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## Psychologists' use of, familiarity, and comfort with Alcoholics Anonymous slogans in psychotherapy

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Pepperdine University  
Graduate School of Education and Psychology

PSYCHOLOGISTS' USE OF, FAMILIARITY, AND COMFORT WITH  
ALCOHOLICS ANONYMOUS SLOGANS IN PSYCHOTHERAPY

A clinical dissertation submitted in partial satisfaction  
of the requirements for the degree of  
Doctor of Psychology

by

Sarah L. Randall

December, 2010

Robert R. de Mayo, Ph.D., ABPP - Dissertation Chairperson

This clinical dissertation, written by

Sarah L. Randall

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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## DEDICATION

This dissertation is dedicated, with so much love and appreciation to my parents, David and Karen Randall and to my husband, Spencer Brown.

Mom and Dad, there are truly not enough words to express how much your love, confidence, patience, and support has meant to me throughout my life. I have always told you that I could not have done any of this without you. I hope you know that in your hearts and know that I am the woman I am today because of your belief in me. It makes all if this worth it to make you proud. I love you both so much and cannot thank you enough.

Spencer, you are the greatest gift I have received thus far in life, and I am grateful every day that we have found each other and love each other so completely. I could not have completed this dissertation without your patience, confidence, and brilliant sense of humor. Thank you so much for standing by me, encouraging me, and making me laugh to keep from crying, every step of the way. I love you so much.



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I would like to first thank my amazing chairperson, Dr. Robert de Mayo, for believing in this project from day one and holding a steady course throughout. You are a wonderful and patient mentor and I am proud to have worked with you on this project. Thank you for encouraging me throughout this process. Thank you Dr. David Foy for jumping right in to this project as a committee member and offering great suggestions and valuable support to make it successful. To my committee member, colleague, mentor and friend, David W. Schafer, I have so much thanks to give. Your humor, guidance, and faith in me have been instrumental to my journey as a psychologist. I would also like to thank Dr. Yuying Tsong for embracing this SPSS neophyte with your great sense of humor and patience. Thank you for not letting me get too overwhelmed and helping me succeed.

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Thank you to my extended family, Aunt Pat and Uncle Gary for always believing in me and showing how proud you are of me. It has always meant so much. Alexis Randall, my beautiful, positive, amazing cousin - thank you for your inspiring presence in my life. You brighten the world. Thank you to my extended

Brown family; Linda, Jim, Evan, Kelly, Grandma & Grandpa Brown, and Grandma & Grandpa McCollum for your open arms, loving support, and great sense of humor. I love you all so much.

I would like to extend an enormous thank you to Emilee Healing Paulson. You are my rock, my anchor, my partner in crime, and my best friend. Your words of wisdom and utter hilarity keep me going when I feel like I have nothing left. You're the best! I would also like to deeply thank Micha Mikailian for always lending an ear, an office cubicle, or great advice. I deeply admire you and I am so grateful for our long friendship; I know it will last forever.

Finally, I would like to extend my heartfelt gratitude to my friends and colleagues who have been a part of this journey and whose guidance and humor have kept me (reasonably) sane. You may not know how much, but you have enriched my life, personally and professionally throughout the years. Thank you so much Jonathan Popkin, Michele Archambeault-Fewell, Psy.D., Tanya Macklin, Stephanie Myers, Ariel Frankel, Rebecca Harvey, Psy.D., Melissa Maglione, Ph.D., David Reinert, Jessica Rubin, L.C.S.W., and the entire Pepperdine faculty.

## VITA

**Education**

Doctoral Candidate in Clinical Psychology  
 Pepperdine University - Graduate School of Education and Psychology  
 Dissertation: *Psychologists' use of, familiarity and comfort with Alcoholics Anonymous Slogans in therapy.*  
 Chairperson: Robert de Mayo, Ph.D.  
 Committee: David W. Schaefer, Psy.D.; David W. Foy, Ph.D.

Master of Arts in Clinical Psychology  
 Pepperdine University, West Los Angeles  
 Degree Awarded: August 2005

Bachelor of Arts in Psychology  
 California State University at Northridge  
 Degree Awarded: 2002

**Professional Experience**

- Act on Your Life July, 2010 - Present  
 Psychological Assistant, PSB 35189  
 Supervisor: David Schaefer, Psy.D., Psy 23303  
 Pasadena, CA & Calabasas, CA
- Provide individual, evidence-based psychotherapy focusing on trauma-related diagnoses, sleep disorders anxiety, depression, relationship difficulties, issues of self-esteem/low motivation, and dual diagnosis problems.
- VA Sepulveda Ambulatory Care Center August, 2008 - August, 2009  
 Doctoral Internship - Intern  
 North Hills, CA  
 Supervisor: Steven Ganzell, Ph.D. Supervisor: Sylvia Boris, Ph.D.
- Provide individual and group psychotherapy in Chemical Dependence Treatment Unit (CDTU), Partial Hospitalization Program, Outpatient Mental Health (OPMH), and Geropsychology
  - Groups facilitated: Acceptance and Commitment Therapy (ACT) for Anxiety & Depression, Cognitive Processing Therapy (CPT) for PTSD, Spirituality, Domestic Violence (mandated for perpetrators), Living With Disabilities, and Relapse Prevention
  - Provided weekly supervision to a pre-intern and attended own weekly supervision with multiple supervisors in varying specialties

Family Stress Center  
 Doctoral Practicum Testing Clerk  
 North Hills, CA  
 Supervisor: Sue Schmidt, Ph.D.

September, 2007 - August, 2008

- Conducted child and adolescent assessments based on Dept. of Mental Health standards and presented diagnostic findings, treatment recommendations and referrals to therapists, teachers, and guardians
- Received supervision geared towards cultural sensitivity and creative solutions for families of patients coping with trauma and difficult socioeconomic circumstances

Harbor-UCLA Dual Diagnosis Program  
 Doctoral Practicum Extern - Psychology  
 Torrance, CA

August, 2006 - August, 2007

Supervisors: John Tsuang, M.D., Marie Moerkbak, Ph.D., & David Martin, Ph.D.  
 Instructors: Lynn McFarr, Ph.D.  
 Consultants: Josh Lichtmann, M.D.

- Provided individual cognitive-behavioral psychotherapy with dually diagnosed adults in an outpatient setting as well as facilitation of process and psycho-education groups
- Participated in bi-weekly discharge interviews of actively psychotic patients in Harbor-UCLA Emergency room with attending staff
- Attended weekly cognitive-behavioral therapy didactics for treating dually diagnosed patients

Pepperdine Counseling Clinic  
 Doctoral Practicum Therapist  
 West Los Angeles, CA  
 September, 2005 - July, 2008

September, 2005 - July, 2008

Supervisors: Aaron Aviera, Ph.D. and Ed Shafranske, Ph.D.

- Provided individual and couple's therapy for adults with anxiety, mood, and substance abuse disorders and administered and interpreted clinical measures assessing current level of functioning as well as follow-up measures used to gauge symptom reduction.

Clearview Treatment Programs (Residential)  
 Program Aide  
 Venice, CA

April, 2005 - October, 2005

Executive Director: Michael Roy, MSW    Supervisor: Jean Campbell, MSW, ASW, CET III, TEP

This facility is an extended care residential program designed to treat dually diagnosed adults.

- Supervised and monitored residents on a twice-weekly basis.
- Responsible for onsite crisis intervention and general administrative duties
- Co-led and planned weekly Family of Origin process group and Family Weekend Workshop for residential and outpatient clients

Clearview Treatment Programs (Outpatient)      September, 2004 - April, 2005  
Program Assistant  
Westwood, CA

Executive Director: Michael Roy, MSW

Supervisor: Carol Hayman, M.A., MFT

This facility is an outpatient organization that treats dually diagnosed clients.

- Prepared materials for case conference including census data, attendance and scheduling for various onsite groups, and urinalysis testing results
- Worked with staff therapists and program director in evaluating and conceptualizing cases and co-led Relapse Prevention group

### **Supervision Experience**

Pepperdine Psychological Clinic      September, 2007 - August, 2008  
Peer Supervisor

West Los Angeles, CA

Supervisor: Aaron Aviera, Ph.D.

- Provide weekly supervision for one year to two first-year Psy. D. student therapists utilizing therapist feedback, progress notes and taped sessions.

## ABSTRACT

Alcoholics Anonymous (AA) is often included as an adjunct to psychotherapy for individuals suffering from addiction. As a culture unto itself, AA has its own customs, philosophy, and language, including what is commonly referred to as AA slogans. This study investigated the frequency with which psychologists use these slogans as well as how familiar and comfortable they are with them. Additionally this study investigated whether these variables were related to psychologists' work setting or percentage of addicted caseload. Using a mix of quantitative and qualitative methodology, results indicate that more than 80% of respondents utilize AA slogans at least some of the time. Familiarity varied greatly depending on the slogan. Over 80% of those surveyed are at least somewhat comfortable using AA slogans in psychotherapy. Work experience in an addiction treatment setting was a mediating variable for familiarity as well as use of specific AA slogans, though not for overall use of AA slogans or levels of comfort. A higher rate of use and familiarity was related to a higher caseload of addicted patients and comfort was not related to caseload. Frequency of slogan use, familiarity and comfort were significantly positively related to frequency of referral to AA. Themes regarding reasons for discomfort using AA slogans as well as their clinical utility were also explored.

## Introduction

Alcoholics Anonymous (AA) is one of the most well-known self-help organizations associated with helping people to recover from alcohol dependence or problem drinking. As a free, self-sustained service available worldwide, it is easily accessible and its anonymous nature makes it alluring to those curious, but unsure of their drinking status or in need of privacy. AA's famous Twelve Steps have been formatted and used to accommodate a host of other mental and social disorders and conditions including drug addiction, overeating, gambling, and co-dependency. According to a recent membership survey, the self-proclaimed Fellowship, which first formally began in 1935 with only a handful of members, has over two million members now (AA World Services, 2010). This is likely a conservative estimate considering that AA's anonymous nature precludes the organization from extracting exact data about its members and they do not attempt to keep a formal census. Room and Greenfield (1993) placed the actual number in 1990 at closer to 3.5 million members and one can only assume that these numbers are even greater nearly twenty years later.

As one of the longest running forms of treatment for alcoholism, AA has garnered attention from the psychological and medical community, which has sought to determine its efficacy and uncover the organization's therapeutic elements. Research indicates that affiliation with AA improves abstinence outcomes (Bodin & Romelsjo, 2006; Galanter, Talbott, Gallegos, & Rubenstone, 1990; Lemke & Moos, 2003) and that the unique spiritual component of the

program contributes to better abstinence outcomes and increased quality of life (Kubicek, Morgan, & Morrison, 2002; Wysong, 2008).

It is estimated that at one point in their lives, up to seventeen percent of U.S. adults will meet criteria for alcohol abuse and nearly thirteen percent will meet criteria for alcohol dependence (Hasin, Stinson, Ogburn & Grant, 2007). According to data collected through the National Institute on Alcohol Abuse and Alcoholism (NIAAA), within a twelve-month period (2001-2002) nearly five percent of the population is estimated to have abused alcohol (Grant, Dawson, et al., 2004). Not only are alcoholism and associated disorders impacting the lives of millions, it has been shown that many of these same individuals also meet criteria for another psychiatric disorder (Grant, Stinson, et al., 2006; Hasin, Stinson, Ogburn, & Grant, 2007; Kranzler & Rosenthal, 2003; Petrakis, Gonzalez, Rosenheck, & Krystal, 2002). Kessler, Crum, Warner, and Nelson, (1997) analyzed data collected from the National Comorbidity Survey to reveal the lifetime patterns of co-occurrence of alcohol abuse and dependence (based on *DSM-III-R* criteria) with other psychiatric disorders in a sample of 8,098 respondents (aged 15-54). Results indicated that females have a stronger co-occurrence than males and that anxiety and affective disorders comprise the majority of lifetime co-occurring disorders for females while substance disorders, conduct disorder, and antisocial personality disorder were the most common co-occurrences among males.

Because of the considerable overlap of substance abuse and co-morbid psychiatric disorders, it is unsurprising that many members of AA will or have at some point sought out professional mental health treatment. The American



Psychiatric Association (2006) recommends referral to self-help groups, including but not limited to AA, as an adjunct to the treatment of patients with substance use disorders and/or as part of a patient's care. High rates of referral to 12-Step format and other self-help groups have been stimulated both by the endorsement in the American Psychiatric Association (2006) practice guidelines for the treatment of substance use disorders as well as the growing number of professionals with personal experience with these organizations (Humphreys, 1997) who may be eager to "carry the message" as indicated in the twelfth step. In a 2007 AA membership survey, 33% of members indicated that one of the most common sources of their referral to AA came from a treatment facility. Counseling centers and health professionals made up 15% of the common referral sources (AA World Services, 2004). A study of 127 AA members with varying lengths of sobriety indicated that over 75% received some form of mental health/addiction treatment other than AA, and that they experienced the treatment as helpful (Zemansky, 2005). The treatment that these participants received was not necessarily addiction-focused.

When compared to other forms of treatment and through listening to the narratives of addicts who are members, perhaps one of the Program's most enduring and unique elements is its message to participants, both in terms of its structure and its language (Hall, 2008). An important aspect of AA's language is the instructional message of abstinence and practices for daily living which exist in what are known as AA slogans. Psychological researchers have shown interest in better understanding how AA slogans are commonly used to disseminate information, increase affiliation, and change perspectives in AA

(Barton, 1999; Bristow-Braitman, 1995; Hall, 2008; Rogers, 1989). Matching the language of a patient can help facilitate the growth of rapport and perceived empathy (Turan & Stemberger, 2000) and integrating the language of a patient's subculture is important to culturally sensitive therapy. As noted by Charlés et al. (2003), "speaking the client's language" is the skill of "marking and utilizing clients' words and phrases as a way to facilitate therapeutic conversation" (p. 56).

This dissertation will focus on psychologists' use of AA slogans, a facet of 12-Step participation which may appear different than many traditional forms of psychotherapy. More specifically, this dissertation seeks to examine the level of familiarity psychologists have with specific AA slogans and their comfort level with using them in therapy. The following research questions will be considered. How often do psychologists use AA slogans in treatment? How familiar are psychologists with specific well-known AA slogans? How comfortable are psychologists with using AA slogans in treatment? Will use of, familiarity and comfort with the slogans be related to psychologists' primary work setting or the size of their caseload of addicted patients?

### **Definition of Terms**

There are many concepts and terms related to the culture and treatment of alcohol-related problems and they are not well standardized and it is difficult to find a universally accepted definition for such terms as alcohol abuse, alcohol dependence, alcoholism, and addiction that satisfies professional organizations, lay persons, and experts (Babor & Hall, 2007). Diagnostic definitions will defer to those found in the *Diagnostic and Statistical Manual, Fourth Edition, Text*

*Revision (DSM-IV-TR; American Psychiatric Association, 2000)*. In this study, the following terms will be used accordingly.

The phrase alcohol and other drug (AOD) use captures a wide range of behaviors related to the use and/or abuse of alcohol and other drugs which may lead to dependence. This term does not always apply to adverse use patterns. The term does reflect the concept that alcohol is recognized in the field of addiction as a drug. In this study AOD use, alcohol abuse, substance abuse, and drug use will be used interchangeably.

Substance dependence refers to a maladaptive pattern of substance use leading to clinically significant impairment or distress (*DSM-IV-TR, 2000*). This pattern of use is associated with (three or more of) the following indications: (a) tolerance, (b) withdrawal, (c) taking the substance for longer and in larger amounts than intended, (d) unsuccessful efforts to curtail or stop substance use, (e) considerable time and effort directed towards obtaining and/or using substance, (f) reduction or elimination of important social, occupational, or recreational activities, and (g) substance use continues despite knowledge of physical or psychological problems that are caused or exacerbated by the substance use. The term alcohol dependence refers to the same criteria listed above, with the substance being alcohol. The terms alcohol dependence, substance dependence, substance use disorder, chemical dependence, problem drinking, addiction, and alcoholism will be used interchangeably in this study.

Various terms are often used to describe people with substance abuse problems. In this dissertation the term alcoholic refers to an individual that meets criteria for alcohol dependence as defined by *DSM-IV-TR (2000)*. The term

addict refers to an individual that meets criteria for substance dependence as defined by *DSM-IV-TR* (2000).

Addiction treatment refers to any form of treatment that specifically targets as a goal or priority, the reduction or cessation of substance use or dependence. Other psychological or physical problems may also be addressed by treatment providers in addition to the addiction. This can refer to formats including but not limited to individual psychotherapy, group psychotherapy, 12-Step formatted therapy, dual-diagnosis treatment, inpatient/outpatient rehabilitation facilities, and detoxification services. In this dissertation, this is sometimes referred to as AOD treatment.

The term 12-Step group refers to any self-help group whose content and approach are based on the guiding principles set forth in Alcoholics Anonymous' twelve steps and twelve traditions. These groups are self-governed, maintain the anonymity of their members, and focus on a range of social and psychological problems including overeating, other forms of substance abuse, compulsive gambling, debting, and co-dependency, to name a few. Certain aspects of these groups have been adapted for treatments called Twelve-Step Therapies or Twelve-Step Facilitated therapy (TSF). For the purposes of this study, the non-professional groups will be referred to as 12-Step groups and any professional adaptation for the purposes of treating addiction will be referred to as Twelve-Step Therapy or TSF.

Addiction treatment provider refers to any treatment provider whose primary training or target population is in the field of addiction recovery. This can include professionally trained psychotherapists, psychologists, psychiatrists,

medical doctors, drug and alcohol counselors, and non-trained specialists whose personal experiences with recovery uniquely qualify them to counsel others with similar problems. For the purposes of this study addiction treatment providers and addiction counselors will be used interchangeably.

The term recovery, in the context of this study, borrows in part a definition proposed by White (2007):

Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life. (p. 236)

As most persons in the program of AA consider themselves to be “in recovery” if they are maintaining abstinence from substance use and those who are in a harm-reduction program may not include abstinence as a goal, the terms abstinent and sober will refer only to persons who are abstaining fully from alcohol and other drugs. Any reference to “the program” suggests that the format of treatment that an individual is receiving is through a 12-Step program and that they “work the steps”.

The term slogan refers to a pithy phrase, usually with notable brevity, that can often take the form of metaphor, axiom, adage, proverb, acronym, or saying. They are typically associated with a certain group or idea. For the purposes of this study, “AA slogans” will be defined as short commands, maxims or

statements recognized as germane to the organization of AA (“Easy does it”) and can include what is more commonly known as a proverb or adage that comments on a problem or dilemma in such a way as to deliver advice, support or instruction, either solely related to AA or otherwise (“High bottoms have trap doors”). Comparisons to metaphor and proverb are frequent as many of the AA slogans are of this format.

## Method

### Subjects

Participants were recruited for this study through invitations to participate in a survey distributed to online electronic mailing lists for members of the following psychological associations: the Los Angeles County Psychological Association (LACPA), Division 1 of the California Psychological Association (CPA), and Division 12 and Division 28 of the American Psychological Association (APA). Due to the variable nature of membership on these electronic mailing lists, only approximate values are available. LACPA has over 900 members on its electronic mailing list and represents psychologists in Los Angeles County (although membership can include people all over California). CPA Division 1, has over 200 electronic mailing list members, and represents clinical psychology practitioners in California. Divisions 12 and 28 of APA represent the Society for Clinical Psychology and Psychopharmacology and Substance Abuse, respectively. These are national divisions. Division 12 has approximately 3,000 members on its electronic mailing list. Division 28 has approximately 180 members on its electronic mailing list.

This survey was completed by 160 participants recruited through their membership to electronic mailing lists associated with several psychological associations. Forty-nine responses were excluded due to the following reasons: failure to submit proper consent, failure to meet criteria of at least five face-to-face therapy hours per week, failure to meet criteria of holding a doctoral degree, or failure to complete a majority of the survey. The following statistical

summaries are reflective of the final 111 eligible participants; about 3% of the targeted electronic mailing list population.

### **Instrumentation**

The instrument used in this study was a survey (Appendix B) developed specifically to measure psychologists' utilization of, familiarity, and comfort with Alcoholics Anonymous Slogans in the therapeutic context. This survey contains questions related to common practices in treatment as related to the treatment of individuals with substance abuse problems. Participants were asked how often they use slogans associated with AA and how comfortable they are with using them. In addition, a list of slogans associated with AA was presented to the participants for them to rank how often they use them and how familiar they are with them. This list was constructed based upon a literature review of AA slogans, the researcher's observations of slogan use in clinical settings, and through consultation with a psychologist who specializes in chemical dependence treatment. Both popular and obscure slogans were utilized and the main criteria for inclusion on the list was that they be strongly associated with AA rather than with popular culture. Participants were given the opportunity to answer open-ended questions regarding discomfort using AA slogans as well as how AA slogans may be useful in treatment. In addition, general socio-demographic questions, including age, gender, education level, primary therapeutic orientation, and ethnicity have been included. The survey was created and using the web-based service SurveyMonkey.



## Procedures

This study utilized a confidential nationwide survey to investigate psychologists' use of, familiarity, and comfort with AA slogans in the therapeutic context. Further, analysis was used to determine if a significant relationship exists between psychologists' use of, familiarity and comfort with AA slogans and their primary work setting and the percentage of their patient caseload with substance abuse problems.

The survey was sent via email to electronic mailing list members of LACPA, CPA, and the aforementioned divisions of APA. The survey was distributed upon approval from the Pepperdine University Graduate and Professional Schools Institutional Review Board (GPS-IRB). The survey included the researcher's contact information so that individuals had the opportunity to address questions, concerns or technical difficulties with the survey. At the outset of the survey participants were informed of their rights as a participant and were asked to consent to having their responses used for the purposes of research before continuing with the survey. In addition, a waiver or alteration of consent form was completed in order to comply with standards set forth by GSP-IRB.

As surveys were completed the results were automatically filtered into categorical data by the SurveyMonkey website. There was no trace back to the person who completed the survey, and therefore, the results were anonymous. The data collected will be kept for a maximum of one year on the investigator's password protected computer, to which only the investigator has access. After one year the data will be destroyed.

## Data Analysis

This study investigated the frequency with which psychologists use AA slogans, how familiar they are with specific AA slogans, and how comfortable they feel using them in therapy. This study attempted to establish whether a relationship exists between these investigated variables and the psychologists' primary work setting and the percentage of their caseload with a substance use disorder. The study investigated reasons psychologists have for feeling uncomfortable using AA slogans and also ways psychologists believe AA slogans can be useful in treatment.

The data were coded and prepared for computerized analysis using SPSS-PC 17.0. Descriptive statistics and other appropriate statistical analyses were generated, including (a) means and standard deviations, (b) independent sample t-tests to compare groups, (c) Pearson Correlation to yield information about the inter-correlation between all measured variables, (d) Spearman's rho correlation to yield information between measured variables that are not ordinal in nature, and (e) qualitative constructive analysis based on consensual qualitative response method to extract common themes and categories of responses related to open-ended questions.

## Results

The results of this study describe characteristics of practicing psychologists and illustrate aspects of their use, familiarity, and comfort with slogans associated with Alcoholics Anonymous. The results provide information regarding relationships between work setting exposure as well as types of patients served and psychologists' use of, familiarity, and comfort with slogans associated with Alcoholics Anonymous.

### Demographic Information

A summary of the participants' gender, age range, and ethnic background is available in Table 1. Information regarding their degree, licensure status, years practicing, and primary theoretical orientation is summarized in Table 2.

### Participants' Professional Profiles and Common Practices

All of the participants spend at least five hours per week providing face-to-face therapy services to their patients; this was a criterion for inclusion in the study. Participants in this study primarily treat adults ( $n = 95$ ; 86%). A small group works primarily with an elderly population ( $n = 4$ ; 4%) and the rest work with children and/or adolescents ( $n = 12$ ; 11%). A summary of participants' primary work settings is provided in Table 3. The majority indicated that their primary work setting is within a private individual or group practice ( $n = 73$ ; 66%), followed by a medical inpatient or outpatient setting ( $n = 11$ ; 10%). Responses for other work settings made up a small percentage of the remaining responses and are as follows: community clinic ( $n = 8$ ; 7%), psychiatric inpatient/outpatient ( $n = 4$ ; 4%), state or federally funded rehabilitation center ( $n = 4$ ; 4%), Prison ( $n = 3$ ; 3%), private rehabilitation center ( $n = 2$ ; 2%), and Other ( $n = 2$ ; 2%).

When asked if they have ever worked in a setting where the treatment of alcohol or other drug (AOD) addiction was a primary focus, 51% of participants indicated that they had ( $n = 56$ ), and 49% had not ( $n = 55$ ). Many participants are currently working with a patient with an AOD problem, regardless of whether it is the primary focus of treatment. Only 5% indicated that none of their current caseload had a problem with drugs or alcohol ( $n = 6$ ). Nearly thirty-one percent of participants described their caseloads as comprised of 10% or less patients with AOD problems ( $n = 34$ ). Thirty-four percent indicated that between 11% and 30% of their caseload has a substance problem ( $n = 38$ ). Over fourteen percent indicated that between 30% and 50% of their current patients has a substance problem. The rest of the group gave estimates between 51% and 100%, as outlined in Table 3a. Of those who indicated that their current caseload contains some patients with AOD problems ( $n = 105$ ), 54% also indicate that between 91% and 100% of those individuals have a comorbid psychiatric diagnosis ( $n = 57$ ). Table 3b summarizes the participants' percentage of these dual-diagnosis patients.

Considering their most common practices, 80% of respondents indicated that they use slogans at least some of the time. Nearly twenty percent indicate that they never use slogans in therapy ( $n = 22$ ; 20%). Sixty-four percent endorse slogan use in therapy sometimes ( $n = 71$ ), 14% use them often ( $n = 15$ ), and 3% use them very often ( $n = 3$ ). Regarding referral to AA, 97% indicate that they refer patients with alcohol or other drug problems to AA at least some of the time. With regards to comfort using slogans associated with AA in therapy, over 83% are at least somewhat comfortable with this practice. Table 4 summarizes the

common practices of psychologists as it relates to Alcoholics Anonymous referral, as well as use of and comfort with AA slogans in therapy.

### **Results for Primary Research Questions**

**Question one: AA slogan use.** The first research question was regarding psychologists' frequency of use of AA slogans in therapy. As previously stated, the results of frequency of slogan use indicate that the majority of participants use them at least some of the time in therapy and are summarized in Table 4. While not a specific research question, this survey also looked at frequency of use among specific slogans to attempt to determine if any were used more often than others. Only respondents who indicated that they used slogans at least sometimes were asked to answer these questions. Table 5 summarizes how often psychologists' indicate using these ten specific phrases in psychotherapy. The most frequently used slogan was "One day at a time," with 24% indicating that they use it very often. The least frequently used slogan was "Take the cotton out of your ears and put it in your mouth," which 97% indicated that they never used.

**Question two: AA slogan familiarity.** The second research question was regarding psychologists' familiarity with AA slogans commonly associated with Alcoholics Anonymous. Ten slogans associated with AA were used for this question. Results indicated that 100% of respondents who use AA slogans were at least somewhat familiar with the slogan, "One day at a time." Participants were least familiar with "Take the cotton out of your ears and put it into your mouth" ( $n = 88$ ; 80%). Table 6 summarizes participants' levels of familiarity across the slogans.

**Question three: Comfort using AA slogans.** The third research question asked how comfortable psychologists are using AA slogans in psychotherapy. As previously stated, 84% of psychologists surveyed indicate that they are at least somewhat comfortable using slogans in psychotherapy and 16% are not comfortable with it. Table 4 further summarizes the discrete levels of comfort among participants.

**Question four (a): Impact of work history on variables.** The fourth research question was divided into two inquiries concerned with determining whether use of, familiarity or comfort with slogans would be related to: (a) psychologists' primary work setting, or (b) with the percent of their caseload with an addiction. Due to insufficient group numbers in primary settings other than individual or group private practice, this comparison could not be made. In lieu of the original research question, a post-hoc research question was formulated utilizing data regarding participants' work history related to substance abuse treatment. The researcher investigated whether use of, familiarity or comfort with AA slogans would be related to whether the psychologist had ever worked in a setting where the primary focus AOD treatment.

Each participant was asked whether they had ever worked in an AOD treatment setting. The group was fairly evenly divided with 51% having worked in such a setting ( $n = 56$ ) and 49% never having done so ( $n = 55$ ). Each participant was asked how frequently they used slogans associated with AA in therapy ( $n = 111$ ). The results of the independent sample t-test indicated that there were no statistically significant differences in frequency of use between those who have worked in an AOD treatment setting and those who have not,  $t(109) = 1.29, p =$

.20, when equal variances assumed, Levene's  $F = .00$ ,  $p = .97$ . Of those who stated that they did use slogans as least some of the time (i.e. did not endorse "never"), ( $n = 88$ ), there were statistically significant differences between those who have worked in an AOD treatment setting and those who have not,  $t(86) = 2.9$ ,  $p = .01$ , when equal variances assumed, Levene's  $F = 1.26$ ,  $p = .26$ . This suggests that, among those who report using slogans, having worked in an AOD treatment setting at some point is related to more frequent use of specific slogans than those psychologists who have not worked in an AOD treatment setting.

Each participant was asked to rate their familiarity with ten AA slogans. An average of levels of familiarity with these slogans was used to determine whether familiarity with slogans is related to having worked in an AOD treatment setting. The results of the independent sample t-test indicated that there was a statistically significant difference in overall familiarity with the slogans between those who have worked in an AOD treatment setting and those who have not,  $t(109) = 3.71$ ,  $p = .00$ , when equal variances assumed, Levene's  $F = .06$ ,  $p = .81$ . This suggests that having worked in an AOD treatment setting is related to a higher average of familiarity with specific slogans.

Each participant was asked to rate their level of comfort with using AA slogans in therapy. The results of the independent sample t-test indicated that there were no statistically significant differences in levels of comfort between those who have worked in an AOD treatment setting and those who have not,  $t(108) = 1.80$ ,  $p = .075$ , when equal variances assumed, Levene's  $F = .12$ ,  $p = .73$ . This suggests that levels of comfort with using AA slogans in therapy are unrelated to whether the individual has worked in an AOD treatment setting. A

summary of values for each independent sample t-test described can be found in Table 7.

**Question four (b): Impact of caseload on variables.** The second inquiry within the fourth research question was regarding whether use of, familiarity, and comfort using AA slogans was related to the amount of patients in the participants' caseload with an addiction. Using Spearman's rho, a correlation analysis was made to determine if participants' use of, familiarity, and comfort with AA slogans was related to the amount of their patients with substance use problems. The percentage of addicted patients psychologists reported in their caseload was significantly related to the frequency of their use of slogans in general ( $\rho = .214$ ;  $p = .02$ ), use of specific slogans ( $\rho = .263$ ;  $p = .01$ ), and familiarity with specific slogans ( $\rho = .307$ ;  $p = .00$ ). There was no significant statistical relationship between their percentage of addicted and their level of comfort using slogans in therapy ( $\rho = .115$ ;  $p = .23$ ). Table 8 shows correlations between these variables.

### **Post-hoc Tests**

**Intercorrelations.** Correlations for multiple variables were analyzed using Pearson's correlation to examine whether any unexpected or relevant relationships exist. Interestingly, the amount of years spent practicing psychology had no statistically significant relationship with referral to AA or use of, familiarity, and comfort with slogans generally or specifically. Psychologists' frequency of referral was significantly related to higher levels of general use, specific use, familiarity and comfort with AA slogans. There were statistically significant relationships found between use of, familiarity, and comfort with AA



slogans as well. Table 9 shows several statistically significant relationships among variables.

### **Qualitative Analysis**

The approach taken in analyzing the qualitative portions of this study is loosely based on consensual qualitative research (CQR) in that the researcher coded open-ended responses to develop specific domains and core ideas in the data (Hill et al., 2005). The present analysis differed from the traditional format of this methodology in that only one judge was used to codify the data rather than multiple, which is a standard component of consensual qualitative research (CQR) in determining a consensus of various viewpoints. An attempt was made to control for this deviation by having a dissertation committee member review the themes and domains that the researcher extracted. Another way that limited viewpoints and bias were minimized was through the lack of contact between the researcher and participants. As Hill et al. (2005) point out, "The interviewer's role is typically as a trustworthy reporter trying to uncover what the participant truly believes, rather than as someone who engages with the participant in a deeply relational way to co-construct meaning" (p. 197). Further, in an effort to minimize bias, the researcher has examined expectations and personal experience going into this study, which cannot be excluded entirely from the coding process, but will hopefully be marginalized through recognition.

The researcher acknowledges that because of her own work in settings where treatment for alcohol and other drugs is the primary focus, exposure to principles of AA has been frequent, and for the most part, positive. Further, the researcher acknowledges the following attitudes and expectations: (a) AA

slogans are a useful therapeutic tool when working with patients, particularly those who abuse substances, (b) it is expected that several psychologists will feel uncomfortable using AA slogans due to lack of experience or feeling disingenuous due to non-addict status, and (c) exposure to substance-abusers in treatment will promote use of, familiarity, and comfort with AA slogans in therapy.

Bearing these biases in mind, every attempt was made to be objective in the summarization of the participants' viewpoints and declarations. The summarization process was based on the CQR method of developing domains, core ideas, and cross-analyzation among participants to identify categories of frequency (Hill et al., 2005). This was achieved by reviewing the data and extracting topical categories that differentiate the responses, then further editing them down into a more concise statement or viewpoint as a core idea. The cross-analyzation consists of determining whether core ideas were shared across participants and how frequently this occurred. Using the suggestions of Hill et al. (2005), frequency can be placed into three categories, "general" applies to all or all but one of the participants, "typical" applies to more than half, "variant" applies to less than half, but at least two to three participants, and "rare" is used in cases where the sample size is greater than 15, and exists in two to three cases.

**Discomfort using AA slogans.** The first data set examined was directed only at psychologists who endorsed that they are very uncomfortable using slogans associated with AA in therapy ( $n = 24$ ). The follow-up question for these participants was open-ended, "Can you describe why using slogans associated with Alcoholics Anonymous in therapy is something that you are uncomfortable

with?" The data was examined without preset domains; rather, the domains were developed through evaluation of that data.

With the exception of two responses, the results indicate that reasons for discomfort using slogans fell into one of five of the following core ideas: (a) Beyond the scope of training/experience, (b) Psychologist is not aligned with AA model, (c) Dislike connotation of slogans, (d) Slogans are not aligned with therapeutic style, and (e) Slogans are harmful to patients. Several responses yielded information that qualified for more than one core idea. All of the core ideas are qualified as variant; they occur in two or more of the responses, but in less than half. One response was considered rare, related to the appropriateness of AA slogans for the psychologists' demographic of patients, which was children. Table 10 summarizes the frequency of these core ideas and outlines some of the topical domains within them. Examples of the raw data are given as well.

**Psychologists' opinions on the utility of AA slogans.** The second open-ended question was, "Please describe how you think slogans associated with Alcoholics Anonymous can be useful when treating patients." This yielded 126 responses. However, there were some responses that were not applicable due to irrelevance (answer did not appear to apply to the question), or ambiguity. Ambiguous responses were difficult to evaluate without the risk of tainting the data with the researcher's opinion. Such ambiguity could not be clarified due to the anonymous nature of the study and therefore, these responses were eliminated. A total of 116 responses were coded and analyzed for core ideas and domains.

As was the case in the first open-ended question, responses regarding utility of slogans often contained more than one domain and core idea. The data was evaluated three separate times to first identify domains, then again to more narrowly define domains, and finally to extract core ideas. Psychologists' opinions of how AA slogans can be helpful when treating a patient fall into the following eleven categories or core ideas, which are presented in order of highest frequency: (a) Succinct articulation of key concepts, (b) Facilitate psychological change, (c) Bridge therapy and 12-Step treatment, (d) Enhance therapeutic process, (e) Universality, (f) Memorable, (g) Provide encouragement, (h) Relapse prevention, (i) Demonstrate psychologists' knowledgeability, (j) Connection to others in recovery, and (k) Meaning Making. Table 11 shows the frequency of the core ideas and outlines the topical domains that they consisted of.

## Discussion

The data and analyses reported in this dissertation are representative of a preliminary exploration of variables associated with psychologists' use of, familiarity, and comfort with Alcoholics Anonymous Slogans in therapy. Further, this study sought to gain a rudimentary, yet important grasp of the ways that such slogans are considered useful intervention strategies when working with patients and reasons why they may create discomfort for others.

In attempting to answer the first research question regarding frequency of slogan use among psychologists, the results indicate that the majority of psychologists surveyed use slogans at least some of the time. Nearly 20% of respondents indicate that they never use slogans, which is also consistent with reported levels of discomfort using slogans; over 16% are not comfortable with slogan use. When examining use of specific slogans, only participants who endorsed using slogans some of the time were asked to evaluate their use of ten slogans associated with AA. The most popularly used slogan was "One day at a time," used at least some of the time by a little over 94% of those who generally use slogans. Other more popularly used slogans were "Keep it simple" and "Progress, not perfection," both of which are used at least some of the time by over 55% of those who use slogans. Participants were given the option of listing up to three other AA slogans that they use and 60 responses were generated. The most popular was the Serenity Prayer, followed by "H.A.L.T. - Never get too Hungry, Angry, Lonely or Tired," "Keep coming back, it works if you work it," and "The definition of insanity is doing the same thing over and over again expecting different results."

The least used slogan was “Take the cotton out of your ears and put it in your mouth,” which nearly 97% indicate that they never use. Other unpopular choices were “Play the tape all the way through” and “Let go and let God.” The results from this study indicate that two of the least frequently used slogans; “Play the tape all the way through” and “Take the cotton out of your ears and put it in your mouth” were also the ones rated with the least amount of familiarity.

Responses to items addressing the second research question relating to respondents’ familiarity with specific slogans suggest that use of slogans is strongly related to respondents’ familiarity and awareness of that slogan. The clearest example of this is that all of the participants are familiar with the slogan, “One day at a time” and it was also the most commonly used. Another example of this works in the reverse. Since “Take the cotton out of your ears and put it in your mouth” and “Play the tape all the way through” appeared to be unfamiliar to many respondents, it is unsurprising that they are not used. An exception to this appeared in response to the most explicitly religious slogan, “Let go and let God.” Over 87% of participants indicated that they are at least somewhat familiar with this popular slogan, yet 80.5% of those who use slogans indicate that they never use it. As indicated in the literature review, this may be due to a reticence on the part of psychologists to endorse such an explicitly religious directive, to bring spirituality or religiosity into the therapeutic setting (Laudet & White, 2005) or a lack of alignment with spirituality related to higher education (Schaler, 1996).

Assessing the levels of psychologists’ comfort using AA slogans in therapy was the third research question. A little over 83% indicate that they are at least somewhat comfortable using slogans in therapy. This may indicate that there is a

growing overlap of vernacular from the popular treatment program and traditional therapeutic language. Further, while some reticence or personal discomfort may still exist, this suggests that for the most part, psychologists are comfortable bringing in these AA sound bites. When analyzing the qualitative data related to how AA slogans can be useful in therapy, more than once it was stated that the slogans are complementary to the style of therapy or specific technique being used (e.g. motivational interviewing or CBT). Perhaps the psychologists' own style of practicing therapy may already have within it tenets that are slogan-friendly (i.e. CBT's "musterbating" and "shoulding on yourself"). Fifteen percent of respondents were not at all comfortable using AA slogans in therapy and many may feel that using them involves an approach more suitable for substance abuse counselors than psychologists. Indeed, in the open-ended response section related to reasons for discomfort using slogans, the most common reasons given were related to a lack of training or experience and slogans not being aligned with the psychologist's therapeutic style. One response explicitly stated, "It is not my specialty. I leave that to the CADAC counselors" (Anonymous, personal communication, August 27, 2010).

The fourth research question (part a) considered whether a relationship exists between use of, familiarity, and comfort with slogans and psychologists' primary work setting. There was unfortunately limited variance in primary setting, preventing that analysis. However, a consideration had been made to include a question related to psychologists' history and experience working in settings where the treatment of alcohol and/or other drugs (AOD) was a primary focus. It seemed reasonable to hypothesize that psychologists who had previously

worked in settings where exposure to addiction treatment such as AA was likely to be high would endorse higher levels of use, familiarity, and comfort with AA slogans in therapy. The rationale behind this was based on tenets of the mere exposure effect. Mere exposure to a stimulus has long been shown to enhance positive attitudes towards it (Zajonc, 1968) and can generalize out to constructs that are abstractly similar to the original stimuli (Gordon & Holyoak, 1983). As stated by Zajonc (2001) the mere-repeated-exposure paradigm can be used to explain one way that humans form the basis for preferences. Effects of this phenomenon have even been shown to be strengthened when the presentation of the stimulus is subliminal (Bornstein & D'Agostino, 1992). In the course of working in an environment where 12-Step treatment is common, at least minimal exposure to the language associated with AA is present and could impact attitudes towards it.

The results do not support the hypothesis that having worked in an AOD treatment setting is related to using slogans in therapy more than those who have not worked in such a setting. However, among those psychologists who use slogans at least some of the time (80%), their frequency of use of specific slogans is significantly higher than psychologists who use slogans some of the time and have never worked in an AOD treatment setting. There was also an established relationship between having worked in an AOD setting and increased levels of familiarity with specific slogans and comfort using slogans in general during treatment.

The second part of the fourth research question was considered with the expectation that that psychologist who had a high percentage of addicted patients



in their caseload would likely use AA slogans more often and be more familiar and comfortable with using them. The results indicate that having a higher caseload of addicted patient was positively related to use of slogans in general, specific slogan use, and familiarity with specific slogans, which supports the proposed theory in terms of familiarity. It was not, however, associated with comfort. While treating patients with alcohol or other drug disorders, they may simply prefer other interventions that are better aligned with their philosophy or style. For those that may be using AA slogans with some level of discomfort, it is possible that they are aware of their “outsider” status in relation to those in recovery; assuming that the provider is not themselves a member of the program. Since there is no specific training in AA slogan use, it stands to reason that using these sayings may feel uncomfortable, especially to psychologists who prefer empirically validated interventions. In fact, a major reason cited for discomfort with slogans fell under the core idea of slogans being beyond the scope of the psychologists training or experience, or not being aligned with the psychologist’s therapeutic style.

Post-hoc tests were included to better understand the relationship between certain variables of interest including years spent practicing psychology and common practices as well as to see how these two variables related to use of, familiarity, and comfort with AA slogans. However, there was no demonstrable relationship between these variables. This may reflect a ceiling effect, as 97% of the psychologists surveyed refer to AA at least some of the time, which suggests that virtually all respondents considered AA to be a valuable and appropriate resource for patients. An area for further research would be to

determine whether the term referral implied that the patient was “referred out” and did not continue in therapy or whether AA was suggested as a corollary to continued psychotherapy.

Years spent practicing was unrelated to using slogans generally or specifically, and had no discernable bearing on levels of familiarity or comfort with AA slogans. Perhaps most surprising was that years of experience had no bearing on familiarity with specific slogans, as one might expect that psychologists with more experience may have been exposed more to these sayings either through training or patient use. It may be that the sample of slogans used in the survey was not ones that psychologists most frequently come into contact with or associate with AA. There was some evidence for this in the amount of alternative slogans suggested by the participants when asked if there were others that they use in practice.

Based on the assumption that proponents of AA referral would be more likely to endorse AA slogan use in therapy, and increase familiarity and comfort with them, an analysis was run to determine if such a relationship existed. Strong positive relationships exist between referral to AA and general use of slogans, use of specific slogans, and comfort using slogans. A significant, although less strong relationship existed between referral to AA and familiarity with specific slogans. It is clearly important for psychologists to research the methods that they employ, and this should not stop at referral. It is believed that referring to AA is a practice that is engaged in by people who are likely to support AA and be at least somewhat familiar with its principles and language. Unsurprisingly, general

and specific use of AA slogans was highly intercorrelated as were familiarity and comfort.

This dissertation also sought to understand psychologists' views on the utility of slogans associated with AA and the reasons some may eschew them in treatment. Attempting to survey practicing psychologists to understand these variables has, to the best of the researcher's knowledge, never been attempted before. Two specific questions were asked. First the participants were asked to rate their degree of comfort using slogans associated with AA. All of the participants who reported that they were not comfortable were directed to an additional question, "Can you describe why using slogans associated with Alcoholics Anonymous in therapy is something that you are uncomfortable with?" All participants had the opportunity to answer the final, open-ended question, "Please describe how you think slogans associated with Alcoholics Anonymous can be useful when treating patients."

Participants varied in their responses, and often offered viewpoints that fit into more than one core idea for why AA slogan use is uncomfortable for them. The frequency patterns were determined using the standards suggested by Hill et al. (2005) and it was established that all of the core ideas qualified as being variant, in that not more than half of the respondents endorsed it, but more than a few did. The categories explaining discomfort using slogans associated with AA in therapy were: (a) Beyond the scope of training/experience, (b) Psychologist is not aligned with AA model, (c) Dislike connotation of slogans, (d) Slogans are not aligned with therapeutic style, and (e) Slogans are harmful to patients. Because of the way the survey instrument was designed, it is difficult to know whether the

psychologists who answered this question also indicated any frequency of use of slogans in general. Therefore, interpretations are made cautiously. One reason given for discomfort was a dislike for the connotation, which was twice specified to be because they are religious in nature. This may explain the relatively infrequent use of “Let go and let God” despite its high rate of familiarity among psychologists. These results support theories offered by Bassin (1984) that AA slogans may be avoided by professionals due to their casual style and the idea that they seem unlikely to really help a patient with their problems. Rogers’ (1989) assertion that the field of psychology is highly invested in the delivery of services gained in a positivistic nature and therefore may avoid using interventions that are not empirically validated is also supported by these results.

A rich amount of data was gleaned regarding the reasons psychologists believe slogans associated with AA can be useful in treatment. Eleven core ideas were extracted: (a) Succinct articulation of key concepts, (b) Facilitate psychological change, (c) Bridge therapy and 12-Step treatment, (d) Enhance therapeutic process, (e) Universality, (f) Memorable, (g) Provide encouragement, (h) Relapse prevention, (i) Demonstrate psychologists’ knowledgeability, (j) Connection to others in recovery, and (k) Meaning Making.

Some of these themes have already been commented upon in the existing literature and are supported by these results. The most common relates to AA slogans’ succinct articulation of key concepts. Hall (2008) and Rogers (1989) commented on the slogans’ ability to convey a large amount of information to the new and continuing member in Alcoholics Anonymous. Another of the most commonly endorsed reasons related to the concept of universality; the ability for

the slogans to be understood easily by many and widely utilized in a variety of settings, including outside of the therapeutic context. This is supportive of Chaika's (2000) endorsement of the slogans ability to be applied in everyday situations and Hall (2008) also acknowledged that the slogans and language of AA are variable in their interpretation. Borkman (2008), while acknowledging the crudeness of many of the slogans, indicated that they are useful for their everyday use of practical knowledge. Bridging therapy and 12-Step treatment was another important reason for slogan use in therapy. Barton (1999) and Chaika (2000) both acknowledged the importance of repetition of sentiments shared by the patient and the role that this plays in solidifying attitudes towards the source, which in this case is AA.

Enhancement of the therapeutic process was a core idea consisting of domains related to enhanced rapport, enhanced therapeutic alliance, conveying understanding, treatment compatibility, and provision of a common language. This is consistent with findings regarding increased rapport through proverb use among minority populations (Aviera, 1996; Frame & Williams, 1996; Zhong, 2008; Zuniga, 1992). Bristow-Braitman (1995) acknowledged the compatibility of slogans with cognitive restructuring in therapy as well as their utility for relapse prevention. Duncan, Hubble, Miller, and Coleman (1998) and Messmore (2002) encouraged using the client's language as a way to encourage the building of a new narrative and increase the chances of therapeutic change generalizing outside of therapy. Although it occurred rarely in the results, the theme of meaning making has also been commented on in the literature by Davis and

Jansen (1998) and Gibbs and Beitel (1995) who pointed out the abstract thinking and interpretation involved in understanding metaphorical phrases.

There is some consistency demonstrated among the results of the quantitative data and the qualitative results. The three most popularly used slogans; “One day at a time,” “Keep it simple,” and “Progress, not perfection” seem to convey ideas directly related to the core ideas presented in the results of the qualitative analysis, specifically, providing encouragement, relapse prevention, and facilitating psychological change by encouraging patients to stay in the present moment, not to act hastily, and to focus on goals achievable now.

#### **Limitations of Current Study**

There are some methodological limitations that must be addressed which may have influenced the outcome of this study. First, the investigator cannot know if respondents to the survey are representative of the larger pool of psychologists or are somehow self-selecting in an unrepresentative way. The 111 final respondents represent only 3% of the targeted audience in the various electronic mailing lists utilized (based on approximate electronic mailing list membership). The demographics indicate that many ethnic groups other than Caucasian are largely underrepresented.

This study was limited by the instrument utilized to gather data. The survey utilized has not before been used to measure the targeted variables of use, familiarity and comfort with AA slogans. For that reason, the investigator made every attempt to enhance the face validity of the measure by asking questions as closely related to the research questions as possible. Unfortunately do the wording of the question related to primary work setting, it was unclear to

respondents that they were to indicate one setting in which they see most of their patients. This likely had an effect on the distribution of the responses, and affected the ability of the data to be analyzed.

Unfortunately, it is unclear based on the setup of the questionnaire whether psychologists who are uncomfortable with slogans associated with AA are still using them despite those sentiments. Therefore it is difficult to say conclusively that those who are not comfortable will not use slogans or that all who use slogans are definitively comfortable with them. Another limitation is that utilization of some slogans may not be associated with AA at all - for example, "One day at a time" is something that has become culturally ingrained and used in many settings, regardless of associations with AA. It is impossible to know how people who are using slogans came to be familiar with them. Lastly, because the slogans selected to determine familiarity were based on a limited list it is possible that the levels of familiarity would have varied depending on whether more or different slogans had been presented.

### **Directions for Future Research**

A key finding in this study was that discomfort using AA slogans is significantly linked to a lack of experience or training associated with them. Future research should explore existing training programs in psychology to learn about how psychologists can be more effectively trained in the treatment of alcohol and other drug disorders. It would also be relevant to investigate patients' perspectives about AA slogan use in therapy to determine whether some of the potential benefits cited by the psychologists in this study are reflected in the patients' experience. This may serve to better validate their utility

and mend the ideology that AA slogans are too unprofessional and imprecise to be useful in the context of psychotherapy.



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## TABLES

Table 1

*Participants' Demographic Information*

		<i>n</i>	%
Gender	Female	68	61.8
	Male	42	38.2
Age	24-34 years	11	9.9
	35-44 years	18	16.2
	45-54 years	27	24.3
	55 and over	55	49.5
Ethnic Background	White/Caucasian	105	94.6
	Hispanic/Latino	2	1.8
	African American/Black	1	0.9
	Asian	2	1.8
	Mixed Race	1	0.9

Table 2

*Professional Background of Participants*

		<i>n</i>	%
Degree	Ph.D.	81	73
	Psy.D.	30	27
Licensure Status	Licensed	96	87.3
	Not licensed	14	12.7
Experience Practicing	0-5 years	16	14.4
	6-10 years	22	19.8
	11-15 years	9	8.1
	16-20 years	24	21.6
	More than 20 years	40	36
Theoretical Orientation	Psychodynamic/Psychoanalytic	36	32.4
	Cognitive Behavioral (CBT)	32	28.8
	Integrative/Eclectic	26	23.4
	Humanistic/Existential/Patient-Centered	8	7.2
	Family Systems	5	4.5
	Gestalt	1	0.9
	Other	3	2.7



Table 3a

*Participants' Current Caseload with an AOD Problem*

	<i>n</i>	%
None	6	5
10% or Less	34	31
11% - 30%	38	34
31% - 50%	16	14
51% - 70%	6	5
71% - 90%	9	8
91% - 100%	2	2

Note. AOD=Alcohol or other drug

Table 3b

*Participants' Patients with a Substance Use Disorder and Comorbid Diagnosis*

	<i>n</i>	%
Zero -10%	5	5
11% - 20%	6	6
21% - 30%	4	4
31% - 40%	3	3
41% - 50%	7	7
51% - 60%	4	4
61% - 70%	3	3
71% - 80%	6	6
81% - 90%	10	9
91% - 100%	57	54

Table 4

*Psychologists' Referral to AA and their Use of and Comfort with AA Slogans*

	Never	Sometimes	Frequently	Very Frequently
Refer to AA	<i>n</i> = 3 3%	<i>n</i> = 33 31%	<i>n</i> = 27 26%	<i>n</i> = 42 40%
Use Slogans	<i>n</i> = 22 20%	<i>n</i> = 71 64%	<i>n</i> = 15 13%	<i>n</i> = 3 3%
Comfort	Not Comfortable <i>n</i> = 18 16%	Somewhat Comfortable <i>n</i> = 39 36%	Comfortable <i>n</i> = 34 31%	Very Comfortable <i>n</i> = 19 17%

Table 5

*Psychologists' Use of Specific Slogans Associated with AA*

	Never	Sometimes	Often	Very Often
One day at a time	<i>n</i> = 5 6%	<i>n</i> = 36 41%	<i>n</i> = 26 29%	<i>n</i> = 21 24%
Easy does it.	<i>n</i> = 47 53%	<i>n</i> = 31 35%	<i>n</i> = 8 9%	<i>n</i> = 2 2%
Play the tape all the way through.	<i>n</i> = 77 88%	<i>n</i> = 4 4%	<i>n</i> = 5 6%	<i>n</i> = 2 2%
Let go and let God.	<i>n</i> = 70 81%	<i>n</i> = 14 16%	<i>n</i> = 2 2%	<i>n</i> = 1 1%
Progress, not perfection	<i>n</i> = 37 43%	<i>n</i> = 30 34%	<i>n</i> = 9 10%	<i>n</i> = 11 13%
Fake it 'til you make it.	<i>n</i> = 38 43%	<i>n</i> = 35 40%	<i>n</i> = 10 11%	<i>n</i> = 5 6%
Take the cotton out of your ears and put it in your mouth.	<i>n</i> = 84 97%	<i>n</i> = 2 2%	<i>n</i> = 1 1%	<i>n</i> = 0 0%
Keep it simple.	<i>n</i> = 31 36%	<i>n</i> = 32 37%	<i>n</i> = 21 24%	<i>n</i> = 3 3%
You're only as sick as your secrets.	<i>n</i> = 9 78%	<i>n</i> = 12 14%	<i>n</i> = 6 7%	<i>n</i> = 1 1%
Take what you can use and leave the rest.	<i>n</i> = 32 37%	<i>n</i> = 39 45%	<i>n</i> = 10 12%	<i>n</i> = 5 6%

Table 6

*Psychologists' Familiarity with Specific Slogans Associated with AA*

	Unfamiliar	Somewhat Familiar	Familiar	Very Familiar
One day at a time	<i>n</i> = 0 0%	<i>n</i> = 4 4%	<i>n</i> = 16 14%	<i>n</i> = 91 82%
Easy does it.	<i>n</i> = 26 23%	<i>n</i> = 20 18%	<i>n</i> = 17 15%	<i>n</i> = 48 43%
Play the tape all the way through.	<i>n</i> = 76 69%	<i>n</i> = 17 16%	<i>n</i> = 6 5%	<i>n</i> = 11 10%
Let go and let God.	<i>n</i> = 14 13%	<i>n</i> = 10 9%	<i>n</i> = 24 22%	<i>n</i> = 63 57%
Progress, not perfection	<i>n</i> = 33 30%	<i>n</i> = 24 22%	<i>n</i> = 20 18%	<i>n</i> = 34 31%
Fake it 'til you make it.	<i>n</i> = 23 21%	<i>n</i> = 18 16%	<i>n</i> = 17 15%	<i>n</i> = 53 48%
Take the cotton out of your ears and put it in your mouth.	<i>n</i> = 88 79%	<i>n</i> = 6 5%	<i>n</i> = 7 6%	<i>n</i> = 10 9%
Keep it simple.	<i>n</i> = 21 19%	<i>n</i> = 22 20%	<i>n</i> = 26 23%	<i>n</i> = 42 38%
You're only as sick as your secrets.	<i>n</i> = 47 43%	<i>n</i> = 22 20%	<i>n</i> = 13 12%	<i>n</i> = 28 25%
Take what you can use and leave the rest.	<i>n</i> = 25 23%	<i>n</i> = 23 21%	<i>n</i> = 27 24%	<i>n</i> = 35 32%

Table 7

*Correlations: Psychologists' Work History, AA Slogan Use, AA Slogan Familiarity, and Comfort with AA Slogans*

Variable	Worked in AOD Tx?	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>
Use Frequency	Yes	56	2.07	0.66	1.29	0.201
	No	55	1.91	0.67		
Specific Use	Yes	46	1.77	0.38	2.90	.005*
	No	42	1.55	0.35		
Specific Familiarity	Yes	56	2.82	0.70	3.71	.000*
	No	55	2.34	0.66		
Comfort	Yes	55	2.65	0.97	1.79	0.075
	No	55	2.33	0.94		

Notes. Equal variances assumed for all four variables; significance level 0.05 ( $p < .05$ ).

Table 8

*Correlations Between Investigated Variables and Percentage of Addicted Patients*

	1	2	3	4	5
1. % Addicted Patients		.21*	.26*	.31**	.12
2. Use of Slogans			.42**	.36**	.72**
3. Use of Specific Slogans				.52**	.48**
4. Familiarity - Specific Slogans					.37**
5. Comfort Using Slogans					

Note. \*  $p < .05$ ; \*\*  $p < .01$ .

Table 9

*AA Slogan Use, Familiarity and Comfort: Correlation to Years Practicing and AA Referral*

	1	2	3	4	5	6
1. Years Practicing		-0.01	0.11	-0.10	0.10	0.15
2. Refer to AA			.52**	.32**	.23*	.41**
3. Use Slogans				.41**	.33**	.72**
4. Specific Slogan Use					.52**	.47**
5. Familiarity Specific						.36**
6. Comfort Slogans						

Note. \*  $p < .05$ ; \*\*  $p < .01$ .

Table 10

*Reasons for Psychologists' Discomfort Using AA Slogans in Psychotherapy*

Core Idea	Domains Within Core Idea
Beyond Scope of Training/Experience <i>n</i> = 9; Variant	Not therapists' specialty; Never worked with AA; Unfamiliar; No expertise; Do not understand slogans; Not trained in AA; Not knowledgeable
Slogans Not Aligned with Therapeutic Style <i>n</i> = 6; Variant	Not tailored to individual; Feel inauthentic; Too general; Want to provide something complementary, yet different; Prefer Interpretations; Do not find slogans helpful
Psychologist Not Aligned with AA Model <i>n</i> = 4; Variant	Do not intend to bring AA into therapy; Disagree with AA; Dispute AA's premises
Dislike Slogans' Connotation <i>n</i> = 4; Variant	Some are negative; Some are overly religious; Dislike wording
Slogans Can Be Harmful to Patients <i>n</i> = 2; Rare	Trivializes connection to therapist; Unethical; Promote stereotyped and rigid thinking

Table 11

*Reasons Psychologists Give for the Utility of AA Slogans in Psychotherapy*

Core Idea	Domains within Core Idea
Succinct Articulation of Key Concepts <i>n</i> = 28; Variant	Simplify complex concepts; Succinct; Catchphrases; Simple; Shorthand; Convey therapeutic concepts; Emphasize points
Facilitate Psychological Change <i>n</i> = 27; Variant	Provides coping strategies; Mantras; Changes behaviors; Changes cognitions; Facilitate psychological growth
Bridge Therapy and AA <i>n</i> = 24; Variant	Reinforce AA learning or principles; Enhance learning of AA; Gauge [patient] involvement in AA; Support or endorse patient involvement in AA
Enhance Therapeutic Process <i>n</i> = 24; Variant	Build rapport; Enhance therapeutic alliance; Challenge patient; Compatible with orientation/treatment approach; Increase patient comfort; Provide a common language; Show understanding; Address specific issues in therapy

(continued)

Core Idea	Domains within Core Idea
Universality <i>n</i> = 24; Variant	Easy to relate to; Relates to multiple problems; Can generalize outside of therapy; Uses common sense; Conveys wisdom; Everyone can understand them; Generalizes to other 12-Step programs; Axioms
Memorable <i>n</i> = 22; Variant	Act as mental markers; Crystallize concepts; Aphorisms; Anchors; Easy to remember
Provide Encouragement <i>n</i> = 16; Variant	Motivational; Inspirational; Normalizes experience; Shows support; Connects patient to others
Relapse Prevention <i>n</i> = 7; Variant	Reminder of goals; Reminder of the past; Reminders in the midst of cravings
Demonstrate Psychologists' Knowledgeability <i>n</i> = 6; Variant	Show familiarity with AA; Demonstrate understanding of recovery; Show familiarity with addiction treatment; Demonstrate cultural competency
Connection to Others in Recovery <i>n</i> = 3; Rare	Slogans are effective when coming from others in recovery; Builds camaraderie with others who use slogans
Meaning Making <i>n</i> = 3; Rare	Use to make interpretations; Explore meaning; Reframe issues; Provide new perspectives

APPENDIX A

Review of the Literature

## Review of the Literature

### Efficacy of AA

As participation in AA has grown, a number of researchers have attempted to assess its efficacy in helping individuals attain and maintain abstinence, as well as the variables which contribute to its efficacy. Despite some of the inherent difficulties present when studying an anonymous group, a number of studies have confirmed that AA is effective in helping many individuals attain and maintain abstinence. Vaillant (2003) conducted a 60-year follow-up of two cohorts of alcohol-dependent men and found that one of the strongest predictors of abstinence in both cohorts was participation in AA, with successful abstainers attending approximately 20 times more meetings than men who did not achieve stable abstinence. Bond, Kaskutas, and Weisner (2003) demonstrated that abstinence levels at a one-year and three-year follow-ups were positively correlated to support from others who support less drinking, especially when that support is provided from AA versus non-AA members or family members. Vaillant and Hiller-Sturmhöfel (1996) in an analysis of two longitudinal studies of drinking patterns in 724 male subjects spanning 55 years, found that among stably abstinent participants, four non-treatment-related factors emerge that aid in their recovery. These include the development of a secondary dependence (i.e. smoking, AA involvement, overworking, etc.), reinforcement of abstinence through negative consequences of alcohol use (i.e. legal problems or medical consequences), enhanced self-esteem or hope, or both, and fourth, the development of a new love relationship. Vaillant and Hiller-Sturmhöfel (1996) point out that all four of these factors can be achieved through membership in AA



as well as on the participant's own, and that many of the factors are incorporated into popular cognitive-behavioral relapse prevention programs.

Moos and Moos (2004) examined the influence of duration and frequency of AA participation among 473 individuals with alcohol use disorders on one-year and eight-year outcomes. Their findings indicated that individuals who became affiliated with AA relatively quickly, and who participated longer, had better 1-year and 8-year alcohol-related outcomes when compared to non-participants in AA. This indicates a link between the frequency and length of participation in AA with achievement of abstinence. Further findings of an association between participation in either formal treatment or AA and a higher likelihood of abstinence were made in a study of initially un-treated individuals with alcohol use disorders over a span of 16 years (Ilgen, Wilbourne, Moos, & Moos, 2008). Individuals with goals for abstinence may be more attracted to programs similar to AA, which does not endorse moderate or non-problem drinking.

Moos and Moos (2006) followed a group of 461 individuals with untreated alcohol use disorders to examine differences in drinking patterns between groups who participated in either treatment and/or AA and those who remained untreated after 16 years. When compared to individuals who did not receive treatment for their alcohol use disorder, participants who received formal treatment and/or participated in AA for at least nine weeks during their initial treatment showed more positive outcomes at a 16 year follow-up. Further, relapse rates among these individuals were lower and the overall rate at which change occurred was higher in the group that received treatment. A longer duration of participation in AA was related to abstinence and fewer drinking-related problems at 16 years

independently of participation in treatment. Even when compared to formalized treatment, AA shows strong effects (Finney, Noyes, Coutts, & Moos, 1998) and is especially effective as an adjunct to treatment or an aftercare treatment measure (Bodin & Romelsjo, 2006; Gossop et al., 2003).

Given that there is evidence supporting the efficacy of AA as a treatment of substance used disorders, it is worth noting some of the program's notable distinctions and mechanisms of change which support the goal of abstinence. One such mechanism of change is affiliation. Affiliation is a complex construct composed of several other key aspects of AA involvement defined by Timko, Billow, and DeBenedetti (2006) as including attendance, level of involvement (i.e. having a sponsor, celebrating sober birthdays and taking commitments), step work, and acceptance of the AA philosophy. Levels of affiliation have been shown to be related to rate of abstinence regardless of levels of motivation in several studies (Bodin & Romelsjo, 2006; Galanter, Talbott, Gallegos, & Rubenstone, 1990; Lemke & Moos, 2003). Often, a new member will be encouraged to attend 90 meetings in 90 days, which is likely to increase the probability of exposure to several key aspects of affiliation including opportunity to meet with other members, regular attendance, coverage of AA literature, familiarity with group norms and traditions, and adoption of workable strategies such as sponsorship and service to others. There is evidence to suggest that the degree to which members adopt the ideology of AA regarding powerlessness over their addiction is a mediating variable in abstinence (Fiorentine & Hillhouse, 2003).

AA differs from many medical and psychological treatments in that it has a fundamental spiritual component, and in fact, encourages members to “turn over” their lives to a Higher Power as the individual understands them. The spiritually related dimensions of AA such as belief in a Higher Power have also been studied as a possible mechanism of change. Although AA is not dogmatic about religious beliefs and encourages members to choose their own concept of God (AA World Services, 1976), AA clearly espouses the critical role of spirituality to achieve the type of change in character they believe is necessary to abstain from drinking and acknowledges outright that their program is one that includes a “spiritual awakening” (AA World Services, 1976, p. 60).

Spirituality, according to the literature and testimony of AA members is achieved through the acceptance of a Higher Power as the individual understands them and should be combined with “willingness, honesty, and openmindedness” (AA World Services, 1976, p. 570). Wysong (2008) found that regular AA attendance contributed positively to greater levels of spirituality and quality of life when compared to participants that did not attend as frequently. These benefits may be part of the reason that involvement grows or, conversely, more regular involvement might afford the member the opportunity to experience the spiritual changes as well as improvements in quality of life. Interviews with sober members that continued to attend AA long after abstinence was achieved revealed that the main reasons for continued participation are the social camaraderie, the ability to continue to be of service, the spiritual awakening they have achieved, and the support offered by others (Osborne, 2003). Slogans such as “Let go, let God, ” “Turn it Over,” “But by the grace of God,” and The Serenity

Prayer, act as gentle introductions to spiritual concepts in AA, without dogmatic religious ties and with recognition and room for individual interpretations of a Higher Power.

Warfield and Goldstein (1996) contend that the alcoholic must be treated holistically, with particular attention paid to spirituality. According to them, an alcoholic suffers from “negative spirituality” in that he/she is insecure, does not believe in his/her lovability, and can be defensive. AA’s Twelve Steps serve to assist the individual in completing developmental processes that can foster a positive spirituality and an ability to love the self and meet needs in a healthy, non-destructive manner. Kubicek, Morgan, and Morrison (2002) compared spontaneous remitters with abstinent individuals who utilized AA in order to achieve abstinence. Results indicated that among the individuals who used AA, support from others, memories of negative consequences from using, not giving up, and acceptance of help from a Higher Power or God were cited as key variables in their ability to achieve and maintain abstinence.

### **Role of Mental Health Professionals in Relationship to AA**

Several factors have influenced the current popular formats for treatment of alcoholism and other substance use disorders in the United States. Alcoholism has been viewed over the years as a problem of moral fortitude, a dearth of willpower, a criminal tendency, and a disease (Brent, 1997). Over time, treatment has progressed toward variants of either abstinence-based or harm-reduction programs to treat what is generally regarded as a chronic and progressive disease requiring multidisciplinary focus. Brent (1997) provides a

detailed chronological history of the shifts in attitudes about alcoholism and its treatment.

In the first 200 years of American history, alcoholism was first regarded as a condition of criminals, referred to as inebriates with weak moral character whose treatment was often punishment (Brent, 1997; Margolis & Zweben, 1998). Later, this view shifted as alcoholism became viewed as a sickness that should be treated morally rather than with punitive measures and that the mental illness aspects of the disorder were to be viewed differently than the modes of insanity reserved for asylums (Brent, 1997). From the morally based treatments, who offered kindness rather than harshness in treating patients, was born many of the tenets of current Alcoholics Anonymous practices as well as other addiction treatment programs of today. Brent (1997) traces some of the doctrines of AA to the Washingtonians, who had several inebriate homes opened throughout the turn of the 19th Century. Some of these tenets include surrender, complete abstinence, sharing personal stories with others, providing mutual support, and meeting regularly.

Alcoholism remained an enigma for literally centuries, reverberating against moral, medical, and legal viewpoints until the mid-20th century when the medical community took the reins (Brent, 1997). The foundation of Alcoholics Anonymous in 1935 was followed swiftly by the inception and fast popularity of the Minnesota model of addiction treatment which focused on various aspects of the patient's well-being including physiological, biological, and psychological variables. Meanwhile, psychological and psychiatric approaches to the problem of addiction were developing spurred by whichever theory of psychopathology

that the practitioner was trained in (i.e. object relations, ego psychology, etc.) and was applied to the treatment of the addict (Zweben & Clark, 1991).

Brent (1997) notes that in the mid-1950s rehabilitation centers were founded which catered primarily to the middle and upper class, while AA continued to be a resource for people regardless of their demographics. The passage of the 1970 Comprehensive Alcoholism Treatment and Prevention Act (commonly referred to as the “Hughes Act” after the Iowa Senator who authored and lobbied for it) made treatment for alcoholism more readily available (Brent, 1997). Spurred largely by AA’s philosophies, many treatment programs adopted the 12-Step approach throughout and after the 1960’s (Margolis & Zweben, 1998) at the same time that the delivery of treatment was largely being made by non-professionals and/or chemical dependence treatment specialists who supported the disease model of addiction (Hshieh & Srebalus, 1997; Washton, 2002). Today, AA has been shown to be a referral of choice for aftercare by clinicians and rehabilitation professionals who work primarily with substance abusers in treatment settings where alcoholism is most prevalent (Fenster, 2006; Koch & Benschhoff, 2002) and where 12-Step participation is already a main component of the facility’s treatment regimen.

There is some evidence to suggest that while AA is commonly used as an adjunct to therapy, and recommended by mental health professionals, there may be little known by these professionals about AA or its mechanisms of change, or about other aspects of treatment germane to substance abusing populations (Aanavi, Taube, Ja, & Duran, 1999). In fact, while it may be encouraged within the professional community to discuss AA literature, meetings, step work,

spirituality or common language in therapy in order to support the member's attendance (Sachs, 2006), it is unclear how often this actually occurs or whether professionals feel comfortable in doing so. A study of 100 clinicians working in outpatient treatment programs revealed that while positive views were held of Alcoholics Anonymous regarding its efficacy, impediments to referral still existed due to discomfort with the spiritual emphasis and the program's position on powerlessness (Laudet & White, 2005).

As mental health services become more entwined with 12-Step treatments, it has become increasingly important for mental health professionals to familiarize themselves with the many faceted elements of AA participation. The development of 12-Step Facilitation (TSF) or Twelve Step Therapy, an evidence-based practice grounded primarily in the steps of the program (Nowinski & Baker, 2003), is an example of a move towards integration of AA-consistent interventions and traditional psychological interventions. Nowinski (2003) indicates that TSF "seeks to be both philosophically and pragmatically compatible with the 12 steps of AA (p. 34). The manualized treatment protocol indicates that the main goals of the program focus largely on the first three steps, having to do with acknowledgement of the problem, conceptualizing a Higher Power, and turning your will or life over to that Higher Power. Further, AA-consistent objectives include facilitating growth and change in the domains of cognitions, emotions, behaviors, social relationships and spirituality (Ries, Galanter, & Tonigan, 2008). The treatment is intended to help patients maximize engagement and affiliation with 12-step meetings of any kind with a goal of abstinence in place (Kelly & McCrady, 2008; Ries, Galanter, & Tonigan, 2008)

while maintaining a marked organizational separation from such self-help groups. The role of the therapist utilizing TSF is to facilitate the patient's acceptance of the diagnosis of alcoholism, encourage involvement in the fellowship of AA, provide psychoeducation regarding the disease of alcoholism, and to obtain adequate knowledge about 12-step recovery and AA literature on their own part (Nowinski, Baker, & Carroll, 1994).

Despite the increasing sophistication of attempts to integrate AA with more evidence-based psychological interventions, myths and stereotypes abound regarding the popular self-help program, including allegations that it is a religion or cult, that the requirement of identifying as an alcoholic is degrading, that it takes power from already disenfranchised groups, and that it is simply a secondary addiction (Davis & Jansen, 1998). Many of these misconceptions continue to prevent professionals from fully understanding the program or utilizing it as a resource for their patients. Professionals' efforts to understand the 12-Step community may be difficult since "the language of AA is the language of narrative and metaphor, it is easily misunderstood outside the context of lived experience and of the meaning-making of the membership as a whole" (Davis & Jansen, 1998 p. 172).

In contrast with the reticence of some mental health professionals to integrate AA principles into clinical practice, AA has been embraced by many paraprofessionals, who often bring their own experiences of being in recovery to assist addicted individuals in recovery. These helpers in recovery are more likely to have attended a 12-Step group and may be more familiar with them and align their treatment modality with tenets of AA. There is some evidence to suggest



that the two sides of this mutually well-intended dichotomy of treatment have experienced tension with each other especially around issues related to experience versus expertise (Brown, Grella, & Cooper, 2002). Paraprofessionals tend to place a stronger emphasis on the importance of life-experience, while professionals place a stronger emphasis on their training, including attention to boundaries and the use of empirically validated interventions, which may lead to a sense of sophistication by comparison. Brown, Grella, & Cooper (2002) suggest that since both sides come to the treatment table with valuable knowledge sets, insecurities may develop within both parties. Paraprofessionals may feel devalued and inferior, while professionals chronically lack the ability to draw upon experiential knowledge of what an addict goes through. In a study examining the spiritual thinking in addiction-treatment providers, Schaler (1996) found that the longer a provider spent time in AA, the more likely they were to be spiritual thinkers. Spiritual thinkers involved in AA were also more likely align their beliefs about addiction to the disease model. Lower spiritual thinking was positively correlated to higher education, which suggests that paraprofessionals and psychologists may have different abilities to relate to patients on a spiritual level which is encouraged by participation in AA.

Alcohol and drug treatment programs, both public and private, are often staffed by both professionals and paraprofessionals. Depending on who sees a patient in those settings, philosophies of treatment may vary greatly. Many psychologists who specialize in problem drinking and substance abuse as part of their general practice are less likely to endorse the disease model or 12-Step model than addiction counselors, although more psychologists than ever before

are embracing disease model concepts (Hshieh, 1995; Wiltsek, 2004). The disease model, which asserts that alcoholism is an illness of a biological and deadly nature, posits that the alcoholic is not to blame for the biological and physiological condition that they are afflicted with (Gabbard, 1994); however, they are responsible for treatment for it. Vaillant and Hiller-Sturmhöfel (1996) assert that addiction is a “primary disease” not caused by moral or psychological deficits although certainly those domains of an individual’s functioning are compromised as the disease runs its course. The position held by AA is that the only effective treatment for the disease of alcoholism is abstinence.

Vaillant (2003) asserts that abstinence is the only viable course of treatment for alcoholism based on his study that tracked 724 alcohol-dependent men and found that intermittent recovery resulted largely in the return of alcohol related problems, including death. A study of therapists treating alcoholic patients indicated that the higher level of adherence to the disease model by these providers was positively correlated to whether they themselves were in recovery (Moyers & Miller, 1993). These therapists were also less likely to be flexible in collaborating with the patient to determine treatment goals or to include goals that include a moderation of drinking. Addiction counselors tend to view complete abstinence as a necessity for recovery and focus largely on identifying and changing addictive behaviors while psychologists may more frequently take a lenient stand on abstinence and tend to focus more on other personal issues separate from the problem drinking and using (Hshieh, 1995). With this said, it appears that many psychologists are not opposed to a collaborative model within

which patients participate in both therapy and a 12-Step program or work with an addiction counselor (Freimuth, 1996; Hshieh, 1995).

There has been considerable interest, with regards to the treatment of addiction, in the various levels of professional training and differences in philosophies of treatment amongst practitioners (i.e. harm-reduction vs. disease model. Aanavi et al. (1999) addressed the status of psychologists' training in substance abuse treatment, finding that a majority are treating substance abusers in some capacity in their practice, while they may have had little to no formal training in substance abuse treatment. Wiltsek (2004) studied psychologists' attitudes regarding two of the most prominent philosophies of alcohol and drug abuse intervention; disease model vs. harm-reduction, taking into consideration the psychologists' own history of substance use. Wiltsek's results showed that most psychologists, regardless of their own substance use history, adhere to the disease model and include abstinence as the preferred treatment goal. Wiltsek notes the likely influence that AA has had on sentiment shift regarding these issues, as psychologists have not always embraced the notion that alcoholism is a disease. Interestingly, Wiltsek's study also confirmed contradictions in philosophy amongst psychologists who adhere to the disease model. Nearly 35% of the sample studied agreed with a statement about an alcoholic's ability to return to controlled drinking, an assertion that is in direct conflict with the disease model. Additionally, over half of the psychologists indicated that the problem for alcoholics is not whether they begin drinking again; rather it is an issue of being in control enough to stop, a sentiment which is also inconsistent with the disease model. These results indicate inconsistencies

between beliefs and philosophies of treatment and likely have an impact on how treatment goals are created and approached.

In a study of marriage and family therapists' attitudes toward alcohol use and misuse concepts and treatment modalities showed that the majority surveyed (78%) endorse the use of AA "some of the time" in treatment and 35% endorse its use "all of the time" (Zygarlicki & Smith, 1992). Most of the marriage and family therapists surveyed indicated that AA should be a prominent part of combined treatment approaches which also include individual and family therapy.

The financial and social costs of addiction are so devastating to most cultures that the advent of harm-reduction programs has gained popularity. These programs are founded both in policy and intervention with the aim of reducing the damages associated with alcohol and drug abuse. This approach does not focus solely on the amount of substance use, rather, it recognizes situations in which total abstinence may not be immediately achievable and reinforces any amount of reduction (Ritter & Cameron, 2006; Single, 1995). In a review of the effectiveness of harm-reduction strategies on alcohol, tobacco and illicit drugs, Ritter and Cameron (2006) highlight the following major features of harm-reduction policy; reducing harm is the primary goal over reducing use, drugs are a social variable that cannot be eliminated, immediate, achievable goals are the focus, and values of "pragmatism and humanism" provide the foundation of the policy (p. 612). These goals and objectives are clearly contradictory to those promoted by AA and other abstinence based programs and depending on a treatment provider's training and beliefs, adoption of either system can greatly influence the approach taken in a patient's recovery.

Drawing upon recent technological and scientific advancements in the study of addiction, the biopsychosocial model focuses on the inter-relationship between the role of genetics, an individual's environment, and the immediate and long-term impact of alcohol and drugs on the brain on the development of alcoholism. Twin and adoption studies have indicated that between 50-60 % of the risk of developing alcoholism can be linked to genetics and is further mediated by being raised in an environment with increased risk (Kendler, Prescott, Neale, & Pedersen, 1997; McGue, 1999; Prescott & Kendler, 1999). A study of the offspring of monozygotic (MZ) and dizygotic (DZ) twins indicated that children of MZ and DZ twins with a history of alcohol dependence were significantly more likely to develop alcohol dependence or alcohol abuse than were offspring of nonalcoholic fathers (Jacob et al., 2003). Also, there was no greater risk for alcoholism in offspring of a MZ twin with no history of alcohol abuse or dependence, whose co-twin was alcohol dependent than there was for offspring of non-alcoholic twins. This research indicates that family environmental effects impact offspring outcomes and seem to indicate that the absence of an alcoholic parent provides a low-risk environment which can act as a mediator of high-risk genetic loading for alcohol-use disorders.

From a psychosocial perspective, studies have indicated that environmental factors play a critical role in a person's likelihood of developing addiction and may co-mingle with existing genetic traits. For example, Wand (2008) found that the introduction of stress, defines as "any stimulus that challenges physiological homeostasis" (p. 119) can influence the progression of alcohol addiction in the brain. This occurs through mediation of the rewarding

system as well as through the organism's increased desire to self-administer alcohol (and other drugs). These environmental and genetic factors overlay in the case of offspring of alcoholic fathers who encounter alcohol and stress. Zimmerman et al. (2009) found that this particular interaction in offspring of alcoholics increases the risk for alcoholism due to their experience of alcohol-induced stress reduction response as measured by a longer lasting presence of prolactin than control subjects. The benefits of using alcohol to mediate stress combined with the genetic loading already present make for a strong likelihood for the development of alcoholism in these individuals. In a study examining cortisol levels and alcohol use during stressful tasks, results indicate that children of alcoholics experience greater levels of stress and use alcohol more frequently to mediate that stress than do children of non-alcoholics (Green, 2002).

Sherman (2007) states that cumulative changes in the brain as a result of drug use can be genetic in nature. Drugs do not directly alter a person's genetic makeup, however, "drugs can prod some genes to increase their production of proteins, leading to changes in cell function or even actual reshaping of the physical structure of cells" (p. 13). Animal studies have shown that the introduction of cocaine and amphetamines to rats' systems causes the genes that generate proteins which build dendrites containing neurotransmitter receptors to be stimulated; a brain activity associated with new learning (Ciccocioppo, Martin-Fardon, & Weiss, 2004). While the rats' brains do indicate signs of structural plasticity, there also appears to be a reduced ability to reach subsequent experiential growth, which may partially explain the unusual amount of preoccupation a drug abuser experiences regarding the acquisition and use of

drugs and alcohol as well as the long-term cognitive and behavioral deficits associated with addiction.

Drugs are intrinsically reinforcing due to the often euphoric effects the user experiences. A special publication by the National Institute on Drug Abuse (NIDA) outlines drugs' effects on the human brain, indicating that biological processes in the brain are disrupted, mimicked, and overwhelmed when the chemical components of drugs are introduced to the brain's existing neurotransmitters, in particular, dopamine (Anderson, 2008). Dopamine is often associated with pleasure and reward systems in the brain, and it also regulates movement, emotion, cognition, and motivation, leading to reinforcement of behavior when the reward system is over-stimulated by drug use (Anderson, 2008). Sherman (2007) cautions that over time, as an individual continues to use drugs of abuse, damage occurs to systems of the brain as "drugs wreak changes in cellular structure and function that lead to long-lasting or permanent neurotransmission abnormalities" (p. 13). Drug tolerance occurs most often due to the reduction of certain neurotransmitters begin released by sending cells or a lowered responsiveness or presence of receptors from receiving cells because of drug-induced increases in chemicals that typically signal neurotransmitter intensities in the brain (Sherman, 2007).

During and after intoxication, the brain implements an anti-reward system with the purpose of regulating the natural reward system which has become overloaded (Koob & Le Moal, 2008). The brain attempts to stabilize itself despite the presence drugs by engaging neurochemicals associated with stress modulation and over time, experiences dysregulation of anti-stress systems. This

dysregulation contributes to a chronic vulnerability to stress experienced by addicts who are both newly sober or have long-term abstinence as well as cravings (Koob & Le Moal, 2005, 2008). Both environmental stimuli as well as biological stimuli can contribute to cravings for substances, even long after cessation, placing the individual in perpetual danger of relapse and leading to the determination of addiction as a chronic, relapsing disorder.

In a recent review of theories derived from animal and human studies of alcoholism and the brain, the innate or acquired trait of disinhibition was found to be positively associated with addiction, and is affected further by dysregulation of key receptors in the prefrontal cortex associated with executive functioning (Zahr & Sullivan, 2008). This is further supported by research which indicates that reduced frontal lobe activity is associated with impulsivity commonly experienced by alcoholics (Chen et al., 2007).

### **AA as a Specific Subculture**

There has been a much needed push in the field of psychology and other mental health professions for the delivery of culturally appropriate or culturally sensitive services. The American Psychological Association (APA) guidelines (2002) outline the goals for cultural competency in psychological practices. They are geared most specifically toward encouraging sensitivity and expertise when working with ethnically and racially diverse clients. Culture is broadly defined by APA (2002) as “belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes” (p. 8) and influences a person’s worldview through “learned and transmitted beliefs, values, and practices” (p. 8). Within the larger culture individuals may develop



affinities for the ideals and activities of factions of the mainstream group.

Sociologists Fine and Kleinman (1979) posit the definition of a subculture as “a set of understandings, behaviors, and artifacts used by particular groups and diffused through interlocking group networks” (p. 18). Fine and Kleinman consider the role of identification as critical to the motivation for an individual to become socialized to a subculture stating, “values, norms, behaviors, and artifacts constitute a subculture only insofar as individuals see themselves as part of a collectivity whose members attribute particular meaning to these ‘objects’” (p.13). They further note the aspects of “salience” and “centrality” which influence identification with a subculture; salience referring to the frequency of the identification and centrality denoting the degree of commitment to the group. A member’s identity as part of the subculture may be at times highly active, perhaps while engaging in group-centered activities, and at other times dormant as they participate in other aspects of their multi-group lifestyle and routine. In a study of organizational identification in Alcoholics Anonymous using social identification theory, Hall (2008) notes that typically, people are drawn to groups because of similarity and prestige; however found that identification with AA was due mostly to members’ perceived similarity to the group’s common experience of drinking problems. The stigma of alcoholism offers little to members in the way of prestige, however, a shared purpose and experience serves to unify members.

Every member of a dominant culture is essentially straddling multiple aspects of culture. APA (2002) considers multiculturalism to be “the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural

dimensions” that a person belongs to. APA notes that these dimensions are “critical aspects of an individual’s ethnic/racial and personal identity, and psychologists are encouraged to be cognizant of issues related to all of these dimensions of culture.”

AA recognizes itself as “an informal society” (AA World Services, 1956, p. 6) and as such contains and fosters a shared ideology and sense of community. AA and other 12-Step programs based upon it can be conceived of as a subculture within the larger, mainstream culture with its own set of values, norms, goals, customs and beliefs. Frequent and long-time attendees who become involved in this society will likely be exposed to the literature of the fellowship and will hear common stories, advice and phrases; commonly referred to as AA slogans. When examining the support and strategies that a group of abstinent dually-diagnosed individuals used, researchers found that the most common response was made in the form of a common AA slogan, “avoiding people, places and things” associated with using (Davis, & O’Neill, 2005, p. 1290). AA maintains the philosophy that an alcoholic must change nearly every aspect of his/her life as it is now in order to support the standard of abstinence believed necessary to achieve recovery. Thus, an important mechanism of change appears to involve encouraging people to exercise control over environmental influences by avoiding situations that facilitate substance use. Attending meetings, developing affiliation with sober members, and severing contact with “slippery” people and places are supported through the AA fellowship.

Alcoholics Anonymous functions as a subculture within which certain norms and customs are established along with the common desire to quit

drinking or using substances. Using Fine and Kleinman's (1979) theory, members are motivated to socialize because of the common purpose of desiring to quit drinking. Further, AA also has unique slogans and phrases, literature, and traditions that distinguish it from other social groups. Membership is privatized and kept confidential, and while not exclusive, attendance is self-selective based on the criteria of problem drinking. Groups of people, who share their culture through common rules of behavior and a basic form of social organization, constitute a society. Members of AA are in a distinct culture of recovery within a form of social organization that is, for all intents and purposes, a society unto itself (Holleran & MacMaster, 2005; MacMaster & Holleran, 2005). In the Preface of the seminal literature of the program, *Alcoholics Anonymous* (AA World Services, 1976), the organization is referred to as both a "Society" and "Fellowship" (p. xi) to which members belong. This is a fitting epithet even as AA's traditions are designed to create a non-organized entity (p. 564). This speaks more to AA's design to protect anonymity, decline professionalization or formal leadership, and not align itself with any other organization, religion, or entity.

Members of AA are indoctrinated into this society by first immersing themselves in the fellowship where they begin to learn the language. Holleran and MacMaster (2005) note that words and phrases such as "recovery," "powerlessness," "turning it over," "Higher Power," "step work," "sponsor," "inventory," "anonymity," and others are incorporated into the new members' vocabulary, with little understanding at first, and eventually become the foundation of "a new belief paradigm for living" (p. 112). Further, shared

ideology is gained through the dissemination of literature advocating community (through service) and the acquisition of new ways of coping with problems (through the 12-Steps) which does not include using substances. Members of AA and other 12-Step programs desire to work with helpers that have an understanding of the recovery culture and a mistake that some clinicians may be in danger of making is to refer clients to these helpful organizations without improving their own familiarity and comfort with 12-Step cultural nuances. Davis and Jansen (1998) assert that AA is a chosen social structure, similar to professional organizations or political parties, within which individuals construct a meaningful narrative. Holleran and MacMaster (2005) encourage clinicians to attend meetings and to adopt a stance of curiosity and teachability with clients in the program, viewing them as “experts” of their culture.

Hays (2008) encourages therapists to develop rapport and foster respect by acknowledging and being responsive to the varying tenets of culture that clients may have including language preferences, communication styles, and value systems. Given that a large number of individuals seeking professional mental health services may have an alcohol disorder, and that they may have exposure or interest in the community of AA, as culturally competent practitioners it is important to consider the patient’s context within that community. Williams and Ogden (2004) conducted a study designed to assess the impact of matched and unmatched vocabulary between patients and general practitioners during an initial medical consultation. Patients were matched on demographic variables as well as medical needs. Doctors were asked to either use medical terminology when discussing patient issues, or to use the patients’ own vocabulary to discuss

anatomical and symptomatic concerns. Results indicated that in the group where matched vocabulary was present, there were significantly higher ratings of rapport, communication comfort, and distress relief and compliance intent than those in the unmatched group.

MacMaster and Holleran (2005) stress the importance of developing cultural competency in treating addicted populations, recognizing that this particular skill set is developed along a continuum and is never completely attained. This can be achieved through required 12-Step attendance as part of training for mental health professionals. This integrates experiential learning with traditional informational learning. Members of AA constitute a subculture whose participation depends on the assimilation of norms, customs, ideology and beliefs that are consistent with the social group of AA. Recognizing the intra-cultural groups that exists such as diversity within AA and diversity among different groups under the 12-Step umbrella (NA, Al-Anon, etc.) is important. MacMaster and Holleran (2005) indicate that there are subtle but important differences between the "program" and the "fellowship" of AA. The program encompasses the Twelve Steps, other literature, and customs while the fellowship speaks more to the mutual relationships of service and support exchanged by members.

### **AA slogans as a Form of Metaphorical Language**

Psychotherapy, in its many forms and variants is intricately intertwined with the use of language; dialogue is the rich product from which insight and understanding spring. Frequently, clients and therapists employ metaphorical language such as slogans and proverbs in their communication. A major variable to consider is the exchange of language that takes place within the

community of AA, both to instruct members about the shared ideology and to maintain positive effects over time (Barton, 1999; Rogers, 1989; Steigerwald & Stone, 1999). In the AA community, popular sayings, metaphors, proverbs, and phrases are collectively referred to as “AA slogans”. Proverbs have traditionally been discussed in the psychological community with respect to assessment of cognitive functioning. Clinicians observe patients’ ability to construct abstract thoughts through metaphorical interpretation. This mode of assessment has typically been used in cases where the presence of schizophrenia (Brüne & Bodenstein, 2005; Gibbs & Beitel, 1995), organic brain disease (Ulatowska et al., 2001), cognitive decline due to aging (Moretti, Torre, Antonello & Cazatto, 2000; Uekermann, Thoma, & Daum, 2008), or limited intelligence (Haynes, Resnick, Dougherty, & Althof, 1993).

Beyond their use in psychological assessment, an emerging body of literature within the psychological community is confirming the utility of proverb and metaphor within psychotherapy. Studies have employed proverbs to tap into individuals’ meaning systems (Kállay & Miclea, 2006), have uncovered the complex thinking strategies they entail for social learning (Tracy, Greco, Felix & Kilburg, 2003), and have been integral in the development of rapport, conveyance of respect, and reduction of defenses in work with Latino (Aviera, 1996; Zuniga, 1992), Chinese (Zhong, 2008), and African-American patients (Frame & Williams, 1996).

Chaika (2000) notes that from a linguistics perspective there are only subtle differences between proverbs and slogans and notes that both are particularly helpful in therapies used for treating addictions. This dissertation

seeks to understand psychologists' familiarity with and comfort using a particular form of proverb known as "AA slogans", which fall outside the traditional bounds of proverb in that they are associated with a particular source, namely Alcoholics Anonymous. Any number of what is collectively referred to as "AA slogans" can fall under the phrase structure of either slogan or proverb from a linguistic perspective. That is, although these catchphrases are commonly referred to as slogans, their actual structural composition is not always circumscribed in a set format. This is important to note because much of the research on the type of linguistic mechanism utilized by AA focuses on what is deemed a proverb rather than a slogan.

While many slogans are typically stated as commands, and may require little interpretation, some are vague enough to warrant reflection on their meaning. AA slogans may vary in their structure. Some are prepositional while others are full sentences. An online search for AA slogans will yield a hodgepodge of slogans, proverbs, acronyms (for example, "H.A.L.T.: Never get too Hungry, Angry, Lonely or Tired), aphorisms, metaphors, hyperbole, personalizations and short meditations such as the Serenity Prayer. Mäkelä et al. (1996, p. 121) compiled a list of over thirty common slogans and noted that an excess of two-hundred fifty have been accumulated by others and further note that their popularity has crossed over into the popular expression of bumper stickers voicing, "Easy Does It". The slogans are known to have in common pithiness, prosody, and ease of recall. For the purpose of this dissertation, slogans will be defined as short commands, maxims or statements recognized as germane to the organization of AA ("Easy does it") and can include what is more

commonly known as a proverb or adage that comments on a problem or dilemma in such a way as to deliver advice, support or instruction, either solely related to AA or otherwise (“High bottoms have trap doors”).

It is beyond the scope of this dissertation to determine where the AA slogans originate from and it would certainly be a challenging undertaking to establish which wise sayings and quips were born from AA or adopted from elsewhere and incorporated into the common discourse of AA. There is an online source that attempts to investigate the source of many commonly used phrases in AA and other 12-Step derivatives in a “Frequently Asked Questions” format (Anonymous Press, n.d.) and not surprisingly, the sources are varied. For example, some slogans are likely borrowed from Scripture, as it is well-documented that one of the founders, Dr. Bob, was a devout Christian and helped write the original text of the “Big Book” of Alcoholics Anonymous. Perhaps the most well-known slogans of AA are, “One day at a time,” “Easy does it (but do it),” “Let go and let God,” and “First things first”. To understand one of the earliest iterations of this sage counseling which has been maintained over time, one can reference the Christian Bible, specifically Matthew 6:33-34, “<sup>33</sup>But seek first his kingdom and his righteousness, and all these things will be given to you as well. <sup>34</sup>Therefore do not worry about tomorrow, for tomorrow will worry about itself. Each day has enough trouble of its own” (King James Version).

Other slogans have been borrowed directly from the text of the Big Book and are often uttered to support a person’s narrative or to confirm an idea when responding to others who are struggling. For example, a person coming to a meeting at his/her wit’s end with the futility of his/her personal attempts to quit



drinking may hear another member reply, "It is a cunning, baffling and powerful disease". This description of the struggle with alcoholism comes straight from the Big Book (AA World Services, 1976, pp. 58-59). In summary, some slogans come directly from the Big Book, which was itself heavily influenced by the bible. In addition, over the course of time, the vocabulary and breadth of slogans has gradually expanded due to various other influences and discourse in the organization.

Bristow-Braitman (1995) considered some of the overlaps that exist between cognitive approaches to therapy and some of the "affirmations" that are utilized in AA. He noted that these slogans are actually consistent with cognitive restructuring techniques and can effectively help with "reprogramming" and curtailing urges when effectively tailored to the patient. Bristow-Braitman further asserts that the perceived competence of the professional is likely to be enhanced when familiarity in conversance of Twelve Step terminology and spiritual conceptualization is demonstrated.

It is commonly accepted that speaking the language of the patient is important in psychotherapy. Charlés et al. (2003) warn against misunderstandings that can result from the therapist not carefully noting the client's own words and descriptions of their problem, not considering whether the client has a different understanding of the therapist's own terms, and not appreciating or accurately estimating the effect of cultural influences on both the client's and the therapist's style of communicating. Providing common terminology or at the very least a willingness to explore important slogans or narratives learned in AA can be a powerful component of rapport building and

can strengthen the therapeutic alliance. Further, rather than creating separation between AA and therapy, inviting slogans into the therapeutic dialogue indicates support for resources the patient uses outside of psychotherapy.

According to Chaika (2000), the idiosyncratic use of language by patients requires investigation into the emotional and affective valences inherent in certain words and communications. For example, if a patient seeking treatment for addiction replies with a slogan to an inquiry about their efforts to stay sober, the therapist must be able to understand the social context of the patient to understand the meaning of the slogan. In fact, investigating context in the interest of ascertaining emotional and affective valences is a primary role of the therapist rather than the responsibility of the patient to provide. Messmore (2002) describes how narrative therapy emphasizes the need for therapists and clients to use the same language to co-construct a life narrative. The challenge is to use words in the patient's existing frame of reference to develop a new narrative that can accommodate progress. Duncan, Hubble, Miller, and Coleman (1998) ascertained that "Speaking the client's language prevents the client from being trapped in and influenced by a particular theoretical view and increases the chances that any change will generalize outside therapy" (p. 302). Proverbs, slogans, and maxims may likely be incorporated into many clients' narratives and their mode of understanding their problems and potential solutions. Further, as Mäkelä et al. (1996) suggests, the slogans serve as "boundary markers on membership in a subculture," and "provide a means of recognition among movement members when outside the meeting" (p. 121).

An interpretation of the nature of slogans and their impact in language and culture can be found in Rogers' (1989) assertion that AA slogans constitute a breadth of sayings "that directs social action" (p. 105). This suggests that across cultures and language, the message of these phrases and sayings has underlying it a suggestion for a way of living or a solution for that culture's problems or successes. The slogans of AA serve to solidify the cohesive purpose of the group, deliver important information to members, and act as continuous agents of cognitive change. At each stage of the members' involvement with the group, be it AA or another form of rehabilitative therapy using 12-Step principles, the slogans serve a particular function.

At the outset of joining a therapeutic community or other group with a common goal, the slogans serve as efficient communication of a tremendous amount of new information to someone coming into the group in a state of crisis (Barton, 1999; Rogers, 1989). It makes sense that a succinct, easy to recall phrase that conveys hope or inspiration could help make members want to stick around. Research on messages received during early recovery that help build organizational identification revealed that many members of AA initially feel that they are in a 'fog,' both because of lingering substance effects and the sudden immersion in AA activities (Hall, 2008). Wilcox (1998) explained that grasping the concepts of AA is not instantaneous and that most AA members indicate that real meaning from meetings usually only came after multiple iterations and exposure. Eventually this leads to gradual changes in thinking and behavior which helped them to cope better without drinking.

Even in their simplicity, the slogans seem to answer complicated and important questions, and the prospective member's trust in the program's ability to help increases. Borkman (2008) notes that while the slogans may seem silly or unrefined, they deliver "various aspects of the practical philosophy to guide everyday behavior" (p. 19). This develops into an ongoing method of persuasive communication between members that increases the commitment to the group's values (Chaika, 2000; Rogers, 1989). Their repetition also elicits a sense of solidarity (Barton, 1999). While this can be viewed as a device of control, in some ways it is very similar to maxims used in more mainstream development of values such as the Golden Rule. For a group of people who in the first meeting are asked to accept that their lives have become unmanageable, simple ways of finding control are likely welcomed, even if they are highly contrary to their usual mode of operating. In addition, many of the slogans emphasize the idea of limited control, and give solace and comfort to the many alcoholics who come to the program with little ability to imagine quitting drinking forever (Davis & Jansen, 1998). For example, "One day at a time," "Easy does it," and "Progress not perfection" help the member to focus on today's challenge and view recovery as an ongoing endeavor. Some slogans have an ambiguity that leaves room for multiple interpretations and perspectives. Chaika (2000) suggests that this leaves room to use the vagueness to increase flexibility around a viewpoint or problem.

Repetition of words and sentiments shared in therapy by the patient is an essential aspect of building rapport and validating their worth as well as solidifying the sentiments of the sponsoring organization (Barton, 1999; Chaika,

2000). Echoing and facilitating expansion on a theme helps individuals establish empathy for others in similar circumstances and encourages further inquiry on their own. Repetition is a fundamental component of learning in discourse (Barton, 1999) and proverbs are recognized as a method of repetition in communication. The repeated use of sayings develops consistent or oppositional associations to learned information from either an experience or the organization from which it comes (Barton, 1999). This is similar to the repetition expected during the sharing of stories within therapy as well as within the context of a 12-Step meeting. Retelling a narrative thickens the account and deepens the insight the patient can achieve. This aspect would be particularly relevant if a patient spontaneously volunteered an AA slogan within their therapeutic narrative, rather than if the therapist introduced one as a topic for discussion or as a way of bridging ideas or themes. One perspective on the utility of proverbs and slogans in therapy may be that at an appropriate juncture the therapist may suggest one that could have particular resonance for the patient and regardless of acceptance or rejection; information can be gleaned from the outcome.

While enhancing group cohesion, Rogers (1989) further suggests that the slogans provide a common vocabulary used to explain and justify the new behaviors necessary for change to occur and sobriety to be achieved. As this happens over and over, the common symbols in the form of slogans become reference points upon which a therapeutic process can be built. AA's slogans act as catch phrases that connect the member to reflections about some of the core issues of addiction including control and distorted thinking (Steigerwald & Stone, 1999). As addicts struggle with distorted thinking on a daily basis, the slogans

are easily accessed as a protective measure against losing self-control. This is compounded by the typical sharing that goes on in AA meetings. AA members share their personal experiences, but they also recurrently refer to previous turns of talk in order to make their own experiences recognizable, understandable and to create mutual relevance (Arminen, 1998). It is this point that psychologists and other mental health professionals can capitalize on; markers in the mind which can begin to motivate people into generalizing healthy behaviors learned in the program into their daily lives. Slogans are typically non-threatening and nearly everyone can discuss their veracity and practical application. Through repeated exposure to the group as a containing environment within which change can occur, the group and its values become an internalized aspect of the member, with the slogans providing familiar, evocative reminders of the key aspects of the program and all that the member has learned. Their concrete vocabulary and creative, witty format make them easy to readily recall. In the act of recalling slogans in a different environment, whether it is with family, friends, or co-workers, or in the context of psychotherapy, new experiential map markers that evoke the learned experience of the group are being applied.

Once a person has completed a program, or is in a maintenance stage of their affiliation with AA, slogans can be readily be accessed and applied to new situations. This is a particularly important phase of recovery. Chaika (2000) suggests that many slogans and proverbs refer to everyday situations in which a crossroads is met or considerations need to be made before taking action (example: "Don't just do something, sit there"). Each successful employment of the slogan or proverb calls to mind, consciously or not, the underlying therapeutic

process in which it was originally learned. Because a life lesson is often contained within the slogans in the form of a relational statement, much like other proverbs, analogical thinking is required of the user. In other words, in order to generalize out the lessons learned in the original context of an AA meeting or an interaction with one's sponsor, the member needs to first have a fundamental understanding of the relationships within the old context, and then tie a connection to the new circumstance where similar relationships exist. Gibbs and Beitel (1995) indicate that understanding proverbs requires more than the ability to note how a proverb can be generalized, but also the fundamental ability to create metaphorical maps in one's thinking to link dissimilar ideas. Davis and Jansen (1998) suggest that the slogans that abound in AA can be interpreted in a multitude of ways depending on context. Further, the slogans may be applicable for life issues beyond those being examined in the framework of addiction treatment (i.e. other mental health problems or life issues).

It is unclear if the language of AA is frequently brought into the fold in practice with addicted patients. Are professionals wary of applying slogans to therapy? Bassin (1984) suggests that to most professionals, the proverbs and sayings tossed around in the rooms of AA are amateurish and would not legitimately help people solve real problems. Chaika (2000) warns that while slogans can be especially helpful and even central to addiction treatment, enhancing behavioral changes, rapport development, palatability of certain painful subjects, and poignancy, a therapist who is perceived to relate solely through slogans would be highly restricted in their range of creativity and communicative flexibility. Rogers (1989) suggests that this could be a belief

reinforced by the field's overwhelming reliance on training that is positivistic in nature, and since slogans have not been empirically shown to influence human behavior, their use is not encouraged. Valverde and White-Mair (1999) comment on the critical, yet unassuming slogans so popular in the programs:

The apparently inane, even vacuous slogans - 'keep it simple', 'easy does it', 'one day at a time' - that are posted on AA meeting room walls are, it turns out, not so vacuous after all. They have little definite semantic content: but as crystallizations of AA's homegrown collective wisdom they are full of practical meaning and power. The little slogans on the placards - repeated in self-help books, in cheap posters adorning waiting rooms and school hallways, and in ordinary speech - may appear to be beneath the notice of the social scientist, especially the social theorist: they are the very opposite of the 'serious texts' favoured by academics. (p. 406)

It is suggested by Williams (2002) that when slogans are utilized in Twelve Step programs they act as brief "soundbites" whose rhetoric provides members with a sense of reassurance and connection with the goals of the program. This is similar to cognitive-behavioral techniques which aim at transforming dysfunctional attitudes and beliefs into new, growth-oriented beliefs that support a life of recovery. According to Rogers (1989), another possibility for the distaste some professionals may have for using slogans in psychotherapy is their oral nature and their folk wisdom flavor; a quality that may be intrinsically uncomfortable to professionals who prefer literary forms of communicating knowledge.



### **Prior Research on Slogans, Proverbs, and Metaphorical Language**

Hall (2008) demonstrated that several types of organizational messages are important to members as they begin their affiliation process with AA, including encouraging messages of hope, belonging, and support. Another important type of message that AA members received initially were instructional messages for not drinking. This particular type of message was considered by participants to be “critically important one in providing initial support because newcomers were wrestling with their compulsion to drink, and many had not yet accepted that they were alcoholics” (p. 82). The slogan, “One day at a time” was cited as one such instructional message of support. Evidence of the variable interpretability of these slogans was found as participants diverged in their interpretation of this slogan in two ways: (a) helps focus on staying sober in daily increments, and (b) provides tools for avoiding triggers and agitation about the past.

Hall’s (2008) study indicated that the slogans had several important functions that helped members in daily life with their recovery:

Participant reports of inclusive language were memorable in their brevity and powerful in the meanings associated with them. Inclusive language reported by participants incorporated messages for taking action such as “Keep coming back” and “It works if we work it,” messages that encouraged identification such as “stick with the winners,” messages of surrender such as “Let go and let God,” messages of daily praxis such as The Serenity Prayer and “one day at a time,” messages conveying commitment such as “cleaning up my side of the street” and “faith without works is dead,” messages of organizational principles such as “carrying

the message,” and messages of humility, such as “selfishness—self-centeredness”. (Hall, 2008, p. 173)

### **Summary**

Alcoholism and related disorders, as well as other forms of addiction are serious mental health issues that many mental health professionals will encounter, especially given high co-occurrence of other psychological problems. Alcoholics Anonymous is one of the most well-known self-help groups used as a method of recovery. Numerous studies provide support for the efficacy of AA in the treatment of alcoholism and related disorders. As the efficacy of AA has become more widely utilized and accepted by those suffering from alcoholism, mental health professionals are called upon to integrate traditional psychotherapy approaches with the 12-step model. By AA’s own account, many individuals that attend meetings were referred through another service such as a mental health professional, clergyman, or medical professional. The American Psychological Association also encourages psychologists to consider referral to self-help groups such as AA for the treatment of addictions.

AA and other 12-step programs can be conceived of as a therapeutic community and a culture unto its own with a distinct set of values, norms, customs, and goals. These values and beliefs are maintained through AA’s literature and common language, including popular group sayings called AA slogans. Research suggests that while professionals may frequently recommend AA as an adjunct to treatment or an aftercare option, there is little known by these professionals about AA or addiction treatment in general. In fact, it is relatively unclear whether AA literature, slogans, step work or other tenets of AA are

discussed at all outside of specific forms of treatment such as Twelve-Step Facilitation or rehabilitation communities staffed largely by paraprofessionals.

In the last fifteen years there has been a marked advance in efforts to provide culturally appropriate and relevant psychotherapeutic interventions. As language and cultural affiliation are linked in the assimilation process of members of AA, and building rapport, engaging meaningfully, and bridging cultural differences are important aspects of psychotherapy, this study is important to the growing literature of how best to work with substance abusing patients in a culturally appropriate manner. The AA slogans represent a relevant linguistic tenet of the AA culture which includes the dissemination of pertinent information, establishing a marker for individual recovery, denoting affiliation with the recovery community, and providing a range of proverbial and metaphoric connotations open for interpretation. Little attention has been paid to these popular phrases and their presence, relevance, and utility by mental health professionals delivering treatment to addicted populations. This dissertation will focus on gaining a greater understanding of psychologists' use of, familiarity, and comfort with AA slogans, and what factors may influence levels of these investigated variables.

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APPENDIX B  
Survey Instrument

## Survey Instrument

The following is a copy of the survey instrument sent to participants via email to their respective electronic mailing lists.

**Informed Consent:** I authorize Sarah Randall, M.A., a doctoral candidate in the clinical psychology program at Pepperdine University, Graduate School of Education and Psychology, to include me in a research project examining the use of slogans associated with Alcoholics Anonymous in psychotherapy. The research project is being supervised by Robert de Mayo, Ph.D., ABPP Associate Dean; Professor of Psychology. I understand the completion of this survey is strictly voluntary. I also understand that I am free to choose not to complete all items on the survey or to discontinue the survey at anytime without penalty.

I have been asked to participate in this study because I am a member of a professional organization for psychologists and other mental health practitioners. I understand my participation in this study will involve answering some demographic questions (e.g., gender, age, education level, etc.) and questions related to my common practices in treatment, in particular, my use and familiarity with slogans associated with Alcoholics Anonymous. The survey should take less than 10 minutes to complete, depending on the nature and length of my responses.

I understand that this study involves no more than minimal risk. However, I may contact the researcher immediately, by email at [sarah.randall@pepperdine.edu](mailto:sarah.randall@pepperdine.edu) if I should feel uncomfortable with any of the questions.

Although I may not directly benefit from completing the survey, the answers to the survey may help individuals who study and work in the field of psychology to better understand the common practices used in psychotherapy and identify areas where training and education may be warranted. Such knowledge may help psychologists to more effectively provide services to patients with various needs.

To protect my privacy, my results are collected using an anonymous link which will contain no identifying information about me. It is possible that the findings of this study may be published or presented at professional conferences. When the findings are presented, no information of individual participants will be disclosed. Only the researcher will have access to the surveys. The information that is collected will be kept for at least 1 year, within a password-protected internet account, and will be cleared by Sarah Randall, M.A. after 1 year.

I understand the information that I provide will be treated in a confidential manner. In other words, no one will be told what I have disclosed in the survey.

Under California law, there are some exceptions to confidentiality. These exceptions are the suspected abuse or neglect of a child; abuse or neglect of an elder or dependent adult; or if a person wishes to inflict serious harm to

him/herself, to someone else, or to someone's property that would involve harm to others. In these cases, the researcher is required to report the situation to the proper authority.

I understand that I may request a summary of the study findings by providing the researcher with my address. I can do this by emailing Sarah Randall, M.A. at [sarah.randall@pepperdine.edu](mailto:sarah.randall@pepperdine.edu). If after completing this study, I have any questions, I understand that I may contact Sarah Randall, M.A. at [sarah.randall@pepperdine.edu](mailto:sarah.randall@pepperdine.edu). I may also contact Robert de Mayo, Ph.D., for answers to my questions at: Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045; [rdemayo@pepperdine.edu](mailto:rdemayo@pepperdine.edu). If you have any questions about your rights as a participant in this study, please contact Doug Leigh, Ph.D., Chairperson of the Graduate and Professional Schools IRB, Pepperdine University, Graduate School of Education and Psychology, CA ; 24255 Pacific Coast Highway Malibu, CA 90263-4608; (310) 568-2389.

1. By clicking "I Agree" below I acknowledge that a) I have read the information provided in this form and understand what my study participation will entail and b) that I am at least 18 years old and voluntarily agree to participate in this research project.

- I Agree
- I Disagree

2. Please choose your age group.

- Under 23 years old
- 24-34 years old
- 35-44 years old
- 45-54 years old
- 55 years and over

3. What is your gender?

- Female
- Male

4. Which of the following best describes your ethnicity?

- White (Not of Hispanic/Latino Origin)
- Hispanic/Latino
- Black or African American
- Asian
- American Indian or Alaska Native
- Pacific Islander
- Other (please specify)

5. What is the highest educational degree you have received?

Ph.D.

Psy.D.

MFT

MA or MS

CADAC

BA or BS

A.A.

Currently enrolled in graduate program

If currently enrolled in a graduate program, please provide degree anticipated:

6. Are you a licensed psychologist?

Yes

No

7. How long have you been practicing psychology?

0-5 years

6-10 years

11-15 years

16-20 years

More than 20 years

8. What do you consider to be your primary theoretical orientation?

Psychodynamic/Psychoanalytic

Gestalt

Behavioral

Cognitive-Behavioral

Multicultural

Family Systems

Humanistic-Existential/Client-Centered

Integrative/Eclectic

Other (please specify):

9. Please indicate which professional organization listserve you accessed this survey through.

American Psychological Association (APA) Division 12

American Psychological Association (APA) Division 28

California Psychological Association Division 1

Los Angeles County Psychological Association

Survey forwarded by a colleague

10. Have you ever worked in a setting where the treatment of alcohol and/or other drug disorders was a primary focus? (Please include training or volunteer experience).

Yes

No

11. What is your current primary work setting?

- Independent/Group private practice
- University counseling clinic
- Medical inpatient/outpatient (Hospital, VA, etc.)
- Psychiatric inpatient/outpatient
- Community clinic
- Private rehabilitation center
- State or federally funded rehabilitation center
- Prison
- Other (please specify)

12. Please indicate the age demographic of patients you most commonly see.

- Adults
- Children/Adolescents
- Elderly Adults

13. Do you spend at least 5 hours per week providing face-to-face therapy services?

- Yes
- No

14. What percentage of your current caseload has clinically significant problems with alcohol and/or drugs; regardless of whether it is the focus of therapy?

- None
- 10% or less
- Between 11%-30%
- Between 31%-50%
- Between 51%-70%
- Between 71%-90%
- Between 91%-100%

15. Of the patients you have identified as having alcohol or other drug problems, what percentage of them has a comorbid mental health diagnosis?

- 0-10%
- 11-20%
- 21-30%
- 31-40%
- 41-50%
- 51-60%
- 61-70%
- 71-80%
- 81-90%
- 91-100%

16. Thinking of your most common practice, when working with a patient with an

alcohol or other drug disorder diagnosis:

I suggest attending a self-help group (e.g. Alcoholics Anonymous):

Never  Sometimes  Frequently  Very frequently

17. Please look at the following slogans associated with Alcoholics Anonymous and rate how familiar you are with them.

	Unfamiliar	Somewhat Familiar	Familiar	Very Familiar
One day at a time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Easy does it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Play the tape all the way through.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Let go and let God.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Progress, not perfection.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fake it 'til you make it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take the cotton out of your ears and put it in your mouth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keep it simple.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You're only as sick as your secrets.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take what you can use and leave the rest.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. How often do you utilize slogans associated with Alcoholics Anonymous when working with a patient?

- Never  
 Sometimes  
 Often  
 Very often

19. In therapy, how often do you use the following slogans associated with Alcoholics Anonymous?

	Never	Sometimes	Often	Very Often
One day at a time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Easy does it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Play the tape all the way through.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Let go and let God.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Progress, not perfection.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fake it 'til you make it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take the cotton out of your ears and put it in your mouth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keep it simple.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Never	Sometimes	Often	Very Often
You're only as sick as your secrets.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take what you can use and leave the rest.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. If there are other slogans associated with Alcoholics Anonymous that you use in therapy, please list them in the space provided, along with how often you use them.

Slogan 1:

Slogan 2:

Slogan 3:

21. How comfortable do you feel using slogans associated with Alcoholics Anonymous in therapy?

- Not comfortable
- Somewhat comfortable
- Comfortable
- Very comfortable

22. Can you describe why using slogans associated with Alcoholics Anonymous in therapy is something that you are uncomfortable with?

23. Please describe how you think slogans associated with Alcoholics Anonymous can be useful when treating patients.

Thank you very much for your time and thoughtful responses. Have a wonderful day.