES OF ALCOHOLICS IN SELF-HELP GROUPS REGARDING THEIR CURRENT STATES OF SOBRIETY

By

Lisa Beth Parsons

This was an exploratory study in which the perceptions of alcoholics at a local Alcoholics Anonymous club were surveyed regarding topics such as the Alcoholics Anonymous program, treatment backgrounds, recreation practices and demographic information. This study introduced a methodology which would gain access to anonymous organizations without violating confidentiality of subjects. The method used indicated that study of alcoholics in the recovering community is possible. The role of recreation was identified as important to recovering alcoholics in a successful recovery program and offer insight to future research exploring any cause-effect relationship. This study also identified confounding variables which needed to be controlled by the researcher.

This paper is dedicated to all those brothers and sisters still living in the madness. May work such as this help you find the circle of recovery and the peace of serenity in the battle against addiction.

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CHAPTER I

INTRODUCTION AND PROBLEM STATEMENT

Introduction

It is estimated that nearly 10.5 million individuals in the United States exhibit some symptom of alcoholism and that an additional 7.2 million abuse alcohol, but do not yet show symptoms of chemical dependence (NIAAA, 1990). It is also estimated that an alcohol-related family problem strikes one out of every four American families (NCADD, 1990). Nearly two-thirds of the United States adult population drink, but 10% of all drinkers (those who drink most heavily) drink half of all the alcohol consumed each year (NCADD, 1990).

Approximately 1.2 million of the estimated 17.7 million Americans with alcohol problems have entered alcohol treatment programs (NCADD, 1990). In the treatment of alcoholism, the most common outcome is relapse, a general term used to describe the return to drinking (Stainback & Walker, 1990). High relapse rates are common, especially during the first three months after treatment (Stainback & Walker, 1990; Vaillant, 1983). Marlatt (1985) estimated over 90% of alcoholics relapse within two years following treatment.

Research, based primarily on relapse rates, indicates that treatment programs and support groups are ineffective in helping the majority of alcoholics maintain long periods of abstinence (Epstein, 1990; Marlatt, 1985; Rancourt, 1991; Stainback & Walker, 1990). According to Stainback and Walker (1990), treatment outcomes based on the time of abstinence are affected by differences in treatment techniques as well as the individual characteristics of both patients and staff (Montgomery et al., 1993). Researchers and

practitioners need to be able to identify and understand what factors are significant indicators of successful recovery for their patients in order to provide more effective treatment methods and increase recovery rates (Rancourt, 1991; Kufner & Feuerlein, 1989). Recovery is viewed as a dynamic, lifelong process and can be defined in terms of the extinction of conditioned responses connected to the use of alcohol that take place over time usually with some form of intervention through treatment, aftercare or after treatment program (Babor et al., 1986; Stainback & Walker, 1990). Intervention affects recovery in that close family members, co-workers, and or clinicians take the first step in addressing concerns of an addiction to the alcoholic and recommend treatment or self-help groups. Treatment affects recovery by educating clients to the deadliness and pervasiveness of the disease called alcoholism. Along with educating alcoholics about the nature of the disease, treatment also identifies the tools used by recovering alcoholics to maintain long periods of abstinence and identifies this entire process as recovery. After care or after treatment programs relate to recovery in that they are designed to provide a continuation of the recovery process begun in treatment or from an intervention.

Need for this Study

Current information related to the recovery process focuses upon the views of practitioners (Edwards et al., 1987; Stainback & Walker, 1990) The relative ease of gaining access to the views of practitioners about alcoholism and recovery has prompted much of the research to focus on this information source. In comparison, reaching out to the recovering community is considerably more difficult. There are many factors which impact on the accessibility to the recovering community. Patient rights that insure the confidentiality of patients in mental health clinics keep data from public access. In

addition, self-help groups such as Alcoholics Anonymous, hold traditions which insure the anonymity of members and promise not to use the members as a research pool. See Appendix B.

Due to the limited access of information from the recovering community, an exploratory study was constructed to identify a method which could be utilized and standardized in this field of research. An exploratory study is designed to discover if a connection exists between factors often reported connected to a particular subject, to describe a methodology not used with this particular population and to generally describe the sample population.

In the relapse prevention model developed by Marlatt and his colleagues, relapse prevention techniques are utilized as guidelines to identify potential relapse precipitants and to construct alternative coping behaviors for the alcoholic (Marlatt & Gordon, 1980; 1985; Stainback & Walker, 1990). These techniques are based on research findings involving demographics of alcoholics in treatment settings and identifying what practitioners believe to be necessary for lengthy periods of abstinence (Gibbs & Flanagan, 1977; Marlatt & Gordon, 1980; 1985; Rancourt, 1991; Vaillant, 1983). Overlooked in the literature is the value of an alcoholic's perceptions. The Twelve Step Program is the account of two recovering alcoholics who were able to remain abstinent; their story and perceptions are the foundation of self-help recovery programs. The recovering community is a resource of treatment, learning and interventions that worked as well as what did not work for the alcoholic.

Data, which support the notion that every individual's recovery process differs (Stainback & Walker, 1990), also acknowledge that there may be similarities in the recovery process within the alcoholic population. It is questionable whether previous studies explored all potential variables that could influence the successful recovery of alcoholics, or whether there are additional aspects. The alcoholic's perception of recovery

needs to be considered because treatment plans and aftercare plans are often developed without taking pertinent factors regarding the alcoholic into account (Lerner & Barr, 1990). Of those pertinent lifestyle factors commonly discussed by medical professionals, research into the role recreation plays in the recovery process has not been initiated (Rancourt, 1991).

Within the diagnostic criteria of chemical dependency, recreation participation is identified as one potential indicator for the disease. The reduction of participation in recreation activities is considered a diagnostic component when, "Important social, occupational or recreational activities are given up or reduced because of substance use. The person may withdraw from family activities and hobbies to spend more time with substance-using friends, or to use the substance in private " (DSMIII-R, 1991, p. 167). According to this diagnostic tool, recreation participation is often decreased to allow more time for the consumption of the chemical substance.

Research Problem

The research problem for this exploratory study was to determine the perception of the alcoholic in recovery regarding the role recreation plays in his/her recovery process. In addition, access or a method allowing access to the recovering community was discussed as part of the research problem due to limitations encountered when working with this population. The study discussed what role recreation activities played in the recovery process and what factors the alcoholic attributed to his/her current state of sobriety. Significant research questions considered to provide insights into this problem were: Was recreation considered by the alcoholic as an important factor in the recovery? How does the recovering alcoholic rank the relative importance of recreation against variables found correlated with a successful recovery such as family support, marital status, employment status, continuance of self-support programs? (Gibbs & Flanagan,

1977; Rancourt, 1991; Vaillant, 1983). What benefits do recovering alcoholics perceive from recreation? Also explored was the amount of involvement in recreation and if that involvement had an effect upon the length of sobriety.

CHAPTER II

LITERATURE REVIEW

Characteristics of Alcoholism

According to the Diagnostic and Statistical Manual, (American Psychological Association, 1991), features of alcoholism are "a cluster of cognitive, behavioral and physiological symptoms that indicate the person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences" (p.166). The National Council on Alcohol and Drug Dependence (NCADD) defines alcoholism as "a chronic, progressive and potentially fatal disease marked by characteristics of tolerance and psychological and/or physical dependency" (NCADD, 1990, p. 1). The dependence is such that the alcoholic exhibits a compulsion to continue to use the substance and is unable to stop.

There are two types of dependency identified in the features of the addiction; physical and psychological dependency (DSMIII-R, 1991). Physical dependency occurs when an individual experiences altered physiological states due to regular, compulsive and continuous use of a chemical substance. Psychological dependence is a condition which drives the addiction and is considered a reinforcing effect (Rech, 1993). The psychological dependency can continue long after the last drop of the alcohol has been consumed (Maddux & Desmond, 1986).

Tolerance, another term often used when discussing characteristics of alcoholism, is "a markedly diminished effect with continued use of the same amount of substance over time" (DSMIII-R, 1991, p. 167). In many instances, the presence of tolerance requires the

increased consumption of the chemical to achieve the desired effect. Withdrawal symptoms result from the cessation of alcohol. Withdrawal symptoms include, but are not limited to, shakes, nausea and vomiting and can be alleviated when the alcoholic once again begins using the substance, thereby reinforcing the behavior to drink (DSMIII-R, 1991).

In an attempt to determine prognostic statements about alcoholics, a study conducted by Gibbs and Flanagan (1977) used lifestyle characteristics of alcoholic patients and found ten positive predictors of treatment outcomes:

1. Patient married or living with a partner
2. Stable marriage or relationship
3. Employed at time of admission
4. High-status job
5. Stable employment history at time of admission
6. High social class background
7. Psychoneurosis
8. Few arrests due to alcohol
9. Contact with Alcoholics Anonymous at time of admission
10. High score on Weschler's arithmetic subtest 10

Pre-treatment factors considered possible to predict recovery have also been examined. For alcoholics, Vaillant (1983) found that social stability of familial and employment issues, absence of arrests and late onset of alcoholism were identified as a positive indicator for recovery. In another study by Vaillant (1983), factors linked specifically to the issue of relapse included:

1. A genetic predisposition
2. A psychological predisposition
3. Physical dependence which may persist for months after use ceases
4. Operant and Pavlovian conditioning
5. Absence of protective conditions, such as stable social network

Alcohol and Recreation

In the United States, consumers spent nearly $88 billion on alcoholic beverages in 1988 (NCADD, 1990). Socially, the consumption of alcohol often occurs on weekends, during parties, after payday, during sporting events, on dates and dinners, as well as a variety of other non-work times. These activities are often clustered into the general category of "free time" activities. Free time, in the general population, has been found to involve the use of alcohol (Simpura, 1985; Young & Kronus, 1977). Involvement in recreation or leisure is somewhat lower for alcoholics than that of the general population (Sessoms & Oakley, 1969; Tuchfield, 1981). If participation in recreation activities which previously involved the use of drug and alcohol occurs, the alcoholic can experience some difficulty and possibly experience a trigger to return to the use of alcohol or drugs (McCormick & Dattilo, 1992). What the previous "use" time has been replaced with and if in fact individuals who have applied activities to this time are better prepared for their new role in recovery have yet to be discussed through research.

A common characteristic of alcoholism is that the alcoholic's time and many social responses revolve around the preferred substance (DSMIII-R, 1991). Helping the alcoholic find non-chemical alternatives to support the process of recovery has been cited as an important variable (Epstien, 1990; Francis, 1991; Rancourt, 1991). One source of non-chemical alternatives can be found in recreation activities. Not only must the physical attachment or dependence to the chemical substance be broken, but the ability of the alcoholic to restructure his/her lifestyle helps eliminate or reduce the opportunities for relapse (Francis, 1991).

Theories of Alcoholism

There are many theories examining how an addiction such as alcoholism develops. Alcoholism can be described using such theoretical beliefs which concern human nature

and development and come from theories like the medical model which considers an addiction incurable to an approach that considers an addiction curable. Theories of personality traits and self-esteem (Ausubel, 1980; Chein, 1980; Hendin, 1980; Jessor & Jessor, 1980; Kaplan, 1980; Loney, 1980; Robins, 1980; Smith, 1980), genetic predisposition (Bejerot, 1980; Goodwin, 1980; Hochhause, 1980; Schuckit, 1980), coping mechanisms (Ausubel, 1980; Khantzian, 1980; Milkman & Frosch, 1980; Peele, 1980), and social and environmental influences (Becker, 1980; Chein, 1980; Coleman, 1980, Hendin, 1980; Jessor & Jessor, 1980; Loney, 1980; Schuckit, 1980; Smith, 1980) attempt to explain how alcoholism develops. Each theory can be used to offer insight into ways of treating or arresting the symptoms related to alcoholism and help place the disease in a state of remission with abstinence and recovery. As pointed out by several researchers who consider alcoholism curable, as long as the perceived positive effects of drug taking out-weigh the perceived negative effects, people will continue to take drugs irrespective of the specific causes (Becker, 1980; Peele, 1980; Smith, 1980). Each of these causes and individual characteristics creates sub-populations within the disease. It seems logical to assume that difficulty in treatment may directly correspond to the fact that the addiction is a combination of many possible causes and thereby explains the relative ineffectiveness of any one treatment approach (Lerner & Barr, 1990).

Theories of Recovery

Under the philosophy of Alcoholics Anonymous and various treatment centers, alcoholism is an addictive disease that can only be treated and arrested, not cured (Spickard, 1990; Appendix A). When an individual abstains from the use of any mood altering substances, he/she is considered to be in the early stages of a lifelong process known as recovery. Treatment of an addiction under the medical model does acknowledge the need for the recovering individual to deal with the symptoms of the

disease. Once the use of the drug has stopped and the symptoms have been identified, the recovery process can begin. The recovery process is designed to help identify how an alcoholic can live a drug free life while understanding that the addiction, alcoholism, will never disappear. This is a biopsychosocial process involving all aspects of an individual's lifestyle and a process which needs work and dedication every day in order to live a happy, healthy, and drug free life. Treatment centers often work from the approach that recovery examines the past patterns of use, deals with the realities of relapse and how to avoid returning to drug usage (Gorski & Miller, 1986). Theories about recovery often describe a *process* of achieving and maintaining abstinence that is not directly related to any particular type or philosophy of treatment (Wesson et al., 1986).

Early Theories of Recovery and Natural Recovery

The concept of recovery from addiction has been around for some time now. In the early conceptual stages, alcoholism and addiction were considered developmental phases that would eventually be outgrown after considerable years of use and by age 35 (Wesson et al., 1986; Winick, 1962). This theory was known as the Maturation Theory and adopted the practice of allowing the addiction to run its course. The original data which supported this theory came for the statistical data of opiate users (Wesson et al., 1986). The alcoholic could continue to drink, knowing one day his/her body would no longer have a problem with the consumption of alcohol.

Individuals who no longer depend on chemical substances without the aid of treatment or support groups are considered to have achieved a natural recovery of the disease and are considered a phenomenon (Gorski & Miller, 1986). These individuals generally use a variety of methods or tools to remain free of the chemicals and often find new interests, new social relationships and new social identities (Wesson et al., 1986)

However, the majority of individuals waiting for the addiction phase to pass never made it. As a direct result of the lack of success by this treatment approach to addictions, a different approach regarding recovery emerged. This new theory was developed by the efforts of two men who wrote down the steps they took to gain sobriety and is now the basis of the Alcoholics Anonymous organization. The underlying assumption of this theory is that an addiction is for life, therefore the process of battling the disease of addiction needs to be a life long process.

Alcoholics Anonymous.

The Twelve Step recovery program as developed and practiced through Alcoholics Anonymous, aids in the understanding of recovery, relapse and addiction. As indicated by the moral code in the program, "Being in recovery implies that the person has accepted that addiction is a lifelong, incurable disease; that the person is participating in 12-step recovery groups; and that the person is learning to live a comfortable and responsible life without the use of psychoactive drugs." (Wesson et al., 1986 p. 15). Here to, the concepts of recovery and relapse were viewed as processes. Within this group, new social networks, new social identity and new interests are incorporated in the recovery steps. The model stresses the importance of remaining clear of any mood altering chemicals and any use of drugs or alcohol is considered relapse. Within this recovery tool, individuals acknowledge that relapse does occur. Through the use of sponsorship and the helping structure, the support group can cut the relapse time and the addict can re-work the steps of recovery again. Alcoholics Anonymous identifies that the recovery process also includes a relapse process. Relapse is not a single nor isolated event but rather the process by which altered attitudes and thinking take hold often referred to as "stinking thinking" (Gorski & Miller, 1986; Wesson et al., 1986). However, due to spirituality statements often misconstrued as religious overtones within the conceptual framework, many

alcoholics are unable to utilize the ideas behind the theory (Wesson et al., 1986). Other organizations, which parallel the self-help format of Alcoholics Anonymous, have developed steps which deal with statements of personal choice, will power and responsibility instead of misconstrued religious overtones (Gelman et al., 1991).

Recovery and Recreation

In the literature, recreation and community interests are highly stressed in the recovery process (Wanigaratne et al., 1990). It is common practice in many forms of recovery groups to include activities as a way of working on coping skills and behavior modification (Marlatt & Gordon, 1985; Wanigaratne et al., 1991). Prevention guide books, which are used to aid the recovering alcoholic, include recreational activities and leisure time assignments for the addict to work on during a session (Gorski & Miller, 1986).

In order to achieve long lasting sobriety, there needs to be something for the alcoholic to look forward to during recovery (Francis, 1991; O'dea-Evans, 1990 ; Rancourt, 1991). The application of recreation in the treatment program, along with relapse prevention groups, can offer additional options in recovery and be beneficial to the recovering community. The philosophy of utilizing recreation in recovery is aimed at helping the alcoholic find alternative activities to replace their "use" time with more positive and healthy drug free choices (Epstein, 1990; Francis, 1991; Rancourt, 1991).

Recreation participation can be a good medium for eliminating feelings of loneliness and boredom commonly reported by recovering addicts, as well as provide an alternative to the drinking (Chein, 1980; McAuliffe, 1980; Rancourt, 1991). In the clinical or community setting, recreation can be incorporated into the biopsychosocial approach towards treating the disease in a variety of ways. Rancourt (1991) listed some of the

treatment goals Therapeutic Recreation Specialists in the treatment setting which can impact on a recovery program. The treatment goals identified include:

- A quality sobriety and improvement in overall life functioning.
- Developing new non-chemical methods for obtaining needs.
- Develop or improve problem solving and social interaction skills.
- Help alcoholics manage/identify stressors without use of addictive behaviors.

Rancourt (1991) found that several researchers (Cohen, 1986; Kaplan, 1990; Kaufman 1990-91; Kunstler, 1992; Martin, 1990; O'Dea-Evans, 1990; Wallace et al., 1988; Wolber et al., 1990) support the provision of recreation and leisure services in treatment. In many instances the literature has suggested that recreation would be useful in treatment and it is common to find practicing activity therapists or Certified Therapeutic Recreation Specialists in treatment settings (Cohen, 1972; Glasser, 1976; Iso-Ahola, 1990; Julien, 1986; Kunstler, 1992). O'Dea-Evans (1990) listed a number of advantages of Therapeutic Recreation (TR) in the treatment setting including but not limited to:

- TR contributes to the overall recovery by assisting clients in learning leisure alternatives and skills that will help them deal with new found leisure time.

- TR enhances the ability to manage stress, teaches stress reduction skills and provides escape of everyday tension.

- TR reduces relapse, studies show a significant increase in abstinence rates when programs utilize TR services.

- TR provides "leisure counseling" that can prevent "work addiction" and other substitution addictions.

- TR increases client self esteem, accomplishment and sense of self worth.

- TR provides an appropriate outlet to process and practice feelings of frustration anxiety, anger, depression, etc.

- TR enhances opportunities for sober adventures, experiences and self creativity while reducing boredom.

Recently, an exploratory study examining free time use and people with alcoholism attending open Alcoholics Anonymous meetings in Urbana, Illinois, was published. It offered insight into gaining access to this population group and identified the leisure behaviors and attitudes (McCormick & Dattilo, 1992).

Theories of Relapse

As stated earlier, there are a wide range of issues regarding recovery that need further exploration. A number of factors which researchers and practitioners view to be of importance to the alcoholic's recovery process have been identified, but clear relationships are difficult to determine (Gibbs & Flanagan, 1977; Kufner & Feuerlein, 1989; Rancourt, 1991; Vaillant, 1983). Relapse is a component within the recovery process. Chances are high that an alcoholic will experience at least one relapse during the struggle for long lasting recovery (Marlatt, 1985; Martin; Stainback & Walker, 1990). From the practitioner's stand point, the rate of relapse is determined not only by the definition used to describe relapse, but also by the method used to determine whether a relapse has taken place (Wesson et al., 1986). Relapse is most often considered the return to use of any mood altering substance. Gorski (1986) and other relapse prevention experts consider relapse not only the return to use of a chemical substance, but also the behaviors developed within the addiction. Relapse is also a process, just like recovery. The relapse process progresses towards the return to chemical use and can receive intervention before the addict takes up use again or before the use is worse than before the period of sobriety (Gorski & Miller, 1986).

Learning Theories and Relapse

Learning theories can aid in the explanation of the alcoholic's recovery process. Both social learning theory and conditioning techniques "explain initiation of drug use,

habituation, withdrawal and relapse" giving practitioners insight into treatment and recovery for the alcoholic (Wesson et al., 1986 p. 8). Under the social learning theory, the focus on the alcoholic and the potential for relapse come from a cognitive approach. Models within this framework focus on the acquisition, maintenance and modification of behavior by the alcoholic throughout treatment and recovery (Wesson et al., 1986). A general model of relapse often used in social learning theories consists of the presence of a high-risk situation confronting the alcoholic during a period of abstinence. Next, determination of likely responses and expectations the alcoholic has regarding the situation's resolve without the use of alcohol, and the resources and skills the alcoholic has to deal with the high-risk situation are then explored and practiced (Wesson et al., 1986). The model also supports the belief that relapse is a process by maintaining that situations handled without use of alcohol increase expectations about self-control, mastery and ability to remain abstinent. A return to the use of alcohol as a result of the high-risk situation can often lead to guilt and feelings of failure, which can precipitate further use (Bandura, 1977; Wesson et al., 1986).

Social learning theory takes steps during the treatment and recovery process to acknowledge patterns within the alcoholic's usage of any mood altering chemicals. It focuses on the chain of behaviors and seeks to intervene at certain stages beginning with what constitutes a "high-risk" for the individual all the way through a full fledged relapse or return to alcohol or drug usage (Wesson et al., 1986). The development or improvement of the alcoholic's coping skills is highly focused in this theory in an attempt to equip the alcoholic with some defenses against the return to the use of alcohol or drugs in high-risk situations. Wesson et al., (1986) further indicate that following a relapse, "interventions include teaching clients how to limit or contain an episode of drug use and... [teach] cognitive restructuring [which] involves conceptualizing the episode of use as a limited slip rather than a major disaster; analyzing the high-risk situation; and learning

new coping skills" (p. 10). Social learning models address the reality of relapse within the recovery process and utilize the experiences caused by the occurrence(s), instead of blaming the alcoholic.

Stress, Social Support and Relapse

Stress and social support shed light onto the subject of relapse. It has been noted that stress, operationalized as negative life events, is implicated in treatment failure and/or as a cause of relapse (Wesson et al., 1986). However, the relationship between stress and relapse is still unclear and may in fact be a secondary symptom of an impending relapse as opposed to the cause of one (Wesson et al., 1986). Findings indicate that individuals reporting large numbers of negative life events are often associated with individuals who have already relapsed or with those persons considered to have poorer treatment outcomes (Moos & Finney, 1983). In a study conducted by Cronkite and Moos (1980), it was found that post-treatment stress affected alcoholic treatment outcomes, especially level of depression. In addition, they found that stressors and coping responses were more strongly related to outcome than family environment. As pointed out in a review by Wesson et al. (1986), the results of the post-treatment study were unable to separate stressors produced by the relapse from stressors leading to a relapse. Stress or the coping with stress has been indicated to be affected positively with participation in certain leisure activities (Coleman, 1980). The use of leisure or recreation can in turn affect the levels of stress in recovery.

Loosely connected to the theme of stress as a factor to relapse is that of social supports. It is suggested that a good social support system can work as a buffer against stressful events (Wesson et al., 1990). As has been noted, there seems to be evidence that social support systems cannot only buffer against stressful events but also produce a

general beneficial effect for the individual independent of stressful life experiences (Wesson et al., 1990; Cohen & Wills, 1985).

It is noted within the theory of relapse prevention, that the particular social structure the alcoholic returns to after treatment is important for a successful recovery. Wesson et al. (1990), state that the support provided by the alcoholic's significant others can have both positive and negative consequences. A healthy, balanced and open social support or family system often increases chances for a good prognosis of recovery. With a stable or strong support base, an alcoholic who is able to work on self-esteem and restructuring his/her previous behaviors increase the chance of success. Studies indicate that stable marital and familial structures correlate with outcomes of post treatment alcohol consumption (Moos & Finney, 1983) as well as a significantly longer period of abstinence before relapse for subjects with partners (Havassy et al, 1986).

Relapse and Relapse Prevention

Relapse prevention is a self control program that combines behavioral skills training, cognitive interventions and lifestyle change procedures. It emphasizes self-management and the techniques and strategies aimed at enhancing maintenance of habit change (Wanigaratne et al, 1990).

According to one view of relapse prevention theory, a relapse is defined as the process, occurring over a period of time, that returns the alcoholic to drug use of at least the same intensity as in the past (Wesson et al., 1986). It does not have to be the previous drug of choice, but of the same magnitude concerning use and pervasive behavior problems. In addition, it is to be noted that an alcoholic may experience times commonly referred to as a lapse, which is considered to be a one time or short term use of a substance with a return to abstinence or treatment before the use turned into a pattern of use (Stainback & Walker, 1990; Wesson et al., 1986).

Alcohol is often reported to be utilized as a coping mechanism for the alcoholic (Huggins, 1990). When the stress is too high, life is too tough, and the personal problems are mounting, consumption of alcohol is the easiest and often only way he or she knows to numb the body and attempt to block out life's problems. It is suggested that the high rate of relapse for alcoholics is due to the fact that they have not been able to adapt to new coping skills and simply return to his/her older and more comfortable methods of drinking (Wanigaratne et al., 1990). Relapse prevention is designed to identify non-chemical ways of dealing with high risk situations to decrease chances of relapse. Every recovering alcoholic needs to learn how to deal with stress, anxiety, depression and anger without the aid of mood altering chemicals (Gorski & Miller, 1986; Kunstler, 1992).

Techniques in Treatment

Treatment for alcoholism can be found in a variety of settings such as hospitals, treatment centers, work, church or an Alcoholics Anonymous site. There is a common assumption within these settings that for every person the recovery process is different and that patients, matched appropriately to treatment, are expected to obtain superior outcomes (Stainback & Walker, 1990). Treatment in most settings provides for alcohol detoxification, a process of removing the physiological effects of the substance. In addition to the physical needs, treatment also focuses on allowing the alcoholic to select alternative methods in an attempt to deal with the long term effects of a psychological dependence. According to Lerner and Barr (1990), it is important to provide alcoholics with a strong support base to help them throughout the recovery process by assisting the alcoholic in the selection of an on-going treatment and support program.

A multi-disciplinary treatment team is often employed in treatment facilities, giving one overall program plan to all (Barr, 1990; Epstein, 1990; Lerner & Barr, 1990). The patient experiences a wide range of therapies that can aid in his/her recovery process. The

exposure to varying therapeutic techniques is useful in developing the skills and behaviors to deal with the lifelong process of recovery. However, personalizing various treatment options to the patient based on initial assessment is still missing (Hester & Miller, 1989). These therapeutic modalities often include such approaches as individual therapy, group therapy, audio/visual educational presentations, written materials, lecture and adjunctive activities (Epstein, 1990). Common approaches in treatment combine some or all the following: individual evaluation, psychotherapy, marital and family therapy, insight groups, problem-solving groups, family support groups, grief resolution groups, special interest groups, relaxation training groups, assertion training groups, leisure counseling groups, occupational therapy groups, relapse prevention groups, step groups adjunctive therapy and audio-visual groups (Epstein, 1990).

In the identification of treatment goals for the recovering alcoholic, as noted by Kunstler (1992) and Rancourt (1991), in many backgrounds both practitioners and researcher stress issues of a quality sobriety and an improved overall life functioning in which the goal is not only to remain abstinent, but to improve one's ability for effective living. Rancourt's (1990) review of this topic indicates the importance of allowing the alcoholic to explore non-chemical alternatives for meeting needs, desires and obtaining personal goals (Kunstler, 1992).

CHAPTER III

METHODOLOGY

Subjects

This was a study of the perceptions of recovering alcoholics in an Alcoholics Anonymous support group regarding the role of recreation in recovery. Data were collected during the period between August 16 and December 15, 1993. The study was designed also to test the methodology used in gathering data from a group of individuals, often considered inaccessible for research. Subjects in this study received full anonymity and confidentiality in line with Human Subject standards and the Twelve Traditions of Alcoholics Anonymous. See Appendix B. A recovering alcoholic was defined as an adult who has identified that he/she cannot control the use of alcohol and was seeking help for the disease through a Lansing area based Alano Club for Alcoholics Anonymous meetings.

Design and Procedures

The overall design of the study was to gather information from a subject pool that lived within the local community and has embedded the beliefs of the organization that anonymity be guaranteed to each member. An instrument was developed and tested using members of the Alcoholics Anonymous organization. Sampling and dispersement procedures were established which insured the anonymity of each subject.

Throughout the literature there is limited research reported regarding recreation and alcoholism. In a study examining free time and the alcoholic, observation techniques were used in addition to participation in local Alcoholics Anonymous meetings (McCormick & Dattilo, 1992). Due to the kind of information needed for this study and

in order to maintain anonymity, the methods used by McCormick and Dattilo (1992) were not deemed appropriate. Methods which utilized the observation of Alcoholics Anonymous open group meetings, those available to any individual, were not considered appropriate to determine the attitude and beliefs of the target population for this study. Even though Alcoholics Anonymous provides open and closed meetings, the Alano Club East is always open to the public, not just individuals in recovery for alcohol. Therefore, a selection method was developed to determine respondents who were in recovery and to differentiate between family members of alcoholics and those individuals in recovery. Since the researcher did not have any recovering alcoholic clientele, there was no clear method that could be used as a model for obtaining a sample within the alcoholic community.

Instrument Development

The following variables were included in this study and, thus, incorporated in the instrument: whether recovering alcoholics considered recreation an important factor to their recovery; how recovering alcoholics ranked recreation as an important factor in their recovery as compared to Alcoholics Anonymous structures, family support, and work; and amount of time recovering alcoholics spent in recreation activities. Each variable was indicated to be of some importance in the literature (Gibbs & Flanagan, 1977; Rancourt, 1991; Vaillant, 1983). Questions were included to investigate the role of recreation in the recovery process more in-depth than had been previously identified in the literature.

This instrument was a self-administered questionnaire booklet which requested a variety of information on the recovery process, attributes of drinking, recreation activity, and demographics. Information was also gathered on the individual's history of recovery

and his/her perceptions as an Alcoholic Anonymous (AA) member regarding recovery and recreation.

There were seven categories included within the instrument: Participation in a support group, Beliefs, Relapse factors, Treatment program information, Recreation, Demographics, and Attributions inventory. The instrument was arranged in such a way as to attempt to separate the different variables to be analyzed. See Appendix E.

Participation in a support group was designed with nominal and continuous variables. The continuous variables included time spent at AA and longest period of abstinence both of which would help gauge any differences in responses for the variable of length of time associated with the AA organization. These questions helped provide a range of AA member involvement.

An individual's belief in the Twelve Step Theory was addressed with two rank order questions comparing the fundamental beliefs of the program (belief in a higher power and belief and use of your support groups) with variables reported in the literature. It was expected that many of the responses would be based on the teachings and beliefs of the Twelve Step Program, since AA members were selected for the subject pool. See Appendix A and Appendix B. Due to the AA structure those responses which are main concepts of the Twelve Step Program were expected to be ranked as most important and therefore to be confounding variables. As a result, those variables related to AA were included to obtain an accurate measure of the role of recreation in recovery. The variables were also thought to offer insight into differences in treatment and attributes regarding recreation use and recovery based on gender, race, and education level (Lerner & Barr, 1990).

Following the beliefs category, relapse factors addressed in the literature were placed on a Likert scale for analysis, then respondents were asked to rank the most

problematic factors to their recovery. Each factor reflected the works of O'Dea-Evans (1990) and Rancourt (1991) as previously noted on page 12.

For those individuals who attended treatment programs, nominal scales were used to examine length of stay and motivation for treatment. These were included to help clarify and identify issues of potential confounding variables. Participation in treatment and Alcoholics Anonymous versus participation in Alcoholics Anonymous only have an undefined relationship throughout the literature. The question whether treatment was potentially confounding in this study led to the inclusion of the variables of attendance in treatment and participation in Alcoholics Anonymous in the instrument.

The amount of time spent in recreation activities by recovering alcoholics was measured through responses in the section on recreation activities. Two different measurement scales were used to quantify the time spent involved in recreation. The first variable being a ratio scale measure of total hours per week spent in recreation activities and the second method being an ordinal scale which measured the number of days a week an individual reported involvement in recreation activities.

Demographics were obtained by nominal scales for the categories of age, employment status, gender, race and education. The issue of demographic characteristics influencing the chances of an individual becoming an alcoholic is discussed in the literature, alcoholism being a heterogeneous disease which can affect anyone. However, the relationship of successful recovery and particular demographic characteristics remains undefined. The categories of age, gender, education, race and work also provided crossbreaks about recreation participation.

The Attribution Inventory by Edwards et al. (1987) was the only section of the instrument used from previous research. It should be noted that the Inventory was modified with the addition of the following items: talking to an activity therapist, increasing my free time, engaging in recreation activities, and being interested in physical

activities. The item focusing on contact with an Activity Therapist used the same format given to other types of counseling professionals listed in the Inventory. The title of Activity Therapist was used instead of Recreation Therapist due to Lansing area hospital's identification of Activity Therapy staff in their treatment centers. The item for increased free time stemmed from access to assessment forms used by treatment centers in which the researcher had work experience and the common reporting of clients who indicated that free time was a problem for their recovery. The literature also indicated that free time could pose a potential problem for alcoholics (Marlatt, 1990; Rancourt, 1991). Finally, recreation activities and physical activities were included to determine any difference in the participant's identification between social activities, recreation activities, free time activities or physical activities.

This study sought to identify issues that the alcoholic felt important to his/her success and continued sobriety. The survey items and response choices incorporated recreation as a potential factor in recovery and presented the subjects with a variety of other factors deemed significant to be tested (Gibbs & Flanagan, 1977; Kufner & Feuerlein, 1989; Marlatt, 1990; Rancourt, 1991; Vaillant, 1983).

Pilot Study. The instrument developed was piloted to evaluate face validity because there were items such as the leisure time involvement and Alcoholic Anonymous beliefs that had not already been tested by other researchers in this particular format. The pilot study also was conducted in order to insure clarity of instructions and to make sure that the wording of Alcoholics Anonymous beliefs was accurate and that there were no missing aspects to the Alcoholics Anonymous program.

The first step taken in this study was to contact the local Alano Club East and ask about previous research that had been conducted with their organization. The club manager informed the researcher that Alano clubs did not conduct nor support the use of

recovering alcoholics as part of research. He referenced the traditions of Alcoholics Anonymous and suggested that the Central Alcoholics Anonymous office in Lansing be contacted. The Central Alcoholics Anonymous office provided the name of a member who was likely to have more information on accessing the recovering community. Through a variety of phone calls with this AA member, a tentative method of accessing the members at Alano Club East was outlined. The method needed to gain access to the recovering community, to gather information about their beliefs regarding a successful recovery program along with personal information about their own recovery progress. The method included the use of the coffee shop located just outside the Alano Club East meeting rooms. This area was considered open to all regardless of the type of meeting or the topic of the meeting. This meant that although a meeting may be closed to any but recovering addicts, non-recovering persons could still remain in the coffee shop without disrupting the meetings or offending the members. Gaining access to the meeting members in accordance with AA traditions was considered a significant barrier to the research. Much care and assurance needed to be given to those individuals participating, yet gaining access also posed a challenge to the researcher for obtaining a pilot study sample and subsequently gaining access to a significant number of Alcoholics Anonymous members with the final instrument.

The organization of AA itself was not a participant in this study. Through contact with members or on the questionnaire packets, no mention of the organization was allowed. This was directly related to the promise the organization has for its members. The organization states that it does not promote or support research studies on individuals who are struggling to maintain their recovery. See Appendix A. Due to this restriction as well as issues of anonymity connected not only through Alcoholics Anonymous, but with Michigan State University's Human Subjects Review Board, direct contact was minimized with subjects and all contacts were made without the use of any last names or methods of

connecting subjects to their survey responses. Face to face contact was made with the participants by the researcher, only before and after AA meetings at the Alano Club East in Lansing.

Through the various conversations in the conceptualizing stages of this study, the contact member also agreed to assist the researcher in obtaining a sample of participants from the various Alcoholics Anonymous meetings offered for the pilot study. The initial instrument was reviewed for the content and format not only with faculty experts in questionnaire design and content at the University, but also with the contact member at the central office. After review, twenty questionnaires were printed and given to the contact member who then assembled fifteen individuals to complete the initial instrument at the Central Alcoholics Anonymous office. Clarification on the directions to complete the Attribute scale was needed from the researcher during the pilot test and was made through a phone call from the contact member to the researcher's home. The remaining five questionnaires were handed out to members not present at the office and they be returned to the researcher by the contact member. Ten questionnaires were returned within two weeks. Responses to the initial instrument were not used in the final analysis.

Final Instrument. On the basis of responses to the initial instrument in the pilot study, instructions and content modifications and a layout design changes to the questionnaire were made. Section five of the initial instrument was completely removed due to confusion and complaints regarding length of completion time. Information removed included the subject's sponsorship in the program, current progress in the Twelve Step Program, and the history for becoming involved in AA. While these were interesting questions, they were not germane to the initial research questions. Simplification of relapse issues were needed to prevent confusion by asking subjects if they have ever had a relapse or a slip, yes or no. The final instrument was arranged and printed in booklet

form, placing the most time consuming section in the center of the booklet. Instructions were added at each section heading, giving a brief description of the subject being presented. Each question had words added to indicate the method of response ("circle number", "circle only one answer", "rank...using the number one as most important" and "circle any that apply"). Simple computer techniques of spacing, boxing and highlighting sections of the instrument were employed to improve readability. Graphics were added only on the cover and information from the cover letter was placed on the front page of the questionnaire booklet to present a professional appearance. All questions and answers were placed into the same design format giving an easy to follow layout. See Appendix G.

Sampling Procedures

An initial review of the literature found a limited number of studies utilizing subjects from Alcoholics Anonymous organizations. Most of the literature focused on practitioners who may or may not have been recovering addicts (Gorski & Miller, 1986; Kufner & Feuerlein, 1986). Other studies gathered subjects from the whole community by sending mailings to the general public (Edwards et al., 1986). Another study, which explored the recovering community, presented information on researcher observation during open Alcoholics Anonymous meetings and conducted brief interviews with a limited sample (McCormick & Datillo, 1990). Observations made during this study could not guarantee that the subject observed was a recovering alcoholic since not all people at open Alcoholics Anonymous meetings are recovering alcoholics. Previous studies that focused on the recovering community utilized clients within a treatment setting and utilized contact with clients after a follow-up period, which ranged from one month to five years after discharge (Kufner & Feuerlein, 1989). The method of questionnaire dispersement used in this study used a different approach than mentioned in previous

studies in order to address confidentiality concerns identified in the promises of Alcoholics Anonymous. See Appendix B.

Packets for this study were handed out by the researcher at the coffee shop of the Alano Club East. Each packet included: (a) a cover letter identifying the purpose of the study, the confidentiality of information within the survey, the use of answers collected in the study and that Michigan State University's Department of Park and Recreation Resources was sponsoring the study and not the Alcoholics Anonymous organization; (b) the questionnaire booklet; and (c) a stamped addressed return envelope.

Questionnaire packets were distributed by the researcher in face to face contact with members at Lansing's Alano Club East in the building's coffee shop during a random sample of all meeting times. See Appendix C. The Alano Club East holds 49 different meetings throughout the week. Meetings begin as early as 11 a.m. and run until Midnight Monday through Friday. Weekend meetings begin at 8 a.m. and finish at Midnight. Originally, a systematic random sampling for meeting times for the dispersement of questionnaire packets was attempted. By selecting every fourth meeting offered based on the order identified in the meeting brochure a random selection would be made. However, this method and the subsequent method of attempting to select every fifth or sixth meeting excluded some days altogether and appeared to be repeating times and topics of meetings. Since observations made by the researcher indicated that recovering alcoholics at the Alano Club East have a tendency to go to meetings at the same time, a different selection approach was necessary.

Presented in Table 1 are the meeting times where questionnaires were distributed. Meetings were selected by the researcher choosing at least two meeting topics every day of the week and trying not to duplicate topics or times.

Table 1:
Surveyed AA Meeting Times.

DAYS	TIMES	TOPICS
Monday	11:30 a.m.	Beginners Group
	12 noon	Nonsmokers Group
Tuesday	3:30 p.m.	Big Book Group
	6:30 p.m.	12 Step Group
	8 p.m.	12 Steps and Traditions
Wed	5:30 p.m.	Happy Hour East
	8 p.m.	Celebration of Sobriety
Thursday	11:30 a.m.	12 Steps Group & Non Smoking Group
	6:30 p.m.	Women Only & Men Only Group
Friday	11:30 a.m.	Discussion Group
	12 noon	Humble Best
	3:30 p.m.	Foundations Group
	5:30 p.m.	New Hope Group
Saturday	8 a.m.	Sunrise Group
	9:15 a.m.	Learning to Live
	11:30 a.m.	Promise Group
Sunday	6:30 p.m.	Sunday Night Serenity
	7 p.m.	Each Day Group (Women)
	8 p.m.	First 4 Steps

Each meeting was visited at least one time. All participants in this study were identified as members of the alcoholic community through their own admission.

For this particular study, sixty questionnaire packets were distributed by the researcher to available members at the Alano Club East coffee shop. No follow-up was conducted. Non-response bias was considered a potential problem for this study considering the high regard for anonymity of the membership.

Researcher's Impact. It is important to note the characteristics of the researcher. As with other studies using interview format, the individual characteristics of the interviewer can

have an impact on the responses and return rate. The researcher was a 23 year old Caucasian female, five feet three inches tall and weighed 107 pounds. In addition, the researcher had been working with recovering addicts for over two years. The researcher possessed an understanding of the disease of alcoholism and a great deal of empathy for individuals struggling with their addiction and recovery. The researcher would show up an hour before the selected meeting and stay up to an hour after the meeting time to insure time to speak with members. In addition, she often spoke with the coffee shop workers or was seen talking with other members. From an outsider's perspective, the researcher appeared to fit in with the other people coming to the club. When approaching potential subjects, the researcher identified herself, her connection with the University and the intent of her study which explored the recovering alcoholic's perceptions.

Data Analysis

Because of the nature of the data and the small sample size, analysis of the data involved descriptive statistics. Percentages and means were used to describe the demographic characteristics of subjects, the length of time involved in AA, and the length of longest abstinence. Frequency counts and rank orderings were used to determine how important subjects regarded recreation in their recovery process. Quality of the recreation experience and benefits gained from recreation were the focus, rather than the average time of participation. This was analyzed by reviewing the open ended responses. A correlation was done on length of time involved in AA and longest period of abstinence to examine the possibility of confounding variables.

Initial analysis of the data from the Attribution Scale by Edwards et al. (1987), involved the ranking of attributes which respondents felt were "helpful" or "harmful" to their alcohol consumption. Attributes were ranked by percentage of responses in one of two categories. In the first set, responses for items which were marked as "greatly helped

stop my drinking" and "somewhat helped stop my drinking" were grouped together as a positive attribute. Each attribute percentage was calculated based on the individual item's sample size. In the second set, responses marked as "made my drinking worse" and "made my drinking very much worse" were grouped together to indicate attributes with a negative impact. The responses which indicated "no bearing, never experienced" were considered neither positive nor negative. The data analysis conducted by Edwards et al. (1987), was not used for this study because items which were added to the inventory were being examined to see how they related to the overall positive and negative attributions.

CHAPTER IV

RESULTS AND CONCLUSIONS

The purpose of this study was to address the question regarding the role of recreation in the process of recovery for the alcoholic, as well as to assess a method for gathering data from a population with strong concerns regarding the protection of their anonymity. This Chapter is in two sections: (1) Results and Discussion, and (2) Conclusions and Recommendations.

Results and Discussion

Subjects

Response Rate. Sixty questionnaires were distributed; 31 questionnaires were returned for a response rate of 51% and 28 members opted not to return the questionnaire. One questionnaire was returned, but more than 95% of the survey was left blank, so it was not usable. Only three potential subjects, when offered a questionnaire, chose not to participate and refused to take the questionnaire. Follow-up procedures to increase the response rates were not considered feasible due to the anonymity required.

Demographics. There were 31 subjects, all over the age of 18 years. There was an almost even division of female subjects (45%) and male subjects (54%), which was considered unusual. Due to stigma, women are considered under represented in both treatment centers and recovery programs. The study was composed of 87 % Caucasian subjects.

There was only one respondent each for African American, Asian and Hispanic races. One subject did not indicate race on the questionnaire. The composition of the sample was not the result of any distribution bias, but rather to the Alcoholics Anonymous club's general membership composition. During the meeting times sampled, observation by the researcher recorded only two African Americans, one Asian, two Hispanics and one Native American at the Alano Club. All subjects reported having at least a high school diploma or General Education Diploma. See Table 2.

Table 2.
Demographic Composition of Sample

Demographic Category	Frequency	Percent[a]
Age		
18-24	1	2
25-34	9	29
35-44	13	40
45-54	2	6
55-64	2	6
65 up	4	12
Gender		
female	14	45
male	17	54
Education		
high school diploma or G.E.D	4	12
some college	11	35
college degree	10	32
post graduate study or degree	6	19
Race		
Caucasian	27	87
African American	1	2
Hispanic	1	2
Asian	1	2

[a]Percentages may not total 100 due to rounding, n = 31.

The mean time of abstinence reported by respondents was 67.4 months, whereas the overall time spent attending AA was 76 months. There is a strong linear relationship between these variables with a correlation of 0.951. This corresponds with the

expectation that relapse does occur within the recovering process. Age also was associated to both time at Alcoholics Anonymous and time of abstinence.

The study was designed to identify characteristics or variables related to recreation and recovery, and was not to determine cause-effect relationships. Each demographic characteristic variable has certain implications to the questions posed. However, generalizations and detailed statistical analyses were restricted due to the limited sample size.

Research Questions

One question posed in this study was the alcoholic's view and use of recreation in recovery. Of the 31 responses, 27 subjects currently recreated and only 4 subjects did not. Of the 4 who did not currently participate in recreation, reasons for the lack of involvement included health reasons, current in-house arrest program, lack of time, and working too much. As far as participant involvement in activities, 6% of respondents claimed that they did not recreate. Other than that, the mean participation in recreation activities was 3-4 days each week for about 5-8 hours each week.

Further analysis of the role recreation plays in recovery focused on how subject's involvement with recreation compares "before treatment" and/or "before involvement in Alcoholics Anonymous". Fifty-one percent of the subjects identified more involvement in recreation at the time of the study than before entering treatment. Seventy-five percent reported more involvement in recreation at the time of the study than before entering AA. Only one subject stated less involvement in recreation at the time of the study than before entering treatment or AA.

In the choice of statements regarding recreation's impact on recovery, approximately 97% of the respondents felt that "recreation was important to or should be a larger part of their recovery". None of the respondents felt that recreation distracted

from the recovery process. Even for the one respondent who did not believe recreation was a part of his/her recovery, recreation was not viewed as negative. See Table 3.

Table 3
Statements About Recreation and Recovery.

Frequency of Response	Statement
19	Felt Recreation was important to their recovery
0	Felt Recreation was a distraction to their recovery
1	Felt Recreation was not a part of their recovery
11	Felt Recreation should be a larger part of their recovery

In the open ended questions, respondents described a variety of feelings and situations in which recreation benefits his/her recovery. Recreation was reported to help with loneliness, curb depression, socialization, time management, inner balance, anger, relaxation, stress, boredom, self-esteem, physical health, teach patience, learn to laugh again and to learn about oneself. All impacts mentioned by participants support the literature discussed in Recreation and Recovery on page 13.

Positive Attributes. Items in the Attribution Scale that related to the beliefs and traditions of Alcoholics Anonymous were rated extremely high by the sample population. Attributes which can be influenced by recreation included "learning to relax" with a 94% positive endorsement, "understanding myself better" 90%, "being involved in social activities 65%, "being interested in physical activities" 48%, "engaging in recreation activities" 39% and "increase in my free time" 35%. See Table 4 and Appendix H.

Table 4
Positive Attributes where Recreation or AA were Identified

RANK	ATTRIBUTE	POSITIVE ENDORSEMENT
1	AA in general	100
"	Hearing other people's stories at AA	100
3	Believing in a higher power	97
"	Telling my own story to others	97
"	Finding friends through AA	97
6	Reminding myself of the positive consequences to sobriety	94
"	Learning to relax	94
9	Taking an interest in other people	93
12	Understanding myself better	90
"	Stopping feeling sorry for myself	90
17	Wanting my self respect	83
18	Keeping away from drinking parties	81
19	Feeling able to love	74
20	Dealing with my resentments	73
"	Getting over depression	68
25	Being involved in social activities	65
26	Keeping out/away from bars	61
28	Being in a treatment center	58
"	Engaging in Recreation activities	39
45	Increasing my free time	35
46	Always being on guard	32

Negative Attributes. Results for those attributes listed as "harmful" to the recovery programs of respondents are indicated in Table 5. These attributes were ranked according to the percentage of times respondents found these to have "made my drinking worse" and "made my drinking very much worse". Several attributes appear in both tables 4 and 5: "Increasing my free time" and "engaging in recreation activities", which received endorsements of 35% and 39%, respectively, also appeared in the negative attributes of recovery at 42% and 35%, respectively.

Table 5
Negative Attributes where Recreation was Identified.

RANK	ATTRIBUTES	NEGATIVE ENDORSEMENT
1	Being or feeling lonely	90
4	Keeping away from drinking parties	81
6	Determination to drink like others	77
8	Using alcohol to be less shy	71
10	Always being on guard	52
11	Increasing my free time	42
12	Engaging in recreation activities	35
14	Getting over depression	29
16	Using tranquilizers	23

Discussion

Some significant aspects of methodology were identified for practical use with this population. A number of issues presented themselves during and after the operation of those methods identified earlier. The random selection of meeting times did present a dilemma for the researcher when the same individuals were encountered at randomly selected meetings. Since it was typical for members to attend more than one meeting a day and often seven days a week, the researcher encountered meetings where all members in the coffee shop had already been approached to complete a questionnaire for the study.

The initial response rate was high considering there was no follow-up method employed. Complications arose when responses were slow to be returned. The majority of questionnaires were handed out after Thanksgiving with a deadline of December 15, 1993, which may not have given some individuals enough time to return the survey. Postings and flyers at the club were strictly reserved for Alcoholics Anonymous meeting information and were not allowed to be used for follow up notices. Flyers left on the tables to remind individuals who had not returned their surveys would be thrown away after the meeting took place according to the policy of the Alano manager. In addition, no record was kept to determine who received a questionnaire other than in the memory of the researcher. This limitation is in direct response to the promise of anonymity for the

respondents. Each questionnaire excluded any space or line asking for name or personal identification and envelopes issued for return mail purposes already had the department address stamped to eliminate the need for a return address.

The face to face contact of the dispersement procedures did allow for assurance that each participant was a recovering alcoholic. One potential subject who refused a questionnaire was actually at the Alano Club to support a recovering spouse. The subject identified herself as having a relationship with the Al-Anon program for family of recovering alcoholics and not AA. This subject therefore was not able to accept a survey. Her husband was offered a survey but opted not to complete one.

The acceptance and subsequent return rates may have been affected by the characteristics of the sample. Although the sample consisted of members from a Lansing area meeting club, the demographic composition of the sample more closely resembled East Lansing's population than that of Lansing's. This may be due to the close proximity of East Lansing and Michigan State University to the East Club. In particular, the large percentage of subjects with at least some college experience may have resulted in subjects who appreciated the value of research, thereby affecting the return rate. It may also be true that the researcher's demographic characteristics closely resembled those of the AA members and accounted for the return rate. In any case, the characteristics of this sample are not representative and restrict generalization to the population of recovering alcoholics as a whole.

An additional dimension of community interests and opportunity to recreate by the respondents may have a bearing on responses collected and the response rate. Availability of community recreation resources may play a role in the large percentage of subjects reporting involvement in recreation. With the resources of Lansing, East Lansing, and Michigan State University at the disposal of the subjects, it is possible that the opportunity

for recreation plays a factor on the use of recreation in recovery just as the lack of resources in a community might correspond to a low report of recreation involvement.

Age and time involved with AA were both strongly correlated to each other in addition to being strongly correlated to the variable of the longest length of time in abstinence. These relationships are confounding and need to be controlled in order to statistically determine the affect of recreation in successful recovery and not the affect of age or time involved with AA. Age and longest length of time in abstinence were highly correlated, which is logical since long term sobriety can happen only when the recovering alcoholic has lived for a number of years. It was not anticipated that people just over the age of 18 would have longer lengths of sobriety than respondents whose ages were in the 50's or 60's. The subject's response indicating that recreation did not present a distraction from their recovery, yet recreation related items scored as likely to make one's drinking worse on the Attribution Inventory, identified an interesting contradiction in responses. Recreation may have been viewed, overall, not to distract from recovery or it may be that the subject responded to the attributions at a time before recovery began and alcohol use took place during recreation activities. These are some interpretations which cannot be clearly answered by the data gathered in this study.

Conclusions and Recommendations

Through this study, a method of gaining access to a specific population group considered unreachable was developed. Even though there were many issues which needed adjustment or modifications, the overall dispersement method employed provided a high initial return rate and the possibility of adding follow-up procedures. Although the sampling method in this study was a process determined by constraints associated with the population limitations, another study conducted by Montgomery et al. (1993) published

after this study was begun verified data collection methods in that they used similar sampling procedures and dispersement methods to gather information from the recovering community. Time, openness and direct participant-researcher contact are necessary to insure a high initial response rate, as well as, approaching the recovering community for their help and input. Future research with this group needs to plan for a long dispersement period in order to receive a statistically significant sample size to breakdown the responses to specific attribute items and analyze them using other variables such as time spent in recreation, time spent in AA and participation in a treatment program.

The instrument used in this study would benefit from additional modifications. Other questions under treatment could be minimized to allow the subject more time to respond to items in the recreation and attribution sections. Further examination into attributes which scored as "no bearing" can be examined closer to determine whether there is a need for changes in programming in the recovery process to address particular attributes. The booklet format was very professional in appearance, but envelopes which fit the booklet without any folding would be encouraged for future studies.

The study identified that recreation is important to recovering alcoholics. It also identified the dilemma that some individuals experience recreation as a positive factor on sobriety and others find it a negative factor. Further investigation as to why this perception exists needs to be undertaken to clarify the potential benefit in recovery and to help individualize recovery programs. The answer to this question may also provide insight into the reasons for relapse in recovery. If recreation poses a threat to recovery, coping strategies need to be developed on in treatment and/or community AA meetings to help the alcoholic work through difficulties as they develop. If recreation represents stability or improved chances at success in recovery, recreation skill development can be incorporated into the treatment setting as well as in community programs such as AA.

Through results found in the attribution scale, one can argue that recreation and leisure time presents both potential benefits and negative consequences to the recovering alcoholic. Based on these results, it would seem that time spent in treatment and recovery should focus on the patient's leisure time to provide the recovering alcoholic an understanding that during activities, his/her guard may drop and a return to the use of alcohol can occur. On the positive note, patients need to have hope for the future. The recovering alcoholic needs to have something "fun" and "enjoyable" in his/her lifestyle change. He/she needs to find non-chemical ways of dealing with emotions and situations, ways which can commonly be found in the realm of leisure or recreation activities.

In treatment centers throughout the country, the benefits of recreation for clients has been recognized through the incorporation of leisure education and activities into treatment programs. However, recreation and leisure counseling remain a low priority in the treatment of recovering alcoholics. Information pertaining to the benefits and potential pitfalls of recreation needs to be examined to determine what it takes to remain drug free and how to prevent a relapse. It is the hope of the researcher that future study can provide a clearer understanding of the impact recreation has on individuals struggling for recovery. This understanding can be used to improve success rates and help maintain longer periods of abstinence in the ongoing battle against alcoholism. The process of recovery is a life-long struggle in which new information will always be useful in understanding the disease of alcoholism. It appears that recreation may be a helpful tool in the process of successful recovery. This topic deserves serious investigation to discover its full potential.

APPENDIX A

Appendix A

The Twelve Steps of Alcoholics Anonymous

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 awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

APPENDIX B

Appendix B

The Twelve Traditions of Alcoholics Anonymous

1. Our common welfare should come first; personal recovery depends upon Alcoholics Anonymous unity.

2. For our group purpose there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

3. The only requirement for Alcoholics Anonymous membership is a desire to stop drinking.

4. Each group should be autonomous except in matters affecting other groups or Alcoholics Anonymous as a whole.

5. Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.

6. An Alcoholics Anonymous group ought never endorse, finance, or lend the Alcoholics Anonymous name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.

7. Every Alcoholics Anonymous group ought to be fully self-supporting declining outside contributions.

8. Alcoholics Anonymous should remain forever non-professional, but our service may employ special workers.

9. Alcoholics Anonymous, as such, ought never be organized; but we may create boards or committees directly responsible to those they serve.

10. Alcoholics Anonymous has no opinion on outside issues; hence, the AA name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.

12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

APPENDIX C

Appendix C

Meeting Times at Alano Club East

Monday	11:30 a.m.	Saturday	08:00 a.m.
	12:00 noon		09:15 a.m.
	03:30 p.m.		09:15 a.m.
	06:30 p.m.		11:30 a.m.
	08:00 p.m.		11:30 a.m.
	08:00 p.m.		02:00 p.m.
			06:30 p.m.
Tuesday	11:00 a.m.		08:00 p.m.
	11:00 a.m.		08:00 p.m.
	01:30 p.m.		11:00 p.m.
	03:30 p.m.		
	06:30 p.m.	Sunday	09:00 a.m.
	06:30 p.m.		09:00 a.m.
	08:00 p.m.		01:00 p.m.
			03:00 p.m.
Wednesday	11:30 a.m.		06:30 p.m.
	03:30 p.m.		07:00 p.m.
	05:30 p.m.		08:00 p.m.
	08:00 p.m.		
	10:00 p.m.		
Thursday	11:30 a.m.		
	11:30 a.m.		
	03:30 p.m.		
	05:30 p.m.		
	06:30 p.m.		
	06:30 p.m.		
	08:00 p.m.		
Friday	11:30 a.m.		
	12:00 noon		
	03:30 p.m.		
	05:30 p.m.		
	06:00 p.m.		
	08:00 p.m.		
	10:00 p.m.		

APPENDIX D

Appendix D

Pilot Cover Letter- Not on Letterhead

August 15, 1993

To Whom It May Concern,

This is a study being conducted through the Department of Park and Recreation Resources, Michigan State University. The enclosed packet contains a questionnaire, stamped return envelope and this letter. The topic of interest for this study is exploring significant aspects an individual at AA associates with their recovery process. If you are a recovering alcoholic, we ask that you examine the questionnaire and answer the questions as complete and honestly as possible. Once the questionnaire has been completed, return it in the envelope provided. This questionnaire takes approximately 20 minutes to complete.

In keeping with the traditions and guarantees of AA, your name or identification is not asked for to insure that your responses will not be able to be connected and your identity will not be known to the researcher. General information and results of this study can be obtained by contacting the central AA office. In addition, a write up of the results will be submitted to a professional journal for publication.

This is a voluntary study. If you choose not to participate, simply dispose of your packet contents and do not mail your responses back. Thank you in advance for your time, effort, and assistance. The information you are providing will hopefully lead to a greater understanding of the recovery process for alcoholics.

Sincerely,

Lisa Parsons
Graduate Student
Department of Park and Recreation Resources
Michigan State University

APPENDIX E

Appendix E

Initial Instrument

PERCEPTIONS OF RECOVERING ALCOHOLICS REGARDING THE RECOVERY PROCESS

The following items are designed to provide information about the recovery process and your perceptions of recovery. This is a confidential survey in that at no time will you be asked to identify yourself for the purposes of the study. Please do not fill out this survey more than one time. Your answers and time are much appreciated and will hopefully aide in the understanding of the addiction and recovery processes.

SECTION ONE: ATTRIBUTIONS INVENTORY

PLEASE INDICATE HOW YOU FEEL ABOUT THE STATEMENTS BELOW BY CIRCLING THE CORRESPONDING NUMBERS ON THE RIGHT-HAND SIDE.

(GI)= Greatly improved my drinking problem (greatly reduced drinking)
(SI)= Slightly improved my drinking problem (slightly reduced drinking)
(NB)= No bearing, equally helpful or unhelpful, never experienced
(SW)= Made my drinking slightly worse
(MW)= Made my drinking very much worse

	GI	SI	NB	SW	MW
1. Wanting my self respect	1	2	3	4	5
2. Keeping company with drinkers	1	2	3	4	5
3. Determination not to be beaten by drink	1	2	3	4	5
4. Putting the blame on other people	1	2	3	4	5
5. What a psychiatrist said or did	1	2	3	4	5
6. Finding a drink helps shyness	1	2	3	4	5
7. Deciding my fate was in my own hands	1	2	3	4	5
8. Understanding my self better	1	2	3	4	5
9. Residence in an alcoholism rehabilitation community home	1	2	3	4	5
10. Being lonely	1	2	3	4	5
11. Switching from one drink to another	1	2	3	4	5
12. Taking an interest in other people	1	2	3	4	5
13. Fear of what drink was doing to my physical health	1	2	3	4	5
14. Belief in my higher power	1	2	3	4	5
15. Getting into a new marriage	1	2	3	4	5
16. Facing up to reality	1	2	3	4	5
17. Reminding myself of the good consequences of sobriety	1	2	3	4	5
18. Fear of going to prison through drink	1	2	3	4	5
19. Finding a drink made shakes better	1	2	3	4	5
20. Determination to drink like others	1	2	3	4	5

PLEASE INDICATE HOW YOU FEEL ABOUT THE STATEMENTS BELOW BY CIRCLING THE CORRESPONDING NUMBERS ON THE RIGHT-HAND SIDE.

(GI)= Greatly improved my drinking problem
(SI)= Slightly improved my drinking problem
(NB)= No bearing, equally helpful or unhelpful, never experienced
(SW)= Made my drinking slightly worse
(MW)= Made my drinking very much worse

	GI	SI	NB	SW	MW
21. Engaging in recreation activities frequently.	1	2	3	4	5
22. Spouse's real understanding of my problem	1	2	3	4	5
23. Antabuse or Abstem	1	2	3	4	5
24. Getting out of a marriage	1	2	3	4	5
25. Admitting to myself that I am/was an alcoholic	1	2	3	4	5
26. Stopping feeling sorry for myself	1	2	3	4	5
27. What a nurse said or did	1	2	3	4	5
28. Spouse threatening to leave because of my drinking	1	2	3	4	5
29. Making rule only to drink in company	1	2	3	4	5
30. Thoughts on what I could do for my family if sober	1	2	3	4	5
31. Dealing with my resentments	1	2	3	4	5
32. Keeping out of bars	1	2	3	4	5
33. Increasing my free time	1	2	3	4	5
34. Feeling able to give love	1	2	3	4	5
35. Making sure I never carry too much money	1	2	3	4	5
36. Spouse getting help for me	1	2	3	4	5
37. Tranquilizers	1	2	3	4	5
38. Telling my own story at AA	1	2	3	4	5
39. Out-patient treatment for alcoholism	1	2	3	4	5
40. Fear of what drinking would do to my family	1	2	3	4	5
41. Reactions of my friends to my drinking	1	2	3	4	5
42. Spouse's unhappiness over my drinking	1	2	3	4	5
43. Learning to relax	1	2	3	4	5
44. AA in general	1	2	3	4	5
45. Moving to new accommodations	1	2	3	4	5
46. Spouse getting angry over my drinking	1	2	3	4	5
47. In-patient treatment for alcoholism	1	2	3	4	5
48. Growing up emotionally	1	2	3	4	5
49. Fear I was losing my mind	1	2	3	4	5
50. Working very hard at my job	1	2	3	4	5
51. Getting the house spic and span	1	2	3	4	5
52. Making sure there was no drink at home	1	2	3	4	5
53. What an activity or recreation therapist said or did	1	2	3	4	5
54. Friendship through AA	1	2	3	4	5
55. Reactions of other family members to my drinking	1	2	3	4	5
56. Fear of losing everything I had through drinking	1	2	3	4	5

PLEASE INDICATE HOW YOU FEEL ABOUT THE STATEMENTS BELOW BY CIRCLING THE CORRESPONDING NUMBERS ON THE RIGHT-HAND SIDE.

(GI)= Greatly improved my drinking problem
(SI)= Slightly improved my drinking problem
(NB)= No bearing, equally helpful or unhelpful, never experienced
(SW)= Made my drinking slightly worse
(MW)= Made my drinking very much worse

57. Moving to a new district	1	2	3	4	5
58. What a social worker said or did	1	2	3	4	5
59. "rock-bottom"; hitting an absolute low point	1	2	3	4	5
60. Admitting to others I am/was an alcoholic	1	2	3	4	5
61. Seeing other people's point of view	1	2	3	4	5
62. Fear of becoming unemployed through drink	1	2	3	4	5
63. Being ashamed of my drinking	1	2	3	4	5
64. Interest in activities or recreation	1	2	3	4	5
65. Keeping away from drinking parties	1	2	3	4	5
66. Believing that I could control my drinking	1	2	3	4	5
67. Getting a new job	1	2	3	4	5
68. Always being on guard	1	2	3	4	5
69. Worry about alcoholic "blackouts"- patches of memory loss	1	2	3	4	5
70. Getting over depression	1	2	3	4	5
71. Hearing other people's stories at AA	1	2	3	4	5
72. Reactions of my children to my drinking	1	2	3	4	5

SECTION TWO: PARTICIPATION IN A SUPPORT GROUP

THE FOLLOWING ITEMS RELATE TO YOUR PARTICIPATION IN A SUPPORT GROUP

1. How long have you been attending AA meetings?_____months

2. How often do you usually attend meetings each week?
   _____ONCE A WEEK
   _____TWICE A WEEK
   _____THREE TIMES A WEEK
   _____FOUR TO SIX TIMES A WEEK
   _____DAILY

3. For how many months have you been seeking support for alcoholism? _____MONTHS

4. What is the longest period of abstinence you have been able to maintain?_____months

5. Are you currently a sponsor?____yes ____no

6. How long have you sponsored this person(s)?_____months _____months _____months

7. How many people total have you sponsored?_____

8. What step are you currently working on? _____(1-12)

9. HAVE YOU EVER COMPLETED A TREATMENT PROGRAM? _____YES _____NO

10. How did you find out/become involved with AA?(Explain)

SECTION THREE: RELAPSE AND RECOVERY

FOR THIS SECTION, USE THE FOLLOWING DEFINITIONS PROVIDED TO MAKE YOUR DECISION.

RELAPSE: A RETURN TO THE USE OF A CHEMICAL SUBSTANCE IN WHICH PROGRESSIVE USE A SUBSTANCE IS OF THE SAME INTENSITY AS WHEN YOU FIRST SOUGHT TREATMENT OR ASSISTANCE.

LAPSE: A SHORT PERIOD OF TIME OF USE OF A CHEMICAL SUBSTANCE IN WHICH YOU USE ON MORE THAN ONE OCCASION BUT EITHER SPONTANEOUSLY RETURN TO ABSTINENCE OR SEEK TREATMENT OR ASSISTANCE BEFORE YOU RETURNED TO YOUR PREVIOUS LEVELS OF USE.

SLIP: A ONE TIME USE OF A CHEMICAL SUBSTANCE WITHOUT ANY CONTINUED OR PROLONGED PERIOD OF USAGE. NOTE YOU CAN HAVE A SERIES OF SLIPS OVER A LONG SPAN OF TIME. IF IT IS CONSECUTIVE OR A CLUSTERING OF TIME IN A GIVEN PERIOD THAT WOULD BE A LAPSE VERSUS A SLIP.

1. HAVE YOU EVERY EXPERIENCED A RELAPSE? _____YES _____NO
IF YES, WHICH OF THE FOLLOWING TRIGGERED THE RELAPSE? (YOU MAY CHECK MORE THAN ONE)

_____FAMILY _____WORK/JOB _____FRIENDS_____TROUBLE WITH THE LAW_____STRESS_____UNSTRUCTURED BLOCKS OF TIME (FREETIME)_____NOT GOING TO MEETINGS REGULARLY _____NOT KEEPING IN CONTACT WITH SPONSOR
_____NOT FOLLOWING SUGGESTIONS IN THE BIG BOOK_____OTHER (EXPLAIN)

1A. WHAT STEP WERE YOU WORKING ON WHEN THE RELAPSE OCCURRED? _____
1B. HOW MANY TIMES HAVE YOU EXPERIENCE A RELAPSE? _____

2. HAVE YOU EVERY EXPERIENCED A LAPSE? ____YES _____NO_
IF YES, WHAT TRIGGERED THE LAPSE?
_____FAMILY _____WORK/JOB_____FRIENDS _____TROUBLE WITH THE LAW_____STRESS_____UNSTRUCTURED BLOCKS OF TIME (FREETIME)_____NOT GOING TO MEETINGS REGULARLY _____NOT KEEPING IN CONTACT WITH SPONSOR
_____NOT FOLLOWING SUGGESTIONS IN THE BIG BOOK_____OTHER (EXPLAIN)

2A. WHAT STEP WERE YOU WORKING ON WHEN THE LAPSE OCCURRED? _____
2B. HOW MANY TIMES HAVE YOU EXPERIENCE A LAPSE? _____

3. HAVE YOU EVERY EXPERIENCED A SLIP?_____YES _____NO
IF YES, WHAT TRIGGERED THE SLIP?
_____FAMILY _____WORK/JOB_____FRIENDS _____TROUBLE WITH THE LAW_____STRESS_____UNSTRUCTURED BLOCKS OF TIME (FREETIME)_____NOT GOING TO MEETINGS REGULARLY _____NOT KEEPING IN CONTACT WITH SPONSOR
_____NOT FOLLOWING SUGGESTIONS IN THE BIG BOOK_____OTHER (EXPLAIN)

3A. WHAT STEP WERE YOU WORKING ON WHEN THIS OCCURRED? _____
3B. HOW MANY TIMES HAVE YOU EXPERIENCE A SLIP? _____

4. WHAT DO FEEL IS THE MOST IMPORTANT FACTOR IN YOUR SUCCESSFUL RECOVERY?
CHECK ONLY ONE.
_____FAMILY SUPPORT
_____WORK
_____STRUCTURED LEISURE OR FREE TIME
_____YOUR SUPPORT GROUP
_____A HIGHER POWER
_____YOURSELF
_____OTHER (EXPLAIN)

5. RANK THE FOLLOWING AS YOU PERCEIVE HOW THEY PERTAIN TO YOUR RECOVERY.
1= MOST IMPORTANT 7= LEAST IMPORTANT
_____FAMILY SUPPORT
_____WORK
_____STRUCTURED LEISURE OR FREE TIME
_____YOUR SUPPORT GROUP
_____A HIGHER POWER
_____YOURSELF
_____OTHER (EXPLAIN)

6. WHAT SITUATIONS DO YOU FIND PROBLEMATIC IN YOUR RECOVERY?
RANK ANY AND ALL ITEMS THAT APPLY USING 1 AS MOST PROBLEMATIC

_____STRESS
_____CONFLICT
_____FEELINGS OF LONELINESS
_____WEEKENDS
_____FAMILY/SOCIAL EVENTS(BIRTHDAYS, ANNIVERSARIES)
_____HOLIDAYS (CHRISTMAS, NEW YEARS, 4TH OF JULY)
_____FRIENDS THAT DO NOT HAVE A DRINKING PROBLEM
_____BOREDOM
_____I DON'T FIND ANY SITUATIONS PROBLEMATIC TO MY RECOVERY
_____OTHER (EXPLAIN)

7. BRIEFLY DESCRIBE A SITUATION WITHIN THE PAST SIX (6) MONTHS IN WHICH YOU FELT THE TEMPTATION TO USE? WHAT CAUSED IT?

SECTION FOUR: RECREATION

1. DO YOU CURRENTLY PARTICIPATE IN AN ACTIVITY OR HOBBY? _____YES _____NO

2. HOW OFTEN DO YOU PARTICIPATE IN ACTIVITIES OR HOBBIES?
_____ONCE A WEEK
_____TWICE A WEEK
_____THREE TIMES A WEEK
_____FOUR TO SIX TIMES A WEEK
_____DAILY

3. APPROXIMATELY HOW MANY HOURS A WEEK DO YOU ENGAGE IN RECREATION?
_____HRS

4. PLEASE INDICATE YOUR INVOLVEMENT IN ACTIVITIES NOW AS COMPARED TO,
BEFORE ENTERING A TREATMENT PROGRAM
_____MORE SO THAN BEFORE TREATMENT
_____SAME AS BEFORE TREATMENT
_____LESS THAN BEFORE TREATMENT
_____NEVER ENTERED A TREATMENT PROGRAM

BEFORE BECOMING INVOLVED WITH AA
_____MORE SO THAN BEFORE AA
_____SAME AS BEFORE AA
_____LESS THAN BEFORE AA

5. WHY DO YOU OR DON'T YOU PARTICIPATE IN RECREATION OR LEISURE ACTIVITIES?

6. WHAT DOES RECREATION AND LEISURE MEAN TO YOU WITH RESPECT TO YOUR RECOVERY?
PLEASE EXPLAIN IN YOUR OWN WORDS WHAT IMPACT, IF ANY, RECREATION OR ACTIVITIES HAVE ON YOUR LIFESTYLE AND RECOVERY.

7. HOW DO YOU FEEL ABOUT ACTIVITIES WITH RESPECT AID YOUR RECOVERY?
_____ACTIVITIES ARE IMPORTANT TO MY RECOVER
_____ACTIVITIES ARE A DISTRACTION TO MY RECOVERY
_____ACTIVITIES ARE NO PART OF MY RECOVERY

SECTION FIVE: BELIEFS RELATED TO RECOVERY AND ALCOHOLISM

INDICATE HOW YOU FEEL ABOUT THE FOLLOWING STATEMENTS TO THE BEST OF YOUR KNOWLEDGE BY USING THE FOLLOWING KEYS:

1 = STRONGLY DISAGREE 2 = DISAGREE 3 = NO OPINION 4 = AGREE 5 = STRONGLY AGREE

	SD	D	NO	A	SA
I am comfortable with my current state of abstinence/sobriety	___	___	___	___	___
I have accepted the fact that I am an alcoholic	___	___	___	___	___
I have a long way to go before I am cured	___	___	___	___	___
I am content with my life at this time	___	___	___	___	___
I feel supported regarding my addiction	___	___	___	___	___
by my family	___	___	___	___	___
by my friends	___	___	___	___	___
by my support group	___	___	___	___	___
by my employer	___	___	___	___	___
I feel that I can remain abstinent/sober	___	___	___	___	___
I am embarrassed that I have a drinking problem	___	___	___	___	___
I feel the temptation to use alcohol drugs	___	___	___	___	___
I will never be cured of my addiction	___	___	___	___	___
I am uncomfortable around alcohol or places that serve alcohol	___	___	___	___	___
My work/job has a lot to do with my sobriety	___	___	___	___	___
I would not be sober, if not for my faith in a higher power	___	___	___	___	___
Since attending meetings, it is okay to go to the bar	___	___	___	___	___
I have no problem keeping in touch with my old drinking buddies	___	___	___	___	___
Alcoholism is curable	___	___	___	___	___
My family is a large factor in my sobriety	___	___	___	___	___
A routine physical workout/exerCise is important to me	___	___	___	___	___
Alcoholism is controllable	___	___	___	___	___
I am willing to help others through their drinking problems	___	___	___	___	___
I feel that personal problems might cause me to go back to drinking	___	___	___	___	___
I feel anxious about returning to my past pattern of drinking	___	___	___	___	___
I am not afraid to go out to social gatherings	___	___	___	___	___
I have been successful in replacing my drinking with other activities	___	___	___	___	___

My personal relationships have improved since I stopped drinking	___ ___ ___ ___ ___
I am happy	___ ___ ___ ___ ___
My support group is a large factor in my sobriety	___ ___ ___ ___ ___
I am satisfied at work	___ ___ ___ ___ ___
I often feel a need to make sure my time is structured	___ ___ ___ ___ ___
I need to structure my time to avoid temptation	___ ___ ___ ___ ___
I am satisfied in my leisure or free time	___ ___ ___ ___ ___
I am satisfied with my life	___ ___ ___ ___ ___
My will power has increased throughout treatment/meetings	___ ___ ___ ___ ___
I feel that I have control over my addiction	___ ___ ___ ___ ___
I feel that I have control over my recovery	___ ___ ___ ___ ___
I am sober because of my higher power	___ ___ ___ ___ ___
Without my sponsor, I would find it difficult to remain sober	___ ___ ___ ___ ___
My meetings are a lifeline to my recovery	___ ___ ___ ___ ___

SECTION SIX: DEMOGRAPHICS

IDENTIFY YOUR AGE? _____YRS _____MALE _____FEMALE

INDICATE YOUR STATUS.

_____SINGLE
_____MARRIED
_____DIVORCED, WIDOWED, SEPARATED

INDICATE WHAT LEVEL OF SCHOOLING YOU HAVE COMPLETED.

_____SOME HIGH SCHOOL
_____HIGH SCHOOL DIPLOMA OR G.E.D
_____SOME COLLEGE
_____COLLEGE DEGREE

INDICATE YOUR RACE.

_____BLACK
_____WHITE
_____HISPANIC
_____ASIAN
_____AMERICAN INDIAN
_____DO NOT WISH TO RESPOND
_____OTHER _____

ARE YOU? _____EMPLOYED
_____UNEMPLOYED
_____HOUSEWIFE/HUSBAND
_____STUDENT
_____RETIRED
_____OTHER
_____DO NOT WISH TO RESPOND

HOW DID YOU FIND THIS SURVEY?

____OKAY
____EASY TO UNDERSTAND
____TOO LONG
____CONFUSING

PLEASE MAKE ANY COMMENTS OR SUGGESTIONS YOU HAVE REGARDING THIS SURVEY. IF THINGS WERE UNCLEAR IN THE QUESTIONNAIRE, PLEASE IDENTIFY SO THAT WE CAN MAKE THE ITEMS EASIER TO UNDERSTAND.

THANK YOU FOR YOUR TIME AND EFFORTS IN THIS STUDY. ALL COMMENTS ARE APPRECIATED.

APPENDIX F

Appendix F

Study Cover Letter

October 20, 1993

Dear AA Member,

Issues and theories regarding the addictive cycle are constantly being upgraded and explored throughout the scientific community. However, the majority of studies fail to take YOUR perceptions, as a recovering alcoholic, into consideration. Treatment centers are faced with the knowledge that only one in thirty clients who complete treatment will be able to maintain a lifestyle of sobriety. The AA community is one of the most powerful aftercare and recovery services available to people who suffer from addiction. Your personal beliefs and experiences may help others to understand the various components of recovery. It is our hope that they will also identify key components that need to be focused upon in treatment in order to help all those individuals who are currently using.

Enclosed you will find a survey to a study being conducted through the Department of Park and Recreation Resources, Michigan State University. This packet consists of the survey, a stamped return envelope and this letter.

What is the purpose of this survey?
This survey will provide information about the significant lifestyle aspects YOU as an AA member attribute to your recovery program. Your responses will provide information to the therapeutic community that can help:

1) develop a more rounded and effective treatment program,
2) professionals and recovering alcoholics understand the recovery process better,
3) provide insight into other areas of recovery that have not been explored in past

Will my name be associated with my answers?
No. All your answers and comments will be completely confidential. Your name will never be placed on the questionnaire; rather your responses will be grouped with those of about 100 other AA members.

How will my answers be used?
The results of the survey will be disseminated throughout the therapeutic community in hopes of providing more insight into the needs of recovering alcoholics. A summary of the results will be submitted to a professional journal for publication.

If you are an alcoholic in recovery, we ask that you examine the questionnaire and answer the questions as completely and honestly as possible. This questionnaire takes less than 30 minutes to complete, then please return it in the envelope provided. **We would appreciate the return of the survey by November 30, 1993.** If you have any questions, please feel free to contact me at 131 Natural Resources, Michigan State University, East Lansing, MI 48824 or call the department office at (517) 353-5190.

Thank you for your time, effort and assistance.

Sincerely,

Lisa B. Parsons
Project Leader

APPENDIX G

Appendix G

Study Questionnaire

The following pages are the actual pages used in developing the questionnaire booklet. In order to conform to the margin requirements for this paper, the Questionnaire was reduced. Front and back pages are identified as how the actual pages were numbered.

BACK COVER

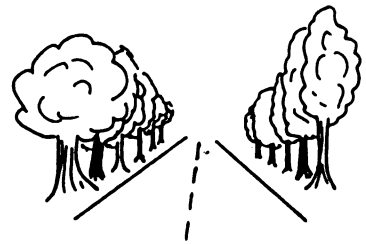
Thank you very much for your time and effort in completing this questionnaire. If you have any additional comments that you would like to make, please do so on this page or on a separate letter. All your answers and comments will remain confidential and will be analyzed together with comments of other AA members.

PLEASE PLACE THE COMPLETED QUESTIONNAIRE IN THE POSTAGE PAID ENVELOPE THAT YOU RECEIVED AND MAIL BY DECEMBER 15, 1993.

THANK YOU.

FRONT COVER

YOUR ROAD TO RECOVERY



This survey will provide information about YOUR perceptions, as a recovering alcoholic, on the recovery process. Your responses will provide information to the therapeutic community which may help them:

1) develop a more rounded treatment program,
2) understand the recovery process better,
3) provide insight into other areas of recovery that have not been explored in the past.

Please answer all of the questions. If you wish to make additional comments or add to your answers, please feel free to use the margins or additional sheets of paper.

Thank you for your help.

Return this questionnaire to:
Lisa B. Parsons
Department of Park
and Recreation Resources
131 Natural Resources Bldg
Michigan State University
East Lansing, MI 48824-1222

The following items relate to your participation in a support group.

Q1 How long have you been attending AA meetings? *Enter your best time estimate.*

_____ YEARS _____ MONTHS

Q2 In the past 6 months, how often have you attended meetings each week? *Circle number.*

1 LESS THAN ONCE A WEEK
2 ONCE A WEEK
3 TWICE A WEEK
4 THREE TIMES A WEEK
5 FOUR TO SIX TIMES A WEEK
6 DAILY

Q3 What is the longest period of abstinence you have been able to maintain since you first started attending AA? *Enter your best time estimate.*

_____ YEARS _____ MONTHS

Q4 In the past 6 months, have you attended any of the social functions sponsored by AA? *Circle number.*

1 YES
2 NO

Finally, we would like to ask some questions about your personal characteristics (for statistical purposes only) that will help us interpret the results. Your answers to these questions will remain completely anonymous.

Q95 Are you? *Circle number.*

1 FEMALE
2 MALE

Q96 Identify your age range. *Circle number.*

1 UNDER 18 YEARS
2 18-24 YEARS
3 25-34 YEARS
4 35-44 YEARS
5 45-54 YEARS
6 55-64 YEARS
7 65 YEARS AND OVER

Q97 What is the highest level of schooling you have completed? *Circle number.*

1 SOME HIGH SCHOOL
2 HIGH SCHOOL DIPLOMA OR G E D
3 SOME COLLEGE
4 COLLEGE DEGREE
5 POST GRADUATE STUDY/DEGREE

Q98 Please indicate your race (optional). *Circle number.*

1 CAUCASIAN
2 AFRICAN AMERICAN
3 HISPANIC
4 ASIAN
5 NATIVE AMERICAN
6 OTHER_____

Q99 Related to work, are you currently? *Circle number.*

1 EMPLOYED FULL-TIME
2 EMPLOYED PART-TIME
3 A STUDENT (employed or unemployed)
4 UNEMPLOYED
5 RETIRED OR SEMI-RETIRED

Q92 Indicate your overall involvement in recreation activities now as compared with before you got involved with AA. *Circle number*

1 MORE INVOLVEMENT THAN BEFORE AA

2 SAME INVOLVEMENT AS WITH AA

3 LESS INVOLVEMENT THAN BEFORE AA

Q93 Please explain in your own words what impact, if any, recreation has played on your recovery.

Q94 With which of the following statements do you most agree? *Circle only one number.*

1 RECREATION IS IMPORTANT TO MY RECOVERY

2 RECREATION IS A DISTRACTION TO MY RECOVERY

3 RECREATION IS NOT A PART OF MY RECOVERY

4 I WOULD LIKE RECREATION TO BE A LARGER PART OF MY RECOVERY

The following items are related to issues of relapse in recovery

Relapse: A return to the use of a chemical substance in which progressive use of a substance is of the same intensity as when you first sought help or treatment. Substance does not have to be your drug of choice

Slip: A short period of return to use of a chemical substance of less intensity than the first time you sought help or treatment. This period has a duration of less than three months usage

Q5 Have you ever experienced a relapse or a slip? *Circle number*

1 YES

2 NO ☛ *(GO TO Q6)*

If YES, which of the following triggered or preceded the most recent incident? *Circle any that apply.*

1 FAMILY DIFFICULTIES

2 WORK/JOB DIFFICULTIES

3 DRINKING FRIENDS

4 TROUBLE WITH THE LAW

5 GENERAL STRESS

6 NOT ATTENDING MEETINGS REGULARLY

7 TOO MUCH FREE TIME

8 OTHER _____

_____

_____

(please describe)

Q6 Which of the following do you believe is the most important factor in your recovery? *Circle only one answer.*

1 FAMILY SUPPORT
2 WORK
3 STRUCTURED LEISURE OR FREE TIME
4 YOUR SUPPORT GROUP(S)
5 YOUR BELIEF IN A HIGHER POWER
6 YOURSELF
7 OTHER _____
_____
_____
(please describe)

Q7 Rank all the following factors as you perceive their impact on your recovery. *Use the number (1) as the most important factor.*

___ FAMILY SUPPORT
___ WORK
___ STRUCTURED LEISURE OR FREE TIME
___ YOUR SUPPORT GROUP(S)
___ YOUR BELIEF IN A HIGHER POWER
___ YOURSELF
___ OTHER _____
_____
_____
(please describe)

Q88 Why do you or don't you participate in a recreation activity?

Q89 In the past 6 months, on how many days did you participate in recreation activities on the average? *Circle number.*

1 1-2 DAYS PER WEEK
2 3-4 DAYS PER WEEK
3 5-6 DAYS PER WEEK
4 DAILY
5 DID NOT RECREATE

Q90 In the past 6 months, approximately how many total hours did you participate in a recreation activity per week? *Circle number.*

1 1-4 HOURS PER WEEK
2 5-8 HOURS PER WEEK
3 9-12 HOURS PER WEEK
4 13 OR MORE HOURS PER WEEK
5 DID NOT RECREATE

Q91 Indicate your overall involvement in recreation activities now as compared with before you entered a treatment program. *Circle number.*

1 MORE INVOLVEMENT THAN BEFORE TREATMENT
2 SAME INVOLVEMENT AS BEFORE TREATMENT
3 LESS INVOLVEMENT THAN BEFORE TREATMENT
4 NEVER ATTENDED TREATMENT PROGRAM

Q85 Did you go through the suggested "ninety meetings in ninety days"? *Circle number.*

1 YES
2 NO

Q86 From which of the following did you receive services? *Circle all that apply.*

1 PHYSICIAN
2 FAMILY THERAPIST
3 PSYCHOLOGIST
4 MUSIC THERAPIST
5 DANCE THERAPIST
6 PSYCHIATRIST
7 SOCIAL WORKER
8 PHYSICAL THERAPIST
9 OCCUPATIONAL THERAPIST
10 RECREATION THERAPIST
11 ART THERAPIST
12 OTHER _____
(please describe)
13 NONE OF THE ABOVE

The following items relate to your involvement in recreation activities.

Recreation: is what happens in any activity in which you participate voluntarily during your own free time. Recreation can be physical, social, educational, cultural, or environmental-related.

Q87 Do you currently participate in a recreation activity? *Circle number.*

1 YES
2 NO

Q8 How problematic to your recovery do you find each of the following? *Circle the corresponding number*

	NOT A PROBLEM		SOMEWHAT PROBLEMATIC		VERY PROBLEMATIC
STRESS	1	2	3	4	5
CONFLICT	1	2	3	4	5
FEELINGS OF LONELINESS	1	2	3	4	5
WEEKENDS	1	2	3	4	5
FAMILY EVENTS (e.g., birthdays)	1	2	3	4	5
HOLIDAYS (e.g., New Year)	1	2	3	4	5
SPENDING TIME WITH USING FRIENDS	1	2	3	4	5
SPENDING TIME WITH NON-USER FRIENDS	1	2	3	4	5
OTHER _____ *(please describe)*	1	2	3	4	5

Q9 From the list of items in Question 8, which are the three MOST DIFFICULT to your recovery?

MOST DIFFICULT _____
2ND MOST DIFFICULT _____
3RD MOST DIFFICULT _____

Q10 Briefly describe a situation in the past six months in which you felt the urge to use.

For each of the following items, identify your belief as to the impact each statement has had on your recovery. *Circle the corresponding number found to the RIGHT of each statement.*

		GREATLY HELPED STOP MY DRINKING	SOMEWHAT HELPED STOP MY DRINKING	NO BEARING AS I'VE EXPERIENCED	MADE MY DRINKING WORSE	MADE MY DRINKING VERY MUCH WORSE
Q11	WANTING MY SELF RESPECT	1	2	3	4	5
Q12	KEEPING COMPANY WITH DRINKERS	1	2	3	4	5
Q13	DETERMINATION NOT TO BE BEATEN BY ALCOHOL	1	2	3	4	5
Q14	BLAMING OTHERS FOR MY PROBLEMS	1	2	3	4	5
Q15	USING ALCOHOL TO BE LESS SHY	1	2	3	4	5
Q16	DECIDING MY FATE WAS IN MY OWN HANDS	1	2	3	4	5
Q17	TALKING TO A PSYCHIATRIST	1	2	3	4	5
Q18	UNDERSTANDING MYSELF BETTER	1	2	3	4	5
Q19	BEING IN A TREATMENT CENTER	1	2	3	4	5
Q20	BEING OR FEELING LONELY	1	2	3	4	5
Q21	SWITCHING FROM ONE KIND OF DRINK TO ANOTHER (e.g., beer to hard liquor)	1	2	3	4	5
Q22	TAKING AN INTEREST IN OTHER PEOPLE	1	2	3	4	5
Q23	BELIEVING IN A HIGHER POWER	1	2	3	4	5
Q24	FEARING HEALTH EFFECTS OF ALCOHOL	1	2	3	4	5

The following items relate to your participation in treatment programs.

Q82 Have you ever been in a treatment program for substance abuse? *Circle number.*

1 YES
2 NO ☛ (PLEASE SKIP TO QUESTION 87)

If YES, have you been in treatment more than one time?

1 YES
2 NO

Use your most recent time in treatment to answer the following. If you were in treatment only one time, use that particular experience.

Q83 How long did you attend treatment? *Circle number.*

1 7-30 DAYS
2 31-60 DAYS
3 61-90 DAYS
4 91-180 DAYS
5 181 DAYS OR MORE

Q84 Identify the most influential reason for entering treatment. *Circle ONLY one number.*

1 FAMILY PRESSURE
2 WORK PRESSURE
3 COURT ORDER/PRESSURE
4 VOLUNTARY/PERSONAL CHOICE
5 THREAT OF DEATH/HEALTH PROBLEMS
6 OTHER _____
(please describe)

		GREATLY HELPED STOP MY DRINKING	SOMEWHAT HELPED STOP MY DRINKING	NO BEARING ON MY DRINKING	MADE MY DRINKING SOMEWHAT WORSE	MADE MY DRINKING VERY MUCH WORSE
Q69	SEEING OTHER PEOPLE'S POINT OF VIEW	1	2	3	4	5
Q70	FEARING UNEMPLOYMENT FROM DRINKING	1	2	3	4	5
Q71	BEING ASHAMED OF MY DRINKING	1	2	3	4	5
Q72	BEING INTERESTED IN PHYSICAL ACTIVITIES	1	2	3	4	5
Q73	KEEPING AWAY FROM DRINKING PARTIES	1	2	3	4	5
Q74	BELIEVING I COULD CONTROL MY DRINKING	1	2	3	4	5
Q75	GETTING A NEW JOB	1	2	3	4	5
Q76	ALWAYS BEING ON GUARD	1	2	3	4	5
Q77	WORRYING ABOUT ALCOHOLIC BLACKOUTS	1	2	3	4	5
Q78	GETTING OVER DEPRESSION	1	2	3	4	5
Q79	BEING INVOLVED IN SOCIAL ACTIVITIES	1	2	3	4	5
Q80	HEARING OTHER PEOPLE'S STORIES AT AA	1	2	3	4	5
Q81	REACTIONS OF MY CHILDREN TO MY DRINKING	1	2	3	4	5

		GREATLY HELPED STOP MY DRINKING	SOMEWHAT HELPED STOP MY DRINKING	NO BEARING ON MY DRINKING	MADE MY DRINKING SOMEWHAT WORSE	MADE MY DRINKING VERY MUCH WORSE
Q25	ADMITTING TO SELF, "I AM AN ALCOHOLIC"	1	2	3	4	5
Q26	ENTERING INTO A NEW RELATIONSHIP	1	2	3	4	5
Q27	FACING UP TO REALITY	1	2	3	4	5
Q28	REMINDING MYSELF OF THE POSITIVE CONSEQUENCES TO SOBRIETY	1	2	3	4	5
Q29	FEARING PRISON DUE TO DRINKING	1	2	3	4	5
Q30	FINDING A DRINK MADE MY SHAKES BETTER	1	2	3	4	5
Q31	DETERMINATION TO DRINK LIKE OTHERS	1	2	3	4	5
Q32	ENGAGING IN RECREATION ACTIVITIES	1	2	3	4	5
Q33	SIGNIFICANT OTHER'S UNDERSTANDING MY PROBLEM	1	2	3	4	5
Q34	USING *ANTABUSE* OR *ABSTEM*	1	2	3	4	5
Q35	GETTING OUT OF A RELATIONSHIP	1	2	3	4	5
Q36	STOPPING FEELING SORRY FOR MYSELF	1	2	3	4	5
Q37	TALKING TO A NURSE	1	2	3	4	5
Q38	SIGNIFICANT OTHER THREATENING TO LEAVE BECAUSE OF MY DRINKING	1	2	3	4	5

		GREATLY HELPED STOP MY DRINKING	SOMEWHAT HELPED STOP MY DRINKING	NO BEARING-NEVER EXPERIENCED	MADE MY DRINKING WORSE	MADE MY DRINKING VERY MUCH WORSE
Q39	MAKING RULE TO DRINK ONLY IN COMPANY	1	2	3	4	5
Q40	THINKING OF WHAT I COULD DO FOR MY FAMILY IF SOBER	1	2	3	4	5
Q41	DEALING WITH MY RESENTMENTS	1	2	3	4	5
Q42	KEEPING OUT/AWAY FROM BARS	1	2	3	4	5
Q43	INCREASING MY FREE TIME	1	2	3	4	5
Q44	FEELING ABLE TO LOVE	1	2	3	4	5
Q45	MAKING SURE I DIDN'T CARRY MUCH CASH	1	2	3	4	5
Q46	HAVING SIGNIFICANT OTHER GET ME HELP	1	2	3	4	5
Q47	USING TRANQUILIZERS	1	2	3	4	5
Q48	TELLING MY OWN STORY TO OTHERS	1	2	3	4	5
Q49	LEARING WHAT MY DRINKING WOULD DO TO MY FAMILY	1	2	3	4	5
Q50	FRIENDS REACTION TO MY DRINKING	1	2	3	4	5
Q51	SIGNIFICANT OTHERS UNHAPPINESS OVER MY DRINKING	1	2	3	4	5
Q52	LEARNING TO RELAX	1	2	3	4	5
Q53	AA IN GENERAL	1	2	3	4	5
Q54	MOVING TO NEW HOME (e.g., apartment, house)	1	2	3	4	5

		GREATLY HELPED STOP MY DRINKING	SOMEWHAT HELPED STOP MY DRINKING	NO BEARING-NEVER EXPERIENCED	MADE MY DRINKING WORSE	MADE MY DRINKING VERY MUCH WORSE
Q55	SIGNIFICANT OTHER GETTING ANGRY OVER MY DRINKING	1	2	3	4	5
Q56	GROWING UP EMOTIONALLY	1	2	3	4	5
Q57	FEARING THAT I WAS LOSING MY MIND	1	2	3	4	5
Q58	WORKING VERY HARD AT MY JOB	1	2	3	4	5
Q59	GETTING HOUSE SPIC AND SPAN	1	2	3	4	5
Q60	MAKING SURE THERE'S NO ALCOHOL AT HOME	1	2	3	4	5
Q61	TALKING TO AN ACTIVITY THERAPIST	1	2	3	4	5
Q62	FINDING FRIENDS THROUGH AA	1	2	3	4	5
Q63	REACTIONS OF OTHER FAMILY MEMBERS TO MY DRINKING	1	2	3	4	5
Q64	FEARING TO LOSE EVERYTHING TO DRINKING	1	2	3	4	5
Q65	MOVING TO A NEW NEIGHBORHOOD	1	2	3	4	5
Q66	TALKING TO A SOCIAL WORKER	1	2	3	4	5
Q67	HITTING "ROCK BOTTOM", ULTIMATE LOW	1	2	3	4	5
Q68	ADMITTING TO OTHERS "I AM AN ALCOHOLIC"	1	2	3	4	5

APPENDIX H

Appendix H

Positive Attribute Rankings of 30% Positive Endorsement or Higher

RANK	ITEM	POSITIVE ENDORSEMENT
1	AA in general	100
"	Hearing other people's stories at AA	100
3	Believing in a higher power	97
"	Telling my own story to others	97
"	Finding friends through AA	97
6	Reminding myself of the positive consequences to sobriety	94
"	Learning to relax	94
"	Admitting to others "I am an alcoholic"	94
9	Taking an interest in other people	93
"	Facing up to reality	93
"	Growing up emotionally	93
12	Understanding myself better	90
"	Admitting to self. "I am an alcoholic"	90
"	Stopping feeling sorry for myself	90
"	Hitting "rock bottom"; ultimate low	90
"	Seeing other people's point of view	90
17	Wanting my self respect	83
18	Keeping away from drinking parties	81
19	Feeling able to love	74
20	Dealing with my resentments	73
"	Fearing that I was losing my mind	73
22	Fearing to lose everything to drinking	68
"	Being ashamed of my drinking	68
"	Getting over depression	68
25	Being involved in social activities	65
26	Keeping out/away from bars	61
27	Reactions of other family members to my drinking	59
28	Being in a treatment center	58
"	Making sure there's no alcohol at home	58
30	Fearing health effects of alcohol	55
"	Significant others understanding my problem	55
"	Fearing what my drinking would do to my family	55
33	Worrying about alcoholic blackouts	55
"	Determination not to be beaten by alcohol	53
35	Working very hard at my job	53
36	Being interested in physical activities	48
37	Fearing unemployment from drinking	47
38	Thinking of what I could do for my family if sober	45
39	Deciding my fate was in my own hands	42
"	Entering into a new relationship	42
"	Fearing prison due to drinking	42
"	Friend's reaction to my drinking	42
43	Talking to a psychiatrist	39
"	Engaging in Recreation activities	39
45	Increasing my free time	35
46	Always being on guard	32

APPENDIX I

Appendix I

Negative Attribute Rankings of 20% Negative Endorsement or Higher

RANK	ITEM	NEGATIVE ENDORSEMENT
1	Being or feeling lonely	90
"	Hitting "rock bottom"; ultimate low	90
3	Believing I could control my drinking	87
4	Blaming others for my problems	81
"	Keeping away from drinking parties	81
6	Determination to drink like others	77
7	Switching from one kind of drink to another	74
8	Using alcohol to be less shy	71
9	Finding a drink made my shakes better	58
10	Always being on guard	52
11	Increasing my free time	42
12	Deciding my fate was in my own hands	35
"	Engaging in recreation activities	35
14	Getting over depression	29
15	Being ashamed of my drinking	26
16	Worrying about alcoholic blackouts	23
"	Working very hard at my job	23
"	Making rule to drink only in company	23
"	Significant other getting angry over my drinking	23
"	Using tranquilizers	23
"	Getting out of a relationship	23
"	Dealing with my resentments	23
23	Reactions of other family members to my drinking	21
24	Fearing unemployment from drinking	20

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