A STUDY OF SELF-HELP RECOVERY PROGRAMS FOR DUAL DIAGNOSIS OF ADDICTION AND DEPRESSION

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By

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APPROVAL

We, the undersigned, certify that we have read this dissertation and approve it as fully adequate in scope and quality for the degree of Doctor of Philosophy:

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DISSERTATION ABSTRACT

Name: Beverly Berg Wry Degree: Doctor of Philosophy

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Title of Dissertation: A STUDY OF SELF-HELP RECOVERY PROGRAMS FOR DUAL DIAGNOSIS OF ADDICTION AND DEPRESSION: COMPARING LEVELS OF SHAME AND GUILT BETWEEN MEMBERS OF ALCOHOLICS ANONYMOUS AND MEMBERS OF BOTH ALCOHOLICS ANONYMOUS AND DUAL RECOVERY ANONYMOUS WHO ARE TAKING ANTIDEPRESSANT MEDICATION

Scope of study: This dissertation attempts to reveal the benefits of Dual Recovery Anonymous meetings for dually diagnosed members of Alcoholics Anonymous who use antidepressant medication to treat depression. This research expands the existing body of knowledge on dual diagnosis and underscores the need for greater social support for this population.

Findings and Conclusions: This study surveys members of Alcoholics Anonymous from Los Angeles, California with an Internet survey. One hundred seventeen respondents took the survey and ninety-seven of those surveys were used for the study. This study shows that members of Alcoholics Anonymous who attend meetings of Dual Recovery Anonymous score lower levels of shame and guilt while attending meetings of Alcoholics Anonymous on seven factors. There was no significant difference between members' shame and guilt levels in day to day living.

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Chair Approval for Publication: Date:

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CHAPTER ONE

Introduction

Dual diagnosis is a vast and rapidly growing field that combines the hard earned knowledge of both the addiction and mental health communities. The term “dual diagnosis” is used in medicine to refer to any two disorders that co-exist and are diagnosed independently of each other. “Dual diagnosis” describes a wide range of co-occurring illnesses, such as mild depression and alcohol dependence, schizophrenia and cocaine addiction, or antisocial personality disorder and marijuana use. The current trend toward gathering research on dual diagnosis can be attributed to the expanding awareness of the high frequency of co-existing addiction and mental disorders and the need for understanding the differences between appropriate support for the person diagnosed with a singular disorder and the person with a dual disorder.

Up until the last few years there were separate treatment structures for alcoholism and mental health disorders. This separateness precluded a collaborative effort between the addiction field and the mental health field to fully explore merged treatment plans. Due to the difficulty and complications in identifying co-existing disorders, treatment models have traditionally viewed one disorder in the secondary position to the other or they have treated a dual disorder as a singular disorder.

This quantitative study compared dually diagnosed

subjects who only attend Alcoholics Anonymous (herein referred to as A.A.) and dually diagnosed subjects who attend both A.A. and Dual Recovery Anonymous (herein referred to as DRA). The author chose to focus on subjects suffering from a dual diagnosis of alcoholism and depression. Therefore, both subject groups suffer from a dual diagnosis of alcoholism and depression, and treat their depression with antidepressant medication.

To date, the variables that create the best treatment plan for the dually diagnosed are still unknown. People who suffer from two disorders, are at greater risk for losing their sobriety than people who suffer solely from alcoholism. Potential relapse, suicide and alienation are very real problems for dually diagnosed individuals who exist in a culture that stigmatizes and rejects the mentally ill. For this reason, future studies of treatment programs for the dually diagnosed should continue to measure for which variables lower shame and guilt in this population. Knowing more about these variables may lower recidivism and promote investment in sobriety and medication adherence.

Shame and guilt levels between subjects who attend A.A. meetings only, and subjects who attend both A.A. meetings and DRA meetings were measured and compared in a preliminary attempt to expose the possibility of real, or perceived, stigmatization within A.A. and its negative impact on dually diagnosed subjects. Real and perceived stigmatization will be fully explained in chapter two.

Dual diagnosis 12 Step support groups have only come into existence since 1995. The late addition of dual diagnosis self-help is due to the historical phenomenon of treating alcoholism and depression as singular, separate disorders. DRA meetings still occur far less frequently then meetings of A.A.. Given the shortage of dual diagnosis 12 Step meetings, dually diagnosed individuals who need access to more frequent social support for both their alcoholism and depression are left to rely on A.A. meetings as part, or even the bulk, of their recovery regime. A.A., however, does not provide support around mental health issues.

Alcoholics Anonymous and Antidepressant Medication

Based on personal recovery needs, members attend meetings of A.A. meetings anywhere from once a month, to 5 days a week, to twice a day. Traditionally, in the initial stages of recovery, the prescription for the newly sober alcoholic is to attend ninety meetings in 90 days, and members are encouraged by other members or sponsors to attend meetings thereafter on a regular basis. Any alcoholic who adheres to the 12 Step program and identifies himself as a member will attest to the helpfulness, if not absolute necessity, of knowing that A.A. meetings are readily available anywhere, anytime, worldwide.

The only requirement for membership in A.A. is “the desire to stop drinking” (*Alcoholics Anonymous,* p.xiv, 1976

Ed.). The AA member—Medications & Other Drugs pamphlet further states that:

> "Alcoholics Anonymous is a program for alcoholics who seek freedom from alcohol. It is not a program against drugs. However, some A.A. members have misused drugs, often as a substitute for alcohol, in such a manner as to become a threat to the achievement and maintenance of sobriety. These incidents have caused all A.A. members to be concerned with what is popularly known as the "pill problem" (The AA member, 1984, p.4.)

Members' personal opinions about medication use combined with interpretations of A.A. doctrine have left dually diagnosed members vulnerable to questions about the legitimacy of their sobriety and potential stigmatization within the A.A. community. A.A. members who are not taking medication, not struggling with comorbid issues, or are treating their comorbid disorder by rigorously adhering to the 12 steps of A.A. alone, fall within this category.

A.A. literature clearly spells out that, "…it is wrong to enable or support any alcoholic to become re-addicted to any drug, [and] it's equally wrong to deprive any alcoholic of medication which can alleviate or control other disabling physical and/or emotional problems" (*The AA Member*, 1984, p.13.) The pamphlet further acknowledges that this directive is specifically to address complaints from members and their physicians about the problem of meddlesome members (p.13.)

A.A. literature presents many opportunities for varied interpretation. The problem of meddlesome members can persist because groups are autonomous and can follow their own format at will (*The AA Group*, 1990, p.16.) Specific

rules for meetings are frequently made by the majority vote of members within a meeting, and a rule such as “anyone who is taking medication that affects them from the neck up may not share” (quote by an anonymous A.A. member) would directly impact a dually diagnosed A.A. member.

The differences between meetings, and the freedom of each meeting to create its own agenda and format, means that A.A. groups are not necessarily governed by the guidelines laid out in the pamphlets. Certain groups and/or members may lean toward a “medication-free” environment and might not be welcoming to individuals who are taking antidepressant medication.

If members of A.A. who suffer from depression are stigmatized against or shamed for their use of antidepressant medication, then, per Helen Block Lewis’ observations, their depression will be exacerbated (Lewis, 1986, p.329, p.331.) Subsequently, the risk of behaving self destructively and losing sobriety would be increased, which could have multiple catastrophic outcomes for dually diagnosed individuals.

Potential Implications of this Study

A pressing issue that plagues the dually diagnosed community is the overall low level of treatment adherence. For the dually diagnosed, treatment adherence rates are even lower than individuals with only one disorder (Daley, p.3, Vogel et al, 1998, p.357.) Some in the self-help community

suggest that the “medication-free” approach of some A.A. members may lower medication compliance in dually diagnosed individuals (Modesto-Lowe and Kranzler, 1999, p.146.) On the upside, Magura et al, 2002, found that, “…consistent participation in Double Trouble in Recovery was associated with better medication adherence” (SAMHSA Report To Congress, 2002, ch.4, p.11.)

Through assessing how dually diagnosed persons experience meetings of A.A., both with and without attendance at DRA meetings, the author hopes to broaden the scope of knowledge about a dually diagnosed person’s experience in A.A..

The Author’s Hypotheses

The author hypothesizes that if dually diagnosed subjects attend DRA meetings, which address sobriety, mental health issues and medication use with acceptance and support, they will experience lower levels of shame and guilt than dually diagnosed subjects who only attend A.A. meetings. Since many dually diagnosed individuals have no alternative but to address their alcoholism in an environment that does not acknowledge their mental health disorders, the author hopes to shed light on the impact of DRA meetings on dually diagnosed individuals.

If a stigma against antidepressant medication does exist in A.A. then dually diagnosed individuals who attend DRA meetings and are treated with a legitimized label of

“dually diagnosed” might be better equipped to dismiss the negative evaluation of any A.A. members who stigmatize against the use of antidepressant medication. Individuals who attend both types of meetings might therefore show lower levels of shame and guilt than individuals who only attend A.A. meetings. Without support around their mental health disorders, individuals are at risk for internalizing the judgment of their peers in A.A. that taking medication of any kind negates sobriety.

The author further hypothesizes that subjects who attend DRA meetings in addition to A.A. are less likely to stigmatize against themselves for using antidepressant medication because attendance of DRA works to address and dispel perceived stigmatization. “Perceived stigma” occurs when a person interprets the actions of others as a prejudice against a specific attribute, and the person then internalizes a negative perception of self. Put simply, a person can experience stigmatization even where a stigma does not exist.

Finally, because individuals with mental illness, specifically depression, are at a high risk for suicide, the test results of the author’s hypothesis could have important preliminary implications in treatment formulation for dually diagnosed individuals. If attending DRA meetings greatly lowers shame and guilt levels in members of A.A., the ramifications for dually diagnosed individuals could be far reaching.

CHAPTER TWO

Review of Related Literature

Introduction

A thorough examination of the experience of antidepressant medication users in Alcoholics Anonymous requires literary analysis of several topics. In summarizing previous scientific research on such complex subjects as depression, alcoholism, dual diagnosis, social support groups, and stigmatization, the author has made every effort to present both general and specific coverage of each topic area that is pertinent to the thesis of this paper.

The author will review the literature in terms of “stigma” as the underbelly of her hypothesis, therefore stigma, its multiple definitions and, specifically, the basic theories in stigma research, the differences between perceived and real stigma, and the potential side effects that accompany a stigmatization will be addressed.

Secondly, the author will present literature on social support groups and Alcoholics Anonymous. An important branch of this discussion is the effectiveness of support groups in sustained recovery from addiction and the impact of rejection by a support group on its individual members.

Thirdly, the current definition and understanding of dual diagnosis will be reviewed. Included in this review will be recent research on comorbid disorders, statistics on dually diagnosed individuals, and treatment options for these individuals. This section will also summarize the 12

Step self-help options available to dually diagnosed individuals.

Finally, the author will present a thorough investigation of shame and guilt, including the characteristics of shame and guilt and potential outcomes of shame and guilt. Shame and guilt will be addressed primarily as a unit, although there will also be a discussion of their differences.

The Literature

The majority of articles and scientific data presented in this paper are published in respected scientific journals or books. In addition to this material, the author has included a small amount of information gleaned from the Internet. This choice stems from a desire to reap the benefits of information available to the average “dually diagnosed” through common media sources such as the National Institute of Health. Without an Internet-inclusive approach, the author feels that this study would be lacking an integral facet of the body of knowledge about the aforementioned topics.

Stigma

Overview

Most scientific literature on stigma approaches the topic in one of two ways: from the inside out or from the outside in. The psychological approach studies the inner

workings of the human mind and tries to discern why and when the need for stigmatization arises, what psychological constructs develop in relation to stigma, what purpose stigma serves in the development of the self, both for the stigmatizer and the stigmatized, and whether the stigma is perceived or real on the part of the stigmatized person.

Alternately, the social-psychological approach begins with a stigmatized group, such as alcoholics (Kurtines, Ball and Wood, 1978) or mental health patients (Link, 1987, Link, Struehning, et al, 1997, Link, Struehning, et al, 2001, Link, Mirotznik and Cullen, 1991, Perlick, Rosenheck, et al, 2001, Sirey, Bruce, et al, 2001, Srinivasan, 2000, Sayce, 1998), and studies the effects of discrimination on these groups, the social constructs that develop due to stigma, and the effects of perceived or real stigma on interpersonal relationships based on group membership.

In terms of this paper, the author’s premise is that measuring the shame and guilt levels of potentially stigmatized subjects will help draw preliminary conclusions about the existence of a perceived or real stigma and the potential effectiveness of utilizing specific self-help groups to diminish that stigma. Therefore, both psychological and social-psychological aspects of stigmatization are relevant.

Erving Goffman

Erving Goffman, one of the preeminent theorists on the topic of stigma, identified stigmatization in his 1963 discourse *Stigma: Notes on the management of spoiled identity* (1963). Goffman is cited in virtually every scientific article on the topic of stigma. His contribution to the study of stigma appears regularly as a starting point for defining the term “stigma” in the articles that have followed his provocative work. Goffman’s paper opened the door to a new world of research into stigmatization and the far-reaching consequences of discrimination (Link and Phelan, 2001, Ainley, Becker, and Coleman, 1986).

The opening of Goffman’s book succinctly articulates the concept of stigma through historical reference and merits citation here as a perfect starting point of understanding stigma. Goffman writes:

> The Greeks, who were apparently strong on visual aids, originated the term *stigma* to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier. The signs were cut or burnt into the body and advertised that the bearer was a slave, a criminal, or a traitor–a blemished person, ritually polluted, to be avoided, especially in public places. (Goffman, 1963, p.1)

He goes on to describe the evolution of the term stigma and its various religious uses, but notes that in modern times the idea of stigma closely resembles the original concept.

Goffman defines stigma as, “an attribute that is deeply discrediting” (Goffman, 1963, p.3). He argues that stigma is

highly contextual–that categorization occurs in every social situation, that there are expectations of people in each social context, and an individual who appears “different,” or fails to meet those expectations, is assessed and defined by others. The stigmatization progresses as the “normals,” (Goffman’s term for those who stigmatize), prescribe how the “different” individual should act based on the defined negative attribute. The stigmatized individual is thus faced with externally created choices for how to interact with a stigmatizing individual, group, or society. In many cases the individual will be expected to act as a second-class citizen, or worse yet, a humble slave, and have no expectations of the stigmatizers in return (Goffman, 1963, Ch. 1).

Overall, Goffman’s paper is widely accepted as a provocative starting point for stigma research, either due to its lack of suggestions for rectifying societal injustice (Sayce, 1998) or as a rich source of unanswered questions that modern stigma research hopes to answer. Each of the theorists reviewed below reference Goffman’s work, directly or implicitly, which is a testament to his contribution to the study of this vast and important topic.

Current Stigma Theorists

From the early 1980’s to the present, Bruce Link has published alone and with colleagues on the subject of stigma against mental health patients. In his recent published work

with Jo Phelan, *Conceptualizing Stigma (2001)*, the problems associated with defining the term “stigma” are addressed in depth. The resulting definition is derived from his previous work and the work of others, namely, “to define stigma in the convergence of interrelated components. Thus stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them” (Link and Phelan, 2001 p.377).

Link and Phelan (2001) acknowledge that there are countless ways within these generic mechanisms for stigma to manifest itself. Particularly important is the idea that discrimination can occur between two people, with one person rejecting another, between groups, with a more powerful group creating barriers for a less powerful group, and within the stigmatized person’s mind, with the self’s perception of others’ negative views creating expectations of rejection (p.372-3).

In regards to discrimination against mental health patients, Link hypothesizes that, “…people develop conceptions of what others think of mental patients long before they become patients. These conceptions include the belief that others devalue and discriminate against mental patients” (Link, 1987, p.96). The result of adopting negative stereotypes and then becoming a member of the stereotyped group can be the development of an expectation of rejection by others (Link, 1987, p.97).

Another important contribution to stigma research is Link et al.'s treatment of the labeling theory (Link et al., 1989). It should be noted that the terminology seems to have mutated over the years, so that early dissertations on the subject use slightly different terminology than current articles. The three important variations of the same theory are the labeling theory of deviance, labeling theory, and modified labeling theory, which was offered by Link et al.

Early definitions of the traditional labeling theory of deviance assert that, "…the most important etiological factor in the stabilization of deviance–from delinquency to mental illness–is the imposition of a deviant identity upon a person" (Gecas and Schwalbe, 1983, p.77). The idea behind labeling here would be both to segregate the deviant individual from society, preventing further deviant influence on otherwise normal individuals, and to redirect the deviant individual through social rejection (or, in some cases, reformatory programs in prison) toward more positive behavior (Gove, 1980). The labeling theorists are in direct opposition to the traditional formula, arguing that treating an individual as a deviant person only perpetuates and creates further deviant behavior (Gove, 1980, p.12).

Link et al (1989) offer their own version of labeling theory, namely that, "…modified labeling theory asserts that stigmatization blocks mental patients when they seek to obtain jobs and develop effective social support networks [thus], according to labeling theorists, the tag one

receives upon becoming a mental patient inhibits access to jobs, housing, marriage, and parenthood" (Link, Mirotznik, Cullen, 1991, p.302-303). In terms of adherence to treatment by the mentally ill, Sirey, Bruce et al. go so far as to suggest that, "…when individuals in treatment stop taking medication, it may be to counter the notion that they are now part of the devalued group of "mentally ill individuals" (Sirey, Bruce et al., 2001, p.6).

Other theorists' research speaks directly to the positive benefits of labeling when a person seeks and receives treatment (Link, Struening, et al., 1997, p. 178). When a mental disorder is treated then the symptoms (presumably) decrease, therefore labeling and association of one's mental illness aid in the recovery process. Link, Struening, et al. present a strong case for both positive and negative effects to result from labeling, and conclude that, "…the effects of treatment and stigma coexist and yield a kind of "package deal" of good and bad effects that result from official labeling" (Link, Struening et al. 1997, p.187).

Another interesting aspect of Link's research looks at the options available to mental patients to contend with their stigma and overcome the negative effects. In their paper *The Effectiveness of Stigma Coping Orientations: Can Negative Consequences of Mental Illness Labeling Be Avoided?* (1991), Link et al. suggest that mental patients develop coping mechanisms due to fear of being stigmatized by their

mental illness. These mechanisms include, "…keeping their history of treatment a secret, educating others about their situation, or avoiding situations in which rejection might occur" (Link et al., 1991, p.302). Link et al. ultimately determined that attempts to manage a stigmatization were unsuccessful and, in fact, often made the patients' situations even worse.

In the same vein, Laura Smart and Daniel Wegner (1999) hypothesized that, "…[people] who have a stigma that can be hidden–a concealable stigma–may be highly motivated to engage in a deliberate effort to conceal the stigma. (p.474)" The focus of their research was to understand how stigmatized individuals are affected by social interaction with non-stigmatized individuals. Their results demonstrate the negative cognitive effects that individuals experience when they attempt to conceal their stigmatized characteristic (p.483).

In contrast to Link's view, Jennifer Crocker (1999) argued that, while cultural biases are internalized, an individual does not create uniform expectations of treatment based on their stigmatized characteristic. Instead, pathology occurs due to being stigmatized (Crocker, 1999, p.102). Crocker hypothesized that,

> the effects of stigma are negotiated, created, and acted upon *in the situation*…[and that]…self-worth, or lack of it, in the stigmatized is not a stable, deep-seated personality characteristic. Rather, it emerges in the situation and is a function of the meaning given to the situation (Crocker, 1999, p.91.)

Crocker (1999) evaluated the effects of stigma based on information about her subjects' collective values and standards, and what happened when she altered the subjects' context for those standards. Her results were consistent with her hypothesis, and Crocker argued for further study of, "…the collective representations that the stigmatized bring with them to situations" (p.102).

Crocker's earlier work with Brenda Major (1994) investigated stigma in terms of self-esteem and the justifiability of the stigma. They argued that if an individual believes that their stigmatization is justifiable, namely,

> (a) when the stigma is judged to be a relevant negative input, (b) when the stigma is controllable, (c) when perceiving negative outcomes based on stigma as unjustifiable threatens other important beliefs or (d) when legitimizing myths support the low status of stigmatized groups…" then there will be a negative impact on the stigmatized individual's self-esteem. (Crocker and Major, 1994, p. 309)

Review

In light of literature presented here, the author concludes that, in the absence of an overt, subtle or completely unconscious suggestion of negative feelings toward antidepressant users by members of the Alcoholics Anonymous community, simply an internal belief by medication users that they are discriminated against can be sufficient to produce the negative outcomes associated with stigmatization. The author further concludes that there was sufficient reason to believe that if a real or perceived stigma existed against antidepressant users in Alcoholics

Anonymous, then the stigmatized individuals would demonstrate negative symptoms of that stigma.

The literature presented above indirectly supports the theory that stigmatized individuals, or individuals who believe they are being stigmatized against, will exhibit some negative effects based on their real or perceived status as a marked individual. Link, Mirotznik, and Cullen (1991) offer the following suggestion in response to labeling of mental health patients:

> Short of…broad-based efforts to overcome stigma, improvement is possible through collective action of patients. In particular, if patients can join together to reject what cultural milieu assigns, they may be able to develop socially reinforced coping efforts that will allow a dramatically different outcome than is possible with individual action only. (Link, Mirotznik, Cullen, 1991, p.316)

This advice seems appropriate not just for the mentally ill but also for all stigmatized individuals, including alcoholics. The review of the literature thus continues with a study of social support groups.

Support Groups Overview

The following section intends to give a general understanding of support group research. The following section will address the Alcoholics Anonymous program specifically and the complexities of testing it's efficacy. In researching the topic of social support groups, the author found that most articles referred to "social support" as an all-inclusive term for support from family, friends,

co-workers, and self-help groups, or anyone who is incorporated into the individual's network of association (Cobb, 1976, Thoits, 1986, Cohen and Syme, 1985). It was not until reading Beattie and Longabaugh's article, *General and alcohol-specific social support following treatment* (1999), that it became clear that the study of self-help groups as an individual facet of social support is still evolving into a category of its own. Beattie and Longabaugh state that, "…both researchers and clinicians have been arguing that problem-specific support should be considered as a relatively independent component of support when there is a specific problem in a person's life…" (p.594). There were many mixed responses in research findings about the efficacy of social support. Hence the importance of knowing what kinds of support are valuable for which stressors, and which are not.

A prominent theory on social support, which was mentioned frequently in the stigma literature as well, is Festinger's (1954) social comparison theory. This theory proposed that,

> …social behaviors could be predicted largely on the basis of the assumption that individuals seek to have and maintain a sense of normalcy and accuracy about their world…[and in] times of uncertainty, Festinger predicted that affiliate behaviors would increase as people sought others' opinions about how they should be thinking or feeling. (Davison et al, 2000, p.2)

As referenced in Davison et al's article, Sarnoff and Zimbardo (1961) proved that this theory achieves mixed

results based on the specific uncertainty the subjects are facing–a desire to affiliate was tempered by a desire to avoid humiliation or embarrassment (Davison et al, 2000, p.2).

Given the general nature of social support literature, it seems appropriate to list a variety of definitions for social support as a way of highlighting the different approaches to the subject. For example, “[social] support is defined as information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations” (Cobb, 1976, p.300). Thoits (1986) states that social support, “…most commonly refers to functions performed for a distressed individual by significant others such as family members, friends, co-workers, relatives, and neighbors…” and goes on to redefine social support in terms of “coping assistance” as a new way to illustrate the relationship between support and well being (Thoits, 1986, p.417).

Mitchell, Billings and Moos (1982) break social support down into various categories in a chart, but they never offer a comprehensive definition, even though they use the term repeatedly (Mitchell, Billings and Moos, 1982). Cohen and Syme define social support as, “…the resources provided by other persons…” and posit that using this definition allows for the study of both positive and negative impacts of social support on health and well being (p.4). Beattie & Longabaugh (1999) consolidate definitions by Cobb (1976),

Foa & Foa (1974), Lin, Dean & Ensel (1981), Schaeffer, Coyne, & Lazarus (1981), and Weiss (1974), to reach the conclusion that,

> [social] support can be viewed as the perceived or actual availability of both affective (emotional) and instrumental support, exemplified by the provision and exchange of a sense of belonging, enhancement or self-esteem, and tangible and intangible aid given via money, goods, services, or information. (Beattie & Longabaugh, 1999, p.593)

In addition to the above definitions of social support, there is also repeated mentioning of the function of social support as a, "…stress buffer moderating the relationship between stressful life events and symptomology" (Heller and Swindle, 1981, p.89, Cohen and Syme, 1985, p.13, Mitchell, Billings and Moos, 1982, p.83). A helpful definition of *stressors* is provided by Thoits (1986), namely, "the experience of negative life events and chronic life strains" (p.416). Cohen and Syme's definition of "buffering effect" is, "buffering effects occur when the support measure assesses the availability of resources that help one respond to a stressful event" (Cohen and Syme, 1985, p. 6).

Given the weighty endorsement of social support by the medical community in treatment of alcoholism, the problem of researching the negatives associated with social support must inevitably be confronted. In her paper, *The Negative Side Of Social Interaction: Impact On Psychological Well being*, Karen Rook (1984) approached the topic of social support from the opposite vantage point to most other research. She argued that, "…there is a tendency among some

researchers to equate social interaction with social support" (p.1097). She also highlighted the inherent problem with accepting a definition of social support as having different degrees of positive effect, and found that, "…negative social experiences with others might detract from well being to a greater extent than positive experiences enhance well being" (p.1098).

It follows, then, that arguments made in other papers, such as Mitchell, Billings and Moos' (1982) pro-social support statement that, "…social support may mediate individuals' appraisal of environmental stressors…" can be reinterpreted to mean a potential downside to social support if the environmental stressors aren't being addressed or, worse yet, are being exacerbated by the support provided (p.81).

Along the same lines, Beattie and Longabaugh (1999) find a correlation between lower levels of social support and a lower proportion of days abstinent for an alcoholic over the long term (p.604). The aforementioned authors thus pave the way toward the crux of this paper, which hopes to provide insight into a problem-specific support group (Alcoholics Anonymous) that is populated with members suffering from more than one stressor, otherwise known as the dually-diagnosed.

Alcoholics Anonymous

A.A. and the Big Book

Bill Wilson and Dr. Bob Smith founded Alcoholics Anonymous (herein referred to as A.A.) in 1935. The first edition of *Alcoholics Anonymous*, otherwise known as “the Big Book” to members, was subsequently published in 1939, offering a clear outline of the founders’ vision for the organization, explanation and instructions on how the program works, as well as twelve poignant “personal stories” which capture the differences and similarities between the average A.A. member’s journey to membership in the organization. The foreword to the 1939 edition mentions that the organization has over one hundred members at printing time, and, interestingly, concludes with the statement that, “[inquiry] by scientific, medical, and religious societies will be welcome” (*Alcoholics Anonymous,* p.xiv, 1976 Ed.).

By the second edition of the Big Book, in 1955, the foreword cites the existence of over 6000 A.A. groups, a membership of over 150,000 and proliferation of the group to over 50 foreign countries (*Alcoholics Anonymous*, p.xv, 1976 Ed.). The foreword describes the complexities of rapid growth for the organization, especially due to the media, which resulted in the need for a clear set of guidelines for A.A. members to follow in order to protect the integrity of the organization’s mission. These guidelines included,

> that each group was to be autonomous…[there] was to be the least possible organization, even in our service

> centers…that all members ought to be anonymous at the level of press, radio, TV and films…[and] in no circumstances should we give endorsements, make alliances, or enter public controversies. (*Alcoholics Anonymous*, p. xix)

The second edition foreword of *Alcoholics Anonymous* (1955) also gives a very promising outlook for recovery from alcoholism, stating that, “[of] alcoholics who came to A.A. and really tried, 50% got sober at once and remained that way; 25% sobered up after some relapses, and among the remainder, those who stayed on with A.A. showed improvement” (p.xx). The vague nature of “really trying” and “showing improvement” are not satisfying on a scientific level and there is no citation to explain how this information was obtained.

The third edition of the Big Book, printed in 1976, cited even greater growth for A.A. with a “conservative estimate” of over 1,000,000 members and almost 28,000 groups in over 90 countries (p.xxii). Again, there is little background given on how these numbers were obtained, other than through “surveys,” and the word “estimate” implies that perhaps these numbers are based on averages. The fact that the Big Book is written specifically for members of A.A. means that the authors have no obligation to provide background for their data, or proof of accuracy. Furthermore, the foreword, the only place in the Big Book which cites any concrete data, is but a page long, while the remaining 575 pages of the book are devoted to story-telling and description of the 12 Steps and how to follow them. The

Big Book, therefore, is not an excellent source of data for testing the efficacy of the 12 Step model for alcoholics.

Recent Scientific Data on A.A.

There are currently close to 14 million adults in the United States who have alcohol abuse or dependency problems (National Institute on Alcohol Abuse and Alcoholism, 2002). Given its importance in the field of recovery, and it's demonstrated durability, there is not enough current scientific data on the outcome of participation in A.A. to understand why, how, if and for whom the 12 Step program works. Therefore, scientists must consolidate what is known about A.A. in order to paint a picture of the community as a whole, the individuals who participate in it, and the philosophy that these individuals adhere to as members.

Unfortunately, times seem to have changed very little from the early reporting on A.A.. As a glaring example of the static body of knowledge on the efficacy of A.A., Tonigan and Hiller-Sturmhofel's 1994 article entitled *Alcoholics Anonymous: Who Benefits?* employs the two subheadings *Does AA Involvement Reduce Drinking?* and *Who Joins AA?* (p.308).

The Tonigan and Hiller-Sturmhofel article further explains the many limitations to conducting scientific experiments within the A.A. community, the difficulty in recruiting participants other than through inpatient or outpatient facilities to track progress, and the,

"…incomplete understanding of processes within A.A. and differences among various A.A. groups" (1994, p.308). A.A. is still an anomaly to the scientific community yet it continues to be a primary source of treatment for alcoholics (Riordan and Walsh, 1994, Emrick, 1987, McBride, 1991).

From a scientific standpoint, A.A.'s "no involvement" approach with the media and other outside entities precludes a comfortable level of access to the organization and a consistent, easily monitored group of subjects which are needed to draw satisfactory conclusions about the impact of A.A. on the recovering alcoholic. Scientists are instead forced to rely on internally generated data, such as the Alcoholics Anonymous 2001 Membership Survey, and to mine recovery treatment centers for patients who are participating in A.A. as a supplement to their treatment. These two options are lacking in appeal because the internally generated data is collected by a biased party, and the inpatient and outpatient subjects are exposed to more than just A.A. as treatment for their alcoholism (Tonigan et al., 1991, Tonigan, Toskova and Miller, 1996, p.65, Tonigan, Connors and Miller, 1998, Emrick, 1987).

Experiments which solicit A.A. member participation do take place, but the results are inevitably thrown into question by the fact that experimenters have limited ability to control for unknowns such as A.A. group size, group characteristics, members who decline to participate, and inability to track and follow up with the same subjects

(Emrick, 1987, McBride, 1991, Galaif and Sussman, 1995, Tonigan and Hiller-Sturmhofel, 1994, Edwards et al, 1967, Davis and Jansen, 1998).

Chad Emrick's 1987 article, *Alcoholics Anonymous: Affiliation Processes And Effectiveness As Treatment* is widely used and cited by modern researchers as a breakthrough in assessing the A.A. community. Emrick assesses approximately seventy sets of empirical data to draw an overall view of A.A. demographics and expected treatment outcomes based on attendance for the A.A. population. He also discusses reasons that A.A. does not work for certain individuals as a treatment option, such as personality type and professional treatment success. Of particular interest to this paper is his observation that, "[the] structure and support provided by the Twelve Step program appears to fit well with alcoholics who rely more on external structure for perceptual and conceptual processing" (Emrick, 1987, p.417).

Emrick also cites several problems with A.A. survey studies such as the fact that, "…only self-selected AA members have been assessed…" and the, "…highly biased sampling (e.g., more active members are more likely to be studied) and the confounding of the effects of AA with those of professional treatment (i.e., a significant portion of respondents have had professional treatment before or during AA)" (Emrick, 1987, p.418). It is impossible to know what motivates an individual to participate in a survey or

dissuades another from responding; therefore the results of any experiments performed will suffer from this bias.

Current articles attempting to measure the efficacy of A.A., or at least uncover positive treatment methods for alcoholics, tend to either draw from previous research or to conduct studies with relatively small subject groups that cannot be representative of the whole organization. J. LeBron McBride's research on abstinence and Alcoholics Anonymous (1991) is a limited study of 50 individuals who were recruited through networking with A.A. group members in urban areas of Florida and Georgia (McBride, 1991, p.117). The results showed a positive correlation between A.A. attendance and abstinence, but the research is far from conclusive.

As will be discussed in the next section, the issue of treating co-occurring disorders is a complex matter that has not been integrated between the two bodies of substance abuse and mental health research. Tonigan and Hiller-Sturmhofel (1994) are alcohol dependence and abuse researchers, and their acknowledgment of the vast issue of co-occurring disorders highlights the positive step toward affirming important differences between substance abusers, namely that many of them suffer from comorbid disorders that must be attended to if alcohol treatment is to be effective.

Review

More information is needed on the efficacy of A.A. and on membership characteristics. It is important to accurately assess the alcoholic before assuming that A.A. is the appropriate treatment model. Alcoholics who are erroneously sent to A.A. may experience further set backs in recovering from their addiction if they feel rejected or unsuccessful (Glaser & Ogborne, 1982).

In terms of assessing the effectiveness of A.A. meetings for alcoholic individuals with a co-existing mental disorder, the role of the support group becomes less clear. A.A. serves the purpose of providing support and structure for recovering alcoholics. Alcoholics Anonymous does not, as a group, purport to attend to the needs of someone who is also diagnosed with a mental disorder. The next section explains the complexities of co-occurring disorders and the current treatment suggestions for dually diagnosed individuals.

Dual Diagnosis

The term “dual diagnosis” is used in medicine to refer to any two disorders that co-exist and are diagnosed independently of each other. The medical term does not specify the types of disorders, however the self-help community has appropriated the term to refer specifically to co-existing mental health and substance abuse disorders.

The Dual Recovery Anonymous Start Up Packet states that, “[a] dual disorder occurs when an individual is affected by both chemical dependency and an emotional or psychiatric illness” (n.d., p.4). This definition uses layman’s terms compared to the clinical definition given by the Substance Abuse and Mental Health Services Administration (SAMHSA), which calls the same diagnosis “co-existing substance abuse and mental health disorders” instead of dual disorders, and adds that the affliction includes “at least one” mental disorder and requires that, “…at least one disorder of each type can be diagnosed independently of the other” (2004, p.2).

To further explain the definition of a dual disorder it should be noted that “addiction” or “chemical dependency” means abuse of or dependence on alcohol or illicit drugs (e.g., marijuana, cocaine, heroine, etc.) and “an emotional or psychiatric illness” refers to a wide range of mental disorders such as depression, schizophrenia, antisocial personality disorder, panic disorder, and anxiety disorder. For the purposes of this paper, the term “dual diagnosis” refers primarily to the Dual Recovery Anonymous definition, but when reviewing literature from various public agencies on dual recovery, the clinical definition applies.

Dual Disorders Are Discovered

The 1980’s brought sweeping ideological change to the world of alcoholism treatment, including the discovery and

subsequent delineation of “co-existing disorders” as a growing problem facing treatment institutions. When the movement began,

> traditional mental health approaches [tended] to view alcohol problems as symptomatic of underlying mental disorder, best treated by psychotropic medications; in direct opposition [was] the traditional alcohol treatment perspective which [focused] on how emotional problems stem from underlying addiction, calling for total drug abstinence. (Schmidt and Weisner, 1993, p.383)

The two treatment approaches were at odds. Further complications arose when trying to diagnose a person with separate, primary disorders because a mental health disorder can also be a secondary disorder to substance abuse and vice versa, such that an alcoholic can experience depression due to their alcoholism or an individual with a mental health disorder often will abuse an addictive substance to “self-medicate” their disorder and relieve the symptoms of depression, anxiety, and so on (Pary, Lippmann and Tobias, 1988, p.1530.)

Present Information On Dual Diagnosis

Statistics on dually diagnosed adults in the United States are limited. According to the 2002 SAMHSA Report To Congress On The Prevention And Treatment of Co-Occurring Substance Abuse Disorders And Mental Disorders, the best data on the existence of dual diagnosis comes from the Epidemiologic Catchment Area (ECA) Survey and the National Comorbidity Survey (NCS) (SAMHSA Report To Congress, 2002, Ch.1, p.3, Reiger et al., 1990, Kessler et al., 1985.)

As of 1990, the ECA was, "…the largest personal interview survey of psychiatric disorder in the general population ever done" (Helzer and Pryzbeck, 1988, p.219.) The study collected data from over 20,000 individuals in five areas around the country, plus an institutionalized population, and the results were used to develop "ORs" or odds ratios for the comorbidity of mental health and substance abuse disorders. The odds ratios determine comorbidity estimates for the entire country, although the authors of the results suggest that the common primary/secondary relationship between the substance abuse and mental health disorders may lead to some false positives (Reiger et al., 1990, p.2512).

The NCS data was collected through a household survey and diagnostic interviews were used to determine diagnoses of the participants (National Institute on Alcohol Abuse and Alcoholism, 2001, p.2). The data from both of these studies is between 15 and 25 years old. An update of the NCS, the National Comorbidity Survey Replication (NCS-R), is currently underway and hopes to provide a better picture of the number of dual disorder cases in the United States today.

Current, specific data on the number of dually diagnosed individuals suffering from both alcoholism and depression is not readily available from public sources. The SAMHSA description of the results of the ECA, the NCS and various smaller surveys is, at best, inconclusive and, at

worst, confusing. The term “dual diagnosis” describes a wide range of co-occurring illnesses, such as mild depression and alcohol dependence, schizophrenia and cocaine addiction, or antisocial personality disorder and marijuana use. Even within the delimited scope of this paper–testing members of Alcoholics Anonymous who are taking antidepressant medication–there are still difficulties in discerning which statistics apply to whom.

In terms of this paper, the subjects’ disorders vary in severity, from sub-clinical to clinical (based on DSM-IV criteria), and in initial exposure to treatment, from self-diagnosis to prior hospitalization, therefore the most pertinent statistic gleaned from the SAMHSA Report To Congress (2002) is the estimate of adults with co-occurring substance abuse and mental health disorders, which is approximately 7 to 10 million adults (Ch.1, p.4). Statistics on the number of adults with the specific combination of alcoholism and depression in the ECA (which is outdated) stated that 37% of individuals who are diagnosed with an alcohol disorder will develop another mental disorder (note this includes all mental disorders, not just depression) and that 29% of individuals with a mental health disorder have a co-existing substance abuse disorder (Reiger et al., 1990, p.2517). Furthermore, individuals diagnosed with a substance abuse disorder are at greater risk of developing a mental health disorder than the general population, and vice versa for individuals diagnosed

with a mental disorder (Modesto-Lowe and Kranzler, 1999, p.144, SAMHSA 2002 Report to Congress, p.3, Daley, n.d., p.8).

In terms of seeking publicly funded treatment for either alcoholism or mental health disorders, the SAMHSA 2002 Report to Congress paints a bleak picture of the options available to dually diagnosed individuals. The separate nature of each service system means that a person who is afflicted with addiction and a mental health disorder is, "…likely to bounce back and forth between the mental health and substance abuse service systems, receiving treatment for the co-occurring disorders serially at best" (SAMHSA Report To Congress 2002, p.1). Vogel et al. go one step further and assert that, "…[it] is not rare to see psychiatric disabilities among the exclusion criteria for admission in a substance abuse treatment program; similarly, many mental health providers may not serve clients with an addictive disorder" (Vogel et al., 1998, p.357).

The theoretical prescription to the problem of treating the dually diagnosed is to integrate the alcohol and mental health treatment models (Sciacca and Thompson, 1996, Magura et al, 2002, Laudet, Magura et al, 2000, Daley, n.d., Modesto-Lowe and Kranzler, 1999, Petrakis et al., 2002). In fact, integration is the only recommendation the author could find in the dual diagnosis literature. The degree to which integration is feasible in publicly funded treatment centers, both in terms of cost and time, is the primary

problem that government agencies like SAMHSA and The National Institute on Mental Health (NIMH) are attempting to solve. For the self-help community, however, the time is ripe for reaching out to a new generation of individuals, and the integration process has already begun.

Dual Diagnosis Self-help and Recovery

As with the plight of alcoholics in the 1930's, the need for treatment and recovery for the dually diagnosed is not being met by the public health system. Over the past fifteen years, 12 Step self-help groups for the dually diagnosed have cropped up across the United States. The Dual Recovery Anonymous 12 Step group (DRA) began to develop in Kansas City, KN, in 1989 and was founded officially in 1993 (DRA Start Up Packet, 2001). Double Trouble Recovery was founded in 1989 in New York City and has proliferated to at least 6 states (Laudet et al., 2000). Dual Disorders Anonymous runs over 20 meetings in Illinois, and has spread to other states, and Dual Diagnosis Anonymous was founded in 1995 in California and has since spread to eight other states plus Canada (Dual Diagnosis Anonymous Worldwide Services, Inc. website, March, 2004). These four groups are all founded on the 12 Steps of Alcoholics Anonymous with the intention to serve a growing population of people seeking treatment for co-existing substance abuse and mental health disorders.

The principal foundation of a support group is the individual desire to recover from an illness or affliction. As discussed earlier in this chapter, support groups are widely used by the medical community, and publicly funded treatment models frequently incorporate the use of 12 Step groups as part of the recovery process for substance abusers. In terms of dual diagnosis self-help groups there is very little information on the actual outcome of recovery for members (Vogel et al., 1998, p.362). However, there is more mention in the few articles that have done preliminary testing in the dual diagnosis self-help arena to imply that the groups have a positive influence on recovery, rather than a negative one (Vogel et al., 1998; SAMHSA Report to Congress, Ch. 4, p.10; Laudet et al., 2000, p.327).

Both the Dual Recovery Anonymous organization and Dual Diagnosis Anonymous Worldwide, Inc., profess the same intent as the founders of Alcoholics Anonymous–to create a safe environment for individuals to share their problems (in this case with substance abuse and mental illness) and gain useful tools in dealing with these difficult issues. The goal of the organization is to help each person step onto the path of recovery. Both groups use amended versions of the original Alcoholics Anonymous 12 Steps. Dual Diagnosis Anonymous even added extra 5 steps which speak directly to the difficulties and realities of dealing with comorbid diseases. For example, Step 3 of the DDA 5-Steps states, “[we] understood the importance of medical management,

clinical interventions, and therapies as well as complete abstinence from all non-prescribed drugs and alcohol" (DDA World Services Inc., n.d.).

Therefore, attending Dual Recovery Anonymous meetings, when available, is a positive step in gaining support around both mental health issues and alcohol dependency. However, the "when available" caveat poses a confound for this solution. Support groups for the dually diagnosed are a relatively recent addition to the myriad offerings of independent self-help groups, with the Dual Recovery Anonymous Central Service Office foundation in 1993 compared to the 1935 founding of Alcoholics Anonymous. Dual Recovery Anonymous meetings are far less frequent and accessible than the well-established Alcoholics Anonymous meetings.

As an example of this disparity, it is listed on the Dual Recovery Anonymous website that thirty-eight Dual Recovery Anonymous meetings are offered each week in Southern California proper, compared to over three thousand Alcoholics Anonymous meetings offered in the Los Angeles area alone (Dual Recovery Anonymous website, 2004; Dual Diagnosis Anonymous website, 2004; Los Angeles Central Office of Alcoholics Anonymous website, 2003). The supply of Dual Recovery Anonymous meetings clearly will not meet the potential requirements of dually-diagnosed recovering alcoholics who rely solely on self-help for recovery, and therefore many dually-diagnosed alcoholics attend Alcoholics Anonymous if they want frequent access to a 12 Step program

to deal with their substance abuse (Vogel et al., 1998, p.362; Laudet, et al., 2000 p.327; Meissen et al, 1999, p.1).

Shame and Guilt

The concluding section of this chapter deals with the two emotions shame and guilt. Due to the strong contributions of several key theorists, this section will focus on the individual work of Helen Block Lewis, Silvan Tompkins, Paul Gilbert and associates, and Potter-Efron and Efron.

Defining Shame And Guilt

The two experiences of shame and guilt are often confused and/or fused with each other in literal terms. People often struggle to give clear definitions of the terms “shame” and “guilt,” but find that describing a situation where one feels ashamed or feels guilty is much easier to accomplish (Lindsay-Hartz, 1984, p.691). The overall consensus of shame and guilt deriving from different experiences means that, subtleties aside, a general definition of each is not greatly debated among the leading shame and guilt theorists today.

Historically speaking, scientific accounts of the development of guilt and shame begin with Sigmund Freud. The author has chosen not to review Freud’s work in this paper because, again, there is much consensus that Freud’s

theories on shame and guilt, while brilliant and unprecedented, did not address the two affects separately, and is therefore not relevant to a discussion of the current understanding of shame and guilt.

Helen Block Lewis is one of the preeminent shame and guilt theorists in modern literature. The author found very few articles discussing shame that fail to mention, let alone entirely base their findings on, Lewis' work. Lewis defines the phenomenology of shame and guilt as follows:

> ["Shame" refers] to a family of affection-cognitive states in which embarrassment, mortification, humiliation, feeling ridiculous, chagrin, disgrace, and shyness are among the variants. "Guilt" is a family of affective-cognitive states that shares the themes of responsibility, fault, obligation, and blame for specific events. (Lewis, 1987, p.329)

To further differentiate shame from guilt, it is important to understand that the locus of the feeling of shame is inside, from a devaluation of the self, while guilt originates from the outside, often with a negative action or feeling that is referenced to an external object. These concepts are generalized here and will be discussed in greater detail with each theorist's work.

Shame and Guilt Theorists

Helen Block Lewis' initial work, *Shame and guilt in neurosis* (1971), used her own experiences as a psychoanalyst to lay the foundation for many contemporary theorists to look at shame and guilt as separate and interconnected affects (Lewis, 1986, p.325). Her subsequent work built on

this notion and explained the shame-guilt relationship with great clarity. Using the mother-child relationship as an early example of the development of shame and guilt through "messaging" Lewis offers the following pattern, "…"rejection" → humiliated fury → guilt…" where the rejection stems from a mother who shames her child over inappropriate desires for cuddling and guilt's her child with the message that crying out of humiliated fury is unnecessary (p.327).

Lewis describes the state of shame in terms of a feeling of "helplessness" due to the physical reactions that often accompany a humiliated state–blushing, sweating, and crying. In opposition to shame's helpless state, guilt is experienced as feeling "able," where the focus of the guilt is an action, not the self, and the guilty party has the opportunity to make amends for the wrongdoing by taking some sort of action (Lewis, 1986, p.330).

Lewis makes several poignant observations that apply directly to the experience of stigmatized individuals. Firstly, Lewis states that, "[because] shame is the self's vicarious experience of the other's negative evaluation, in order for shame to occur, there must be a relationship between the self and the other in which the self "cares" about the other's evaluation" (Lewis, 1987, p.16).

Secondly, Lewis discusses shame-rage, and states that, "[so] long as shame is experienced, it is the other who is experienced as the source of hostility. Hostility against

the rejecting other is almost simultaneously evoked…" which can easily lead directly into guilt over feeling hostile toward a cherished or respected other (Lewis, 1987, p.19). Lastly, Lewis draws important parallels between shame and guilt and different mental health disorders, namely that, "…there is an affinity between the helpless experiences of the self in shame and in depression, and an affinity between the mobilization of the self in guilt to *do* something, which is phenomenally similar to obsessive and compulsive states" (Lewis, 1986, p.331).

These observations pertain directly to the author's hypothesis, given that the subjects used in this experiment are grappling with two comorbid disorders, one of which is a mental health disorder.

Silvan Tomkins' primary contribution to the study of shame and guilt is best known as "affect theory." Tomkins identified nine innate affects, namely interest/excitement, enjoyment/joy, surprise/startle, distress/anguish, fear/terror, shame/humiliation, dismal, disgust, and anger/rage, each of which has a corresponding facial expression (Tomkins, 1987, p.139).

Tomkins defines shame's function primarily as a moderator of interest or joy, or, more specifically, as the affect that serves to *reduce* interest or joy. Donald Nathanson takes Tomkins' theory further and suggests that maintaining interest in life is what keeps us happy, therefore the, "…ahedonia of depression may be a lesion in

the realm of interest" (Nathanson, 1987, p.18). This likely explains why shame and depression are commonly linked—if the shame affect develops in an abnormal way, based on abnormal stimuli, and then it might incorrectly moderate or reduce interest, which results in depression. Put more eloquently by Rybak and Brown, 1996, "[if] shame serves as an inhibitor of interest and/or enjoyment, then one who experiences a sufficient intensity of shame will also experience a significant reduction in the interest and enjoyment of life" (p.73).

In terms of the comparison between shame and guilt, Tomkins finds that,

> [the] common distinction between shame and guilt as resting on the locus of evaluation is in error since I may feel inferior or guilty because someone so regards me, *or* because I so regard myself. Further, I may feel ashamed because *you* should feel ashamed or guilty but do not. I may feel ashamed or guilty because you feel ashamed or guilty but *should not*… (Tomkins, 1986, p.154)

He further finds that shame, guilt, shyness and discouragement are, "identical as affects, though not so experienced because of differential coassembly of perceived causes and consequences" (p.143.)

Tomkins clarifies that shame arises out of "inferiority" while guilt stems from a "moral transgression" (Tomkins, 1986, p.143). The author notes that Tomkins' affect theory does not, in fact, conflict with Lewis' definition of shame and guilt so much as it uses a different lens to look at the same picture. Lewis would agree with Tomkins' delineation of inferiority and moral transgression.

However, Lewis' research unfolds with an eye to ultimately treating shame and guilt, not on uncovering the biological origins of affective reactions, therefore she would likely argue that the two affects are often fused, and the only real separation is through a determination of what ignited the shame or guilt response.

Paul Gilbert and associates have published multiple articles on shame and guilt, including their paper, *The phenomenology of shame and guilt: An empirical investigation* (1994). They note that social psychologists have grown increasingly aware of several emotional experiences, including shyness and shame, which are linked to fear of negative evaluation (FNE) by others, and go so far as to state that, "[in] the sociological literature shame has come under the heading of stigma (Goffman, 1968), a social concept" (Gilbert et al., 1994, p.24). The idea of shame and stigma falling under the same heading is traceable through shame literature based on similarities in how each experience is described. For example, Harder and Greewald's definition of shame that includes, "being exposed to disapproval from others (in reality or in fantasy)…" which coincides with the idea of real or perceived stigma (Harder and Greenwald, 1999, p.271).

Fear of negative evaluation is the other primary focus of Gilbert et al.'s 1994 study, and it is a topic that closely intertwines with the shame-guilt-stigma triangle of this paper. Fear of negative evaluation involves an acute

awareness of one's surroundings, the social structure, the hierarchy, and one's status within that hierarchy. A person who suffers from FNE is threatened by the social structure, and manages to function within the system by avoiding those who are more powerful and interacting with those who are inferior (p.27). Gilbert et al. remark that, "[in] general, FNE shows a marked overlap with shame" (p.28).

In terms of this paper, FNE seems to be a stepping stone between pure shame (and guilt) and perceived stigmatization. Even if there is no stigmatization in Alcoholics Anonymous whatsoever, there is the possibility that subjects are stigmatizing against themselves or, in other words, are fearing negative evaluation from the society of Alcoholics Anonymous. Thus, according to Gilbert et al., these subjects will have high levels of shame.

In slight contrast to Lewis' shame and guilt messaging model, Gilbert and Miles found that,

> [feeling] distressed and upset about criticism was associated with depression, guilt, shame, unfavorable social comparison and fear of negative evaluation. Feeling anger to criticism was associated with depression, shame and fear of negative evaluation. Guilt and social comparison were not significantly associated with anger at criticism. (p.764)

These findings do not correlate with Lewis' belief that hostility toward the critical other would bring about guilt feelings.

In terms of self-blame versus blame of others, Gilbert and Miles (2000) found that, "…blaming others was *inversely* correlated with shame, guilt and social comparison" (p.764.)

This information coincides with the stigma debate on whether labeling has positive or negative effects. Gilbert and Miles' findings indicate that a positive reaction to stigmatization might exist, namely through blaming and dismissing the stigmatizing others.

Finally, Gilbert et al. (1994) make a concluding statement that could be crucial to the results of the experiment this paper intends to carry out. They state that, "…[shame] in particular situations may be less of a pathogenic indicator than shame which taps into global judgments of the self" (p.34.) The implications of this statement are that high levels of shame and/or guilt in subjects experiencing real or perceived stigma are more likely to exist due to chronic shame. It is for this reason that the author will structure the experiment to test for shame and guilt in a general sense, and then to further test for shame and guilt specifically "in A.A." (This will be explained further in chapter three.)

Finally, Potter-Efron and Efron approach shame through the lens of alcohol addiction. Their paper, *Three models of shame and their relation to the addictive process* (1993) gives a comprehensive overview of Heinz Kohut's self psychology, Tompkins' affect theory, and family systems theory all in relation to the development of shame, as well as an eloquent explanation of the disease model of addiction as created by Alcoholics Anonymous.

An interesting addition to the varying definitions of shame is the definition given by the self-psychologists. This group of theorists believes that, “[shame] reflects the disappointment and terror that may accompany one’s discovery, at any age, that we are not the center of the world” (Potter-Efron and Efron, 1993, p.30). Here shame continues to involve the self seeing the self in terms of others, but the implication is that the human condition revolves around an irrational notion of the self at the center of other people’s universes in addition to one’s own. Again, Lewis’ model for shame (and, the author would argue, also guilt) is supported through the mother-child messaging system. The child discovers that she is not the center of her mother’s universe when the mother rejects her desire to cuddle, thus eliciting shame.

Potter-Efron and Efron’s explanation of Kohut’s self-psychology is particularly helpful in drawing links between shame and social support groups. They argue that,

> [one] of Kohut’s major contributions [to defining the self] was his insistence that human beings continually need others to help them define, develop and refine their sense of self. His model of a healthy person is based more on the concept of interdependence than independence. (Potter-Efron and Efron, 1993, p.26)

Perhaps the most important association made by Potter-Efron and Efron in the course of their study of shame and addiction is the statement that,

> [certainly] the AA First Step, in which one admits one’s powerlessness over alcohol, seems to be consistent with [the] effort to break the link between shame and addiction. In AA, a person can be both

> powerless and good enough to belong in the group. (Potter-Efron and Efron, 1993, p.39)

Review

The authors reviewed in this chapter give a comprehensive overview of shame and guilt as individual affects that arise out of different experiences in relation to the self and to others. There are notable similarities between the description of shame and guilt experiences and the earlier description of real and/or perceived stigmatization, with Gilbert and Miles going so far as to call shame and stigma the same experience.

According to theorists reviewed here, shame and guilt experiences are associated with both addictive disorders and mental health disorders–something that Tomkins would likely explain due to abnormal stimuli and responses to the affects during the early development of the self. The congruence of shame states and depression means that the treatment of a dually diagnosed individual must include a method to reduce shame.

CHAPTER THREE

Methodology

Overview

This chapter will describe and discuss the information gathering instruments used for this study and explain the choice of these instruments. The chapter will continue with a discussion of the random sampling strategy that will be used for the two subject populations chosen for this between-subject approach, and a comprehensive description of the two populations. The chapter will conclude by examining the limitations of the design and will address the reliability of the strategies used and the ethical issues raised by this study.

Statement of the Problem

This study will look at the following problem: Does Alcoholics Anonymous have a negative effect on its dually diagnosed members?

Based on the described problem, this study will address the following question: What are the levels of self reported shame and guilt in alcoholics attending Alcoholics Anonymous (herein referred to as A.A.) meetings who are taking antidepressant medication compared to the levels of self-reported shame and guilt in alcoholics taking antidepressant medication who attend both A.A. meetings and Dual Recovery Anonymous meetings?

The specific questions addressed in this section will include:

1. What are the diagnostic criteria used to test for shame and guilt?
2. What are the implications of any difference in shame and/or guilt levels between the two cohorts?
3. What are the confounds associated with these findings?

Recognizing that this is an area not fully explored in the literature and that the implications of being an alcoholic with a mental disorder constitute a complex framework for the therapeutic community, the author emphasizes the preliminary nature of this study. The observations detailed here might best be viewed as useful guidelines for working with dually diagnosed patients rather than a definitive list of tested principles.

Research Design

The method employed in this between subjects study is a quantitative approach using the Beck Depression Inventory-II, Harder and Zalma's Personal Feelings Questionnaire 2, and an additional questionnaire pertaining to the participants' experience in A.A. meetings. The latter set of questions will be designed by the author and will be tested for bias and usefulness in a test pilot. This quantitative research method provides a clear understanding of the effect of the independent variable - attendance of Dual Recovery

Anonymous meetings – and the dependant variables – shame and guilt – on an otherwise identical population of members of A.A..

Research Expectations

Based on the literature reviewed in chapter two, the author expects to find a link between the existence of a stigma or belief that a stigma exists and an individual's level of shame and/or guilt. To recapitulate, stigma is, "…some characteristic individuals possess (or are believed to possess) that conveys a social identity that is devalued in a particular social context (Crocker, Major, & Steele, 1998)..." (Smart & Wegner, 1999, p.474). By this definition, members of A.A. who are encouraged to discontinue use of antidepressant medication by other members of A.A. are stigmatized. Further, members of A.A. who take antidepressant medication and believe that other members in the group stigmatize against medication users will also experience stigmatization.

Literature on stigma suggests that there are two possible reactions to stigma by stigmatized individuals, based on their perception of whether the stigma is justifiable or unjustifiable, namely to, "…react with depressed mood and low self-esteem…" if they believe the stigma to be justified, or to, "…react with anger and high self-esteem" if they believe it to be unjustified (Crocker and Major, 1989). The justified/unjustified distinction is

the primary reason that this study will address both shame and guilt as dependent variables rather than focus on one emotional reaction.

The development of shame and guilt as separate, yet closely intertwined experiences is best described by Helen Block Lewis as beginning in infancy with a series of coded shaming or guilt-inducing “messages” from mother to child regarding “inappropriate” crying (Lewis, 1986, p. 327.) The difference between the two phenomena, according to Lewis, is that shame results from the “other’s scorn of the self,” with an associated feeling of helplessness due to the physical reactions which often accompany shame, namely blushing, sweating and tears (Lewis, 1986, p.330). Shame results from a negative appraisal of the self by others and beliefs about how the self is seen by others (Goss, Gilbert and Allan, 1994). Guilt, on the other hand, is a negative appraisal of, “…*things* done or undone in the world…” by the self (Lewis, 1986, p.330). In guilt, therefore, the self is one step removed from the inappropriate action and does not feel helpless to make amends.

Through the described literature, the author determined that there is a link between the way others see the self and the way the self sees the self, and thus made the decision to test for shame and guilt as “symptoms” of a real or perceived stigma against antidepressant users within A.A.. The author expects that if a real or perceived stigma exists, there will be two possible outcomes. Shame will

result from participants' stigmatization that they believe is unjustified, where participants feel confident in their decision to take antidepressant medication and helpless in the negative judgment of their peers. Participants who experience stigma that they believe to be justified will show higher levels of guilt because they believe that they have been acting immorally, or against the general wishes of the A.A. community, and believe that they can take action to rectify the situation if they so desire.

Finally, to bring the study full circle, if the results of the experiment show that the subject group which attends only A.A. meetings has higher levels of shame and/or guilt, the author will hypothesize that attendance of Dual Recovery Anonymous meetings will have lowered the shame and/or guilt levels of the second subject group by removing the stigma of antidepressant medication and openly addressing specific issues facing subjects with mental health issues. The literature on self-help groups will then be reapplied in a discussion of how to cope with multiple stigmatizing illnesses by finding other people who are coping with the same problems, and whether a self-help group is helpful or harmful if it does not address all of the stigmatizing issues facing its members.

This study expects to find that dually diagnosed members of A.A. taking antidepressant medication who attend Dual Recovery Anonymous meetings will experience lower levels of shame and guilt.

Operational Definition of Variables

The following is a list of operational definitions used in this study:

An alcoholic, as defined by the author for the purposes of this study, is a person who habitually abuses alcoholic substances with an inability to control intake. The author would like to note that, for the purposes of this paper, an appropriate definition for an “alcoholic” is rather elusive. Testing a community of self-diagnosed participants does not lend itself very well to a scientific definition of their disease. However, given that participants in this experiment have at least five years of A.A. membership and attend at least three A.A. meetings per week, the author has determined that these participants are “alcoholics.” The disease is defined by the participants’ continued need for a treatment regime.

A recovered alcoholic, as defined by the author for the purposes of this study, is a person whom has maintained sobriety for at least five years.

A dually diagnosed, as defined by the author for the purposes of this study, is a person whom has been diagnosed with both the disease of alcoholism and a co-existing mental disorder.

A mental health disorder, as defined by the author for the purposes of this study, is a mental health diagnosis that requires prescribed antidepressant medication.

Guilt, as explained by Helen Block Lewis, refers to, “a family of affective-cognitive states that shares the themes of responsibility, fault, obligation, and blame for specific events…” that happen when the self is implicated in an occurrence for which it can make restitution (Lewis, 1986, p.329-330).

Shame, as explained by Helen Block Lewis, refers to, “…a family of affection-cognitive states in which embarrassment, mortification, humiliation, feeling ridiculous, chagrin, disgrace, an shyness are among the variants…” that occur when the self experiences the scorn or disapproval of another person (Lewis, 1986, p.329-330.)

Stigma, “…is commonly defined as some characteristic individuals possess (or are believed to possess) that conveys a social identity that is devalued in a particular social context (Crocker, Major, & Steele, 1998)” (Smart & Wegner, 1999, p.474.)

Selection of Subjects

The subjects selected for this case study will be divided into two groups of fifty participants. Each participant will conform to the following five criteria: has one to five years of sobriety as members of A.A.; is between the ages of thirty-five and sixty-five; attends A.A. meetings at least three times a week; is currently taking antidepressant medication for depression, and has been taking this medication for at least eight weeks. In addition

to the aforementioned qualifiers, subjects in the second group also attend Dual Recovery Anonymous meetings at least three times a month.

In choosing an appropriate subject group for this study, the author's primary decision was whether to divide the groups by gender. There are conflicting views on gender difference in experiences of shame and guilt. Lewis asserts that women are more prone to shame and men are more prone to guilt (Lewis, 1986, p.327). Other literature has disproved and even reversed these assertions (Harder and Zalma, 1990; Harder, 1990). The focus of this study, however, is to compare groups of recovering alcoholics who take antidepressant medication. Whether the subjects experience shame or guilt, or both, in response to stigmatization is accounted for by testing for both as dependant variables. The study, therefore, will not discern between male and female participants.

Designing the Experiment

The Personal Survey

The personal survey will be comprised of eight questions intended to ensure uniformity in the subject groups and to provide more specific information about the relevance of the results of the experiment (see Appendix A.) The purpose of each question is described below.

Are you male or female? Participants will first be asked if they are male or female, although the results of

the study will not be analyzed in terms of gender. Each of the two subject groups will contain both men and women. Accommodating for the potential for an extreme disproportion of one gender is the reason for including the gender question in the personal survey.

Are you between the ages of 35 and 65? In order to achieve a degree of homogeneity in the subject group, the author will survey only those members of A.A. who are middle aged. Middle age, or "middle adulthood," is defined as adults between the ages of 35 and 65 (Schiamberg, 1985, p.522.) This group was the author's choice for this study because they are old enough to have achieved five years of sobriety and they comprise over 51% percent of A.A. membership with the average age of an A.A. member being 46 years (The Alcoholics Anonymous 2001 Membership Survey).

Have you achieved over one year of sobriety in Alcoholics Anonymous up to and including the present? Literature has demonstrated an inverse relationship between the potential for relapse of alcoholics and each passing year of sobriety. In a study of predictors of relapse, Jin et al., found that, "…hazard of relapse was higher in the first 5 year of follow-up (3.8% annually) than in the next 6 years (2.6% annually)…" (1998.) The first 5 years appears to be the time for abstinent alcoholics to build the foundation of their recovering program. Thus, the author will study alcoholics with one to five years of sobriety.

Are you currently taking antidepressant medication? This question ascertains whether the subject is an appropriate subject for the study.

What antidepressant medication are you taking? This question will ensure that the participants are taking a prescribed pharmaceutical antidepressant rather than a homeopathic substitute such as Sam-E or St. John's Wort.

How long have you taken this medication? In regards to the length of time that subjects have taken antidepressant medication, the author has determined that at least eight straight weeks of medication will be required for inclusion in the experiment. The National Institute for Mental Health Medications Booklet suggests that 6 months to 1 year is an outside time limit for antidepressant medication to, "…be effective and to prevent a relapse of the depression once the patient is responding…" (National Institute of Mental, 2002, p.7; National Institute of Mental Health website.) However, the booklet adds that medication should be working within the first 6-8 weeks, and the patient usage literature accompanying most of the newer antidepressants (i.e. those developed in the last three years) also indicates that medication should be working within 6-8 weeks. By testing for depression and removing the participants with high levels of depression from the result set, the author intends to exclude people whose medication isn't working which might, in turn, effect the subjects' experience of shame and/or guilt.

What medication are you taking and what is your daily dosage? This is to be sure that the medication the participant is taking falls under the category of an antidepressant and not some other category for medical treatment.

On average, how many times per week do you attend Alcoholics Anonymous meetings? For inclusion in the survey, the subject's response must be three or more meetings per week. The author has determined that attending three, or more, meetings per week indicates that the subject is a fully participating member of A.A..

Do you attend Dual Recovery Anonymous meetings? The answer to this question determines to which cohort the subject's test results will belong.

If yes, how many times per month do you attend Dual Recovery Anonymous meetings? The author has determined that there is at least one meeting available per week in the geographic area of the experiment. In order for the two subject groups to be adequately dissimilar, the subjects in the second group must attend at least three meetings per month of Dual Recovery Anonymous to be considered recovering through both programs of AA and DRA.

What is your home address zip code? This question will ensure that participants live inside the Los Angeles area, and that they have access to A.A. meetings and Dual Recovery Anonymous meetings within a specific area.

The Questionnaire

The questionnaire will consist of three parts: the Beck Depression Inventory-II, Harder and Zalma's Personal Feelings Questionnaire 2, and the author's modification of the Personal Feelings Questionnaire 2 which explores the subjects' feelings of shame and guilt specifically in the context of A.A. meetings.

Beck Depression Inventory—II

The Beck Depression Inventory—II is a 21-item questionnaire designed to evaluate depression and provide a participant's "depression score" ranging from 0 to 63, with 63 being the highest level of depression. The Beck Depression Inventory was first published in 1967 and has since been updated several times, most recently in 1996 with the publishing of the Beck Depression Inventory—II. It is widely accepted as a diagnostic tool for measuring depression and has been used in over 2000 studies (Barroso, Sandelowski, 2001, p.493). As noted in the research expectations section of this chapter, the Beck Depression Inventory—II has been used as an instrument to test the validity of several shame scales by providing a reliable and valid depression score (Harder and Zalma, 1990; Harder, Cutler, Rockart, 1992; Rybak and Brown, 1996).

In choosing a depression scale, the author was faced with the notoriously difficult task of finding an appropriate measure for the complex entity of “depression.” The author chose from several depression scales, including the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960), the Zung Self-Rating Scale (ZSRS; Zung, 1965), and the Beck Depression Inventory-II (herein referred to as BDI-II; Beck, Steer, & Brown, 1996). The author’s decision to use the BDI-II was based on reliability and validity test results comparing the three scales, on the specific type of depression that the scale purported to test for, and on the fact that the Beck scale had been updated within the last ten years to accommodate for, “…the diagnostic criteria for major depressive disorders (MDD) that are described in the American Psychiatric Association’s (1994) *Diagnostic and statistical Manual of Mental disorders, Fourth Edition* (DSM-IV)” (Steer, Ball, Ranieri and Beck, 1999).

There are two main problems with choosing a depression scale. Firstly, each scale may test for a different variation of depression, and, secondly, there are different methods of data collection (Lambert, Hatch, Kingston, and Edwards, 1986). The field of depression research is vast, and the methods for testing levels of depression are somewhat obtuse. Unlike a visible infection that can be seen to respond to certain treatment, depression is affected by myriad variables. Even the three main depression scales that have been tested and re-tested over the past forty years are

not considered to be all encompassing, primarily because the scientific definitions and variations on depression are continually changing. The author, therefore, determined that since the depression scale is being used solely for the purpose of defining the experiment's population, and not to collect data regarding the depression of the subjects, the choice of scale should reflect the frequency with which it is used in shame and guilt experiments.

The purpose of administering the Beck Depression Inventory—II is to identify and eliminate participants who show high scores on the questionnaire because their score may indicate that the participant's antidepressant medication is not working. Participants who are unresponsive to medication will be removed in order to control for higher shame and/or guilt levels due to unsuccessfully treated depression rather than the absence of Dual Recovery Anonymous meetings. That said, it is also important not to remove participants who show mild depression, as depression is associated with shame and guilt, which we are ultimately testing for.

Secondly, group scores on the Beck Depression Inventory—II can be regarded as further evidence of similarity or difference between the two subject groups. Although this study does not intend to analyze the results of the Beck Depression Inventory—II, it may be of further interest to the study if differences in the resulting shame

levels coincide with differences in the resulting depression levels between the two groups.

Harder and Zalma's Personal Feelings Questionnaire 2

The Personal Feelings Questionnaire 2 is a 22-item questionnaire divided into ten items scored for shame, six items scored for guilt and six neutral items that are not scored. Items are best described as "feelings" that include "embarrassed," "feeling helpless," and "self-conscious." Subjects are asked to rate "how common" the item is for them on a scale of 0-4 points with 0 indicating that "you never experience the feeling" and 4 denoting that "you experience the feeling continuously or almost continuously" (Harder and Zalma, 1992).

In choosing an appropriate measuring tool for shame and guilt, the author considered Cook's Internalized Shame Scale, Tangney's Self-Conscious Affect and Attribution Inventory (1990), the Hoblitzelle Adapted Shame and Guilt Scale (1982), and Harder and Zalma's Personal Feelings Questionnaire 2 (1992).

Although Cook's Internalized Shame Scale has repeatedly proven to be a valid and well-accepted test for shame, it is self-described as testing for trait shame where, "…[traits] are defined as comparatively enduring and generalized feelings…" (Rybak and Brown, 1996; Internalized Shame Scale Technical Manual, 2001, p.20). The present study, however, is testing for emotions that have arisen out of an immediate

and specific stigma based on the subject's decision to take antidepressant medication, therefore the Internalized Shame Scale was not considered to be an optimal scale. Furthermore, the Internalized Shame Scale only tests for shame. The debate over whether shame and guilt are the same emotion, subsets of each other, or entirely separate emotions has not yet been resolved, and thus the author determined that the scale used for this study should test for both emotions. Therefore, the Internalized Shame Scale was discarded as an option.

Tangney's Self-Conscious Affect and Attribution Inventory was discarded as an option once the subject group for this study was decided to be "middle-aged." As described by the author of the scale, June Price Tangney, "[the] Self-Conscious Affect and Attribution Inventory (SCAAI) was developed to assess characteristic affective, cognitive and behavioral responses associated with shame and guilt among a young adult population…" specifically college-aged subjects (Tangney, 1990, p.102.) The inventory is comprised of items that describe a typical event in a college student's day and asks the subjects to rate how they would respond to that situation. The described events do not apply to a middle-aged population that is not currently attending college, so the Self-Conscious Affect and Attribution Inventory was deemed an inadequate measuring tool for this study.

The Adapted Shame/Guilt Scale, designed by Wendy Hoblitzelle, is comprised of a list of 30 adjectives,

divided into 3 categories of “shame,” “guilt” or “filler.” Subjects are asked to rate how well each adjective describes them on a scale of 1-7. The Adapted Shame/Guilt Scale is similar to Harder and Zalma’s Personal Feelings Questionnaire 2, both in approach (Lewis, 1987, p. 233) and with the evident influence of Helen Block Lewis. H. Lewis worked with Hoblitzelle on developing the Adapted Shame/Guilt Scale and subsequently published Hoblitzelle’s findings in her book, *The Role of Shame in Symptom Formation*. H. Lewis also published David Harder’s work with Susan Lewis entitled *The Assessment of Shame and Guilt* in the same book.

In deciding whether to use the Adapted Shame/Guilt Scale, the author looked at the results of a comparison of the Adapted Shame/Guilt Scale and the Personal Feelings Questionnaire 2 in which the Adapted Shame/Guilt Scale was modified by removing 6 unsuccessful items based on Hoblitzelle’s 1982 factor analyses of the scale (Harder and Zalma, 1990). The comparison study found that, “…ASGS Shame correlations appeared marginally more valid with 11 external construct variables than PFQ2 Shame, whereas PFQ2 Guilt was clearly more valid than its corresponding ASGS subscale…” (Harder and Zalma, 1990). In finding that the Adapted Shame/Guilt Scale’s subscale for guilt was far less valid than the Personal Feelings Questionnaire 2’s subscale for guilt, even when the Adapted Shame/Guilt Scale had been

modified for optimum validity, the author decided not to use the Adapted Shame/Guilt Scale.

The Personal Feelings Questionnaire 2 was the final option researched for this paper. Literature comparing different shame and guilt scales found that the Personal Feelings Questionnaire 2 was repeatedly found to be a valid test for shame and guilt (Gilbert & Miles, 2000). The Personal Feelings Questionnaire 2 was also found to be a more quickly administered and easier to understand questionnaire than others (Harder and Zalma, 1990, p.741). These factors made the Personal Feelings Questionnaire 2 a top choice in this experiment because the length of the entire questionnaire is already a sizable time commitment, and the subjects are from varied backgrounds with different levels of education so the questionnaire needed to be accessible to all participants. The Personal Feelings Questionnaire 2 also lends itself to adaptation by the author, which was a final deciding factor (see below).

The Author's Modification of the Personal Feelings Questionnaire 2

By adding the phrase "in A.A." to each item of Harder and Zalma's Personal Feelings Questionnaire 2, the author intends to gather information about the subject's experience of shame and guilt within the context of A.A. meetings (see Appendix C.) The scores of this last part of the questionnaire will be compared to the shame and guilt scores

from the Personal Feelings Questionnaire 2 for further and more specific information about the source of the participant's shame and/or guilt.

Administering the Questionnaire

The subjects will be recruited by handing out flyers at different meetings of both A.A. and Dual Recovery Anonymous within the Los Angeles area, placing advertisements on-line, and in the classified section of the Los Angeles Times (see Appendix B.) Flyers will also be mailed out to local centers that offer both Dual Recovery Anonymous meetings and A.A. meetings in their facility. The flyer will advertise the web site of www.aawebsurvey.com for participants to go to. The flyer will give out the information profile for those that are appropriate participants for a research study being done for a scientific study.

The participant will respond to the advertisement by clicking on the survey link, or going to www.aawebsurvey.com. Both links take them to the first page of the survey, which is also the consent form.

After reading the consent form on the first page of the study, the participants will click "yes" or "no" to indicate whether they have understood the information given regarding the purpose of the study and consent to participating. Only participants who click "yes" will continue through to the next page, which is the personal survey.

The first and last page of the survey provide an email contact address for the author and the date that the study results will be available should the participants want to receive a copy of the results of the study. The contact email address will remain open for at least 6 months following the conclusion of the experiment. The last page of the survey also includes a reminder for participants to remove the "history" of Internet websites visited. This reminder serves to protect the subjects from having their anonymity revealed, per the author's Ethics Committee Application (see Appendix D.)

Sample Size Justification

The sample size and power calculations were carried out using the PASS 2002 software (PASS 2002 Release: May 2, 2002, NCSS Statistical Software, Kaysville, Utah). The sample size was chosen based on the detection of a statistically significant difference in the primary outcome measures of the primary aims of the study. These measures were: 1) Shame score, and 2) Guilt score. These scores are described in detail in chapter 3.

The primary research question to be answered by this study was: Is there a difference in the amount of shame or guilt between subjects in the group that attends A.A. meetings compared to subjects in the group that attends

both A.A. meetings and Dual Recovery Anonymous meetings. The null and alternative hypotheses are:

H0: There is no difference in the amount of shame or guilt between the two groups.

HA: There is a difference in the levels of shame and guilt between the two groups.

A two-sample t-test was used to compare the distribution of shame and guilt scores between the two groups. According to Cohen, small, medium and large effect sizes for a two-sample t-test are: d=0.2; d=0.5, and d=0.8 respectively (Statistical Power Analysis for the Behavioral Science, 1988, Cohen).

The pilot data showed that the average Shame score was 29.7 versus 26.2 for those who did and did not attend the Dual Recovery Anonymous meetings respectively, and the pooled standard deviation was 17.2. This corresponds to an effect size of 0.20. The average Guilt score was 18.7 versus 15.5 for those who did and did not attend Dual Recovery Anonymous respectively, and the pooled standard deviation was 10.1. This corresponds to an effect size of 0.32.

Group sample sizes of 100 and 100 achieve 80% power to detect an effect size of 0.4 with a significance level (alpha) of 0.05 using a two-sided two-sample t-test. Therefore, this study will have adequate power to detect a

small to medium effect size for the primary hypothesis test.

Since the purpose of the study was to determine if attending Dual Recovery Anonymous meetings altered shame and guilt levels, the two subject groups were compared using an independent random sample t-test on 4 sets of results: shame levels “in day to day life,” shame levels “in A.A.” only, and guilt levels “in day to day life” and guilt levels “in A.A.” only.

Further Implications Of The Pilot Study

One change was made from the pilot study questionnaire to the final questionnaire regarding the wording in the personal survey on questions 8 and 10. Instead of asking respondents whether they attend “1-2 meetings per week, 2-3 meetings per week,” etc., respondents were asked whether they attended “1 meeting per week, 2 meetings per week,” and so on. This change reflected a desire to measure the exact number of meetings attended rather than a range of the number of meetings attended. This choice was also made to give more specific data for analysis of the number of meetings attended as a possible variable to be studied.

Methodological Assumptions and Limitations

Due to the complexity of the subject matter of this experiment, there are several limitations that will be

addressed here. Firstly, it is expected that there will be differences in the subjects' severity of alcoholism, differences in the effectiveness of their medication, and differences in their overall mental health disorders. The author will attempt to control for these differences by removing subjects whose depression levels are high so that the result set will include only those subjects whose medication is working.

Secondly, this study does not address personal problems that may be occurring in the subjects' lives at the time of the experiment. For example, a subject's unemployment or illness might cause a degree of shame and/or guilt that isn't related to a stigma against antidepressant medication. Testing for shame and guilt specifically "in A.A." is aimed at controlling for this potential confound.

Thirdly, this study does not address whether subjects who do not attend DRA meetings are getting support from alternate social support resources, such as individual therapy, or group therapy, which might lower their shame and/or guilt levels around the stigma of taking antidepressant medication in A.A.

Fourthly, there is variation in the demographic characteristics, atmosphere and underlying beliefs between A.A. meetings. While the overall intention of the A.A. meeting is to provide support to the alcoholic by following the 12 Steps, there are degrees of difference within meetings. For example, some meetings are "designated as

“women-only,” while other meetings are for “homosexuals only,” or “men only.” This study will not control for differences between these meetings, but by drawing from a large random self-selecting subject group the author intends to measure general levels of shame and guilt among A.A. members.

Lastly, the limitation of web recruitment may affect the results of this study. In the interest of anonymity, there is no way to control for repeat participants, or for participants who have discussed the study with other A.A. members before participating (Rychtarik et al., 2000). However, the web recruitment method does allow for a wider selection of A.A. members to participate in the study that makes it the optimal method for gathering subjects for this experiment. There is also the consideration that the study does not control for the type A.A. or DRA member who uses a computer, compared to members who don’t have access to a computer.

CHAPTER FOUR

Research Findings

Overview

The study examined shame and guilt levels of members of Alcoholics Anonymous who, in addition to issues about alcohol dependence, have been diagnosed with depression and are taking antidepressant medication for the depression. These subjects were categorized into two groups: members of A.A. who regularly attend Dual Recovery Anonymous meetings in addition to A.A., and members of A.A. who only attend A.A. meetings.

Subjects responded to newspaper advertisements, fliers handed out at A.A. and DRA meetings, or Internet advertisements (see Appendix B) that directed participants to the web address www.aawebsurvey.com. Once at the website, subjects answered a series of personal questions, followed by the Beck Depression Inventory-II, herein referred to as the BDI-II (Beck, 1996), Harder and Zalma's Personal Feelings Questionnaire 2, herein referred to as the PFQ2 (Harder and Zalma, 1990), and the author's amended version of Harder and Zalma's Personal Feelings Questionnaire 2, herein referred to as the PFQ2 "in A.A." Two versions of this questionnaire were used. The first PFQ2 seeks to measure the shame and guilt "in day to day life." The PFQ2 "in A.A." measured subjects' shame and

guilt specifically with reference to their feelings while participating “in meetings of Alcoholics Anonymous” (see Appendix C.)

Over a 6 month period, 117 members of A.A. responded to the survey. Of those 117 people, 28 people were removed from the subject pool due to incomplete surveys, or if their personal survey answers excluded them because they did not meet the criteria for subject inclusion. For example, if they answered the survey but were not taking a pharmaceutical antidepressant medication they were removed from the subject pool. The 89 remaining subjects, all of whom were suffering from depression and where taking antidepressant medications, were divided into two groups for comparison; 44 members of A.A., herein referred to as AA subjects, and the 45 members of AA who *also* attend DRA, herein referred to as AA/DRA subjects.

The 2 subject groups were compared in terms of their depression levels, shame levels both “in day to day life” and “in A.A.” meetings, and guilt levels both “in day to day life” and “in A.A.” meetings.

Many A.A. groups react negatively to those members who are taking medication for mental health problems such as depression. The anticipation was that a stigma against the use of antidepressant medications might exist in many A.A. groups, and would lead to higher shame and guilt levels among this subgroup. Further, it was believed that the

AA/DRA subject group would demonstrate lower shame and guilt levels than the AA subject group because DRA meetings directly address and support the use of antidepressant medication among recovering alcoholics.

Findings

The primary research question to be answered by this study was: Is there a difference in the amount of shame or guilt between dual diagnosed subjects attending only A.A. meetings compared to subjects in the AA/DRA group? The null and alternative hypotheses are:

H0: There is no statistically significant difference in the amount of shame or guilt between the two subject groups.

HA: There are significantly lower levels of shame and guilt in the AA/DRA group compared to the AA group.

A two-sample t-test was used to compare the distribution of shame and guilt scores between the two groups. The level of significance was set at the .05 level for a two-tail test.

Since the purpose of the study was to determine if attending DRA meetings altered shame and guilt levels, the two subject groups were compared using an independent random sample t-test on four sets of results:

1. The levels of shame “in day to day life” found in each subject group.

2. The levels of guilt “in day to day life” found in each subject group.

3. The levels of shame “in A.A.” found in each subject group.

4. The levels of guilt “in A.A.” found in each subject group.

Scale Analysis

To determine if the items representing Zalma and Harder’s (1990) Personal Feelings Questionnaire 2 served as reliable measures of shame and guilt, a set of reliability analyses using Chronbach’s alpha reliability coefficient as the statistics were run on each of the items comprising the shame and guilt measures respectively. Analyses were run separately for shame and guilt “in day to day life” and shame and guilt “in A.A.” The analyses revealed that the scales for shame and guilt are reliability (alpha= .90 for shame “in day to day life,” .87 for guilt “in day to day life,” .92 for shame “in A.A.” and .88 for guilt “in A.A.”)

T-test Comparisons Using Shame and Guilt Scales

A set of t-tests were conducted to determine if AA/DRA subjects differed from AA subjects in the levels of shame and guilt they experience “in day to day life” and “in A.A.”

A t-test on shame “in day to day life” revealed that both groups of individuals experience relatively high levels of shame (*M*=3.6 for the AA/DRA group versus *M*=3.7 for the AA group on a 0-4 point scale where 4 indicates that the feeling is experienced continuously or almost continuously). However, the groups did not differ significantly in the levels of shame they experienced.

A t-test on guilt “in day to day life” also revealed that both groups experience high levels of guilt (*M* =3.4 for the AA/DRA group versus *M* = 3.6 group on a 0-4 point scale where 4 indicates that the feeling is experienced continuously or almost continuously). Again, however, the groups did not differ significantly in the level of guilt they experienced.

To determine whether the two groups differed in shame and guilt levels while “in A.A.”, two additional t-tests were conducted. As shown in Table 4.1, individuals who attend both AA and DRA experienced less shame (*M* =3.50 for the AA/DRA group versus *M* = 3.8 on a 0-4 point scale where 4 indicates that the feeling is experienced continuously

or almost continuously.) These results are consistent with HA but do not support it statistically.

As with shame levels “in A.A.,” the AA/DRA subjects experience less guilt (*M* =3.6 for the AA/DRA “in A.A.” vs. the AA group *M*=3.90 on a 0-4 point scale where 4 indicates that the feeling is experienced continuously or almost continuously.) Again, however, the difference was only consistent with HA and did not achieve statistical significance (t=2.38, p=. 13.)

Table 4.1.

Mean Differences in Shame and Guilt for Individuals Attending A.A. and DRA Compared to Those Attending A.A. Alone

Dependent Variable	Mean: People who attend A.A. and DRA	Mean: People who Attend A.A. Alone	t	p
Shame in Day to Day	3.6	3.7	0.02	0.9
Guilt in Day to Day	3.4	3.6	0.48	0.49
Shame in A.A. (using full scale)	3.5	3.8	2.24	0.14
Guilt in A.A.	3.6	3.9	2.38	0.13
Shame in A.A. (using 7 item-scale)	3.3	3.8	4.39	0.04

Items measured on a 0 to 4 scale where 0=never experience the feeling and 4= experience the feeling continuously or almost continuously

A set of factor analyses was also conducted on the shame and guilt scales. Consistent with prior research, it was found that the items indicating guilt “in day to day life” loaded on a single factor. The same was true for guilt “in A.A.” and shame “in day to day life.” However, the shame “in A.A.” scale revealed 2 separate factors. One factor was comprised of items “embarrassment”, “feeling ridiculous,” “self-consciousness,” “feeling humiliated,” “feeling stupid,” “feeling helpless/paralyzed,” and “feeling disgusting to others.” The second was comprised of the items “feeling childish,” “feelings of blushing,” and “feeling laughable.” The first factor seems to clearly reflect shame. The second may represent something akin to self-consciousness, but not necessarily shame. The results are summarized in Table 4.2 and 4.2a.

A new scale was computed (P=. 90) using the 7 items above that seem to indicate shame. A t-test comparison of scores on this scale showed a significant difference between the AA/DRA subject group, on the one hand, and the AA subject group on the other in the level of shame they experience while “in A.A.” ($t=4.39$, $p< .05$). Mean comparison showed that the AA/DRA subject group experience significantly lower levels of shame when “in A.A.” (mean=3.34) compared to the AA subject group (mean=3.78). These results support HA.

A t-test analysis was also conducted to determine whether the AA/DRA subject group differs from the AA subject group in depression levels. Using the BDI-II as the scale (alpha= .05) it was found that the AA/DRA subject group did suffer from somewhat higher levels of depression (*M* = 1.50) than the AA subject group (*M* =1.36.) These differences were not statistically significant (t=2.08, p=. 15); although they indicate directionally that AA subjects experience lower levels of depression than AA/DRA subjects.

Table 4.2a

Factor Analysis of Items Indicating Shame in A.A.: Rotated Component Matrix (a)

	Component	
	1	2
Embarrassment	.888	.247
Feeling humiliated	.871	.203
Self-consciousness	.812	.049
Feeling ridiculous	.802	.425
Feeling “stupid”	.739	.419
Feeling helpless, paralyzed	.639	.473
Feeling “childish”	.173	.866
Feeling laughable	.153	.811
Feelings of blushing	.330	.669

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization a Rotation converged in 3 iterations.

Exploratory Analyses

Although the above analyses report on mean differences for scales of shame and guilt (and depression), a set of additional exploratory (t-test) analyses were conducted to determine if the two groups differed on any of the items representing these various scales. The study examined all of the items in the PFQ2 and the PFQ2 “in A.A.,” even those not designed to indicate shame or guilt (i.e. rage, euphoria,

depression, disgust to others, sadness, mild happiness, enjoyment). The results for those variables for which significant differences were observed between the two groups are reported in Table 4.3.

The results show that AA/DRA subjects are more psychologically buffered than AA subjects. Specifically, AA/DRA subjects feel less “embarrassment” and more “euphoria” than AA subjects in “day to day life.” The results also show that AA/DRA subjects reported less “mild guilt,” less “self-consciousness,” fewer “feelings of humiliation,” less “intense guilt,” more “euphoria,” less “depression,” less “rage,” and less “disgust to others” than AA subjects while in A.A. meetings. It was previously expected that the two subject groups would differ in shame and guilt experienced both “in day to day life” and “in A.A.” The results show differences only in shame levels while attending A.A. meetings.

The items representing the BDI-II were also examined to determine if there were differences between the two groups. As shown in Table 4.3, significant differences were observed for 4 of the 21 BDI items. Consistent with the idea that attending DRA lowers shame and guilt, it was observed that AA/DRA subjects feel less “past failure,” experience fewer “suicidal thoughts,” and have more “interest in sex” than AA subjects.

Table 4.3

Items from the BDI-II, PFQ2 and PFQ2 "in A.A." that show a statistically significant difference between the two subject groups

Dependent Variable	Mean: Attends Dual Diagnosis	Mean: Does not Attend	T	p
Past Failure (BDI-II)	1.45	1.73	3.29	0.07
Suicidal Thoughts (BDI-II)	1.09	1.29	5.09	0.026
Loss of Energy (BDI-II)	1.25	1.51	3.94	0.05
Loss of Interest in Sex (BDI-II)	1.36	1.78	7.55	0.007
Embarrassment (PFQ2 v1)	3.39	3.73	3.8	0.05
Euphoria (PFQ2 v1)	4.11	3.76	3.15	0.08
Embarrassment (PFQ2 v2)	3.2	3.71	5.05	0.03
Mild Guilt (PFQ2 v2)	3.25	3.67	3.49	0.06
Self Consciousness (PFQ2 v2)	2.66	3.24	6.49	0.01
Humiliation (PFQ2 v2)	3.18	4.07	13.36	0.001
Intense Guilt (PFQ2 v2)	3.57	4.04	3.69	0.06
Euphoria (PFQ2 v2)	4.09	3.62	4.33	0.04
Depression (PFQ2 v2)	3.09	3.6	4.03	0.05
Rage (PFQ2 v2)	3.27	3.82	5.35	0.02
Disgust to Others (PFQ2 v2)	3.32	3.98	7.23	0.009

Conclusion

Overall, when comparing the amount of shame and guilt experienced by AA subjects and AA/DRA subjects, the results of the survey did not show statistically significant differences. When scale items were looked at individually, the results showed conclusive differences between the two subject groups. These results are consistent with the author’s hypothesis that attending DRA meetings in addition to A.A. meetings has a positive impact on the AA/DRA subjects’ emotional well-being.

CHAPTER FIVE

Conclusions, Discussion and Future Research

Summary

Currently close to 14 million adults in the United States have alcohol abuse or dependency problems (National Institute on Alcohol Abuse and Alcoholism, 2001.) Alcoholics Anonymous (herein referred to as A.A.) remains the dominant support group for treating alcoholics, dually diagnosed and otherwise. As early as 1957, the medical community was building a case for better access to more information on members of A.A. (Trice, 1957, p. 40).

Given its importance in the field of recovery, it is curious that scientific data to understand why, how, if and for whom the 12 Step program works is quite limited. Due to the nature of the organization, the barriers to getting a complete and reliable set of data were already the lament of scientists interested in studying more about recovery from alcoholism (Trice, 1956, p. 53). Therefore, scientists have had to consolidate what is known about A.A. in order to paint a picture of the community as a whole, the individuals who participate in it, and the philosophy that these individuals adhere to as members.

Strenuous arguments have been made for investigating the treatment approach of A.A., given its rapidly increasing power base as the representative voice for all alcoholics in terms of political and social lobbying, and in terms of its

impact on medical advancement in the understanding of how best to treat the disease of alcoholism (Tournier, 1979, p. 230). The fear of one early researcher, Robert Tournier, was that A.A.'s domination of the field of recovery would handicap the development of other methods of treatment (Tournier, 1979, p. 231).

Today, we continue to face the problem of understanding treatment efficacy of A.A., particularly with respect to a specific group of alcoholics, the dually diagnosed, namely those diagnosed with both alcoholism and clinical depression. The lack of research on recovering alcoholics in A.A. with dual diagnosis has left substance abuse treatment professionals, medical professionals and psychiatrists vulnerable to the ongoing dilemma of what paradigm best treats the client with a dual diagnosis of alcoholism and clinical depression. Laudet, Magura, et al suggest that, "…[it] is important to ascertain what challenges dually diagnosed clients struggle with at various points in their recovery process, and to address these issues in an integrated way in order to promote joint recovery from substance abuse and mental disorders" (Laudet, Magura, Vogel, Knight, 2000, p. 327).

Unfortunately, past and current research available shows that "… [to] date, we know little about the aspects of support that are protective and the mechanisms and conditions that make support attempts beneficial or harmful" (Rook, 1984, p. 416). The author's intention with this study

was to provide insight into and further information regarding treatment options for the dually diagnosed.

Author's Findings

In light of our limited knowledge of what type of treatment program is most effective for a dual diagnosis, this study was designed to determine whether dually diagnosed individuals who attend A.A. differ in their levels of shame and guilt in A.A. meetings and in day to day life compared to individuals who attend both A.A. and DRA. As described in chapter two, DRA is a self-help program that using the same 12 steps as A.A. but also provides help to individuals who suffer from a dual diagnosis. DRA strives to create a safe environment for individuals to share their problems with substance abuse and mental illness. Medication use is addressed openly in DRA and accepted as a necessary component for the recovering alcoholic who suffers from clinical depression and other biochemical disorders. The hypothesis of this paper proposed that subjects who addressed their dual disorder of alcoholism and depression by attending both A.A. meetings and DRA meetings would experience less shame and guilt than those who are dually diagnosed and go to only A.A. meetings.

Whereas past research focused on the extent to which an individual's well being is affected by social support, this study sought to identify important mechanisms—cognitive and emotional experiences—that may demonstrate the presence of

shame and guilt feelings within A.A. meetings and day to day living for dually diagnosed subjects. Further, this study broadened the focus of past research done on the effects of A.A. as a social support group, as well as the need for the extra buffering effects of DRA.

The results of this study showed statistically significant differences between those subjects who attended A.A. alone and those who attended A.A. and DRA. Specifically, AA/DRA subjects felt “less embarrassment” and “more euphoria” than AA subjects in day to day life. AA/DRA subjects also reported significantly “less mild guilt”, “less self-consciousness”, “fewer feelings of humiliation,” “less intense guilt,” “more euphoria,” “less depression,” “less rage,” and “less disgust to others,” than AA subjects while in A.A. meetings.

Although there has been much research on the subject of guilt, this study found no statistical significance within this test group of subjects on differences in levels of guilt in A.A. meetings or day to day living. The author is therefore only able to comment on the variables of shame and depression as they apply to the population of dually diagnosed subjects.

While statistical significance was observed between the two groups on the variables noted above, other variables were not significant. One reason for lower magnitude of differences between the two groups could lie in the fact that the present design accounted for medication as the

treatment variable for depression but did not control for multiple treatment influences on outcome. In reality, some subjects might participate in several treatment programs (i.e., individual, group and family psychotherapy; vocational rehabilitation; social skills training, etc.), may experience buffering effects similar to those experienced in DRA. Thus, multiple treatments in addition to medication could account for the lack of significant statistical differences observed between the two groups.

Implications

Although only a portion of this study's findings proved to be statistically significant, some of the findings of the present research have important implications for support group research and future treatment for the dually diagnosed recovering alcoholic.

First, the results support the importance of considering the social climate of the meetings of A.A. It is reported that some A.A. members may interfere with the treatment of mental health disorders by encouraging dually diagnosed members of A.A. to discontinue use of their medication (Rychtarik, et al, 2000; The A.A. Member-Medications and Other Drugs, 1984; Ortman, 2001, p. 178, Galiaif and Sussman, 1995, Dual Diagnosis Anonymous Worldwide, Inc., n.d., Vogel et al., 1998, p. 358). Dually diagnosed members of A.A. receive these negative messages about medication use from other members who "…are suspicious

of anyone using mood-altering drugs, even if they are prescribed, because of the havoc that alcohol and drugs has unleashed in their lives" (Ortman, 2001, p. 178).

The current study demonstrates that A.A. meetings may have direct harmful effects on a dually diagnosed person's well being. Research on the buffering effect of support groups shows that greater psychological well-being is reported when disclosure is met with feelings of support and understanding by other members of the same group. "Increasing the supportiveness of individuals' social environments is becoming a central focus in the prevention of pathology and the promotion of personal well being" (Mitchell, Billings & Moos, 1983, p. 77).

Second, the results of this study support the idea that negative social interactions have more potent effects on shame levels than positive social interactions. For the purposes of this study, we can then conclude that dually diagnosed A.A. members who attend DRA meetings are buffered against perceived stigma or discrimination of medication use, while those who only attend A.A. meetings are not. It is likely that an A.A. member who feels they have to conceal their medication use in A.A. meetings will experience shame, and it is likely that public rejection of medication use in A.A. meetings fuels shame as well.

The importance of realizing the impact of negative social interaction in Lewis' (1987) research is highlighted by linking shame and depression. If members of A.A. who

suffer from depression are shamed for their use of antidepressant medication, then they are at risk for exacerbating one of their primary disorders-something that can have multiple negative outcomes for a dually diagnosed individual.

Given that many dually diagnosed individuals attend meetings of A.A., it is necessary to assess for social rejection, real or perceived, within A.A. meetings. Studies of this nature will broaden the scope of knowledge about potentially harmful effects of social support groups that stigmatizes against subsets of its members.

In order for other methods of treatment to be considered by newly dually diagnosed patients, hospitals and recovering institutions will need to provide supportive environments for dually diagnosed alcoholics in addition to A.A. meetings. This additional support would be achieved if DRA meetings were organized along with the usual A.A. meetings during 28-day programs, and outpatient programs offering DRA meeting directories and literature to patients, as is standard practice to avail patients with directories and literature for A.A. The well being of dually diagnosed people may depend on these institutions normalizing DRA as a support group to the same degree that A.A. already is.

Strengths and Limitations

This study offers several strengths. The first, and perhaps most important, is revealed in highlighting the

profound importance of incorporating an expanded treatment program for the dually diagnosed person who needs integrated social support for comorbid disorders.

Second, this study reveals possible harmful direct effects of stigmatization that a social support group can have on its members. It also provides limited evidence that going to DRA meetings is associated with increased well-being for the medicated A.A. member. Alternatively, this study provides evidence that A.A. meetings decrease well-being for this same population. This is important information for relapse prevention and for opening the doors to other support groups for a more comprehensive treatment of the dually diagnosed alcoholic. Despite these strengths, generalization of this study's results must be made with caution as several limitations merit consideration.

First, online sampling of respondents who own a computer, or have access to one, eliminates a large portion of the population of dually diagnosed who are living in sober living houses, half way houses, or other facilities where internet access is not available. Therefore, the population of dually diagnosed that we are sampling may be more socially stable than other treatment populations of the same kind.

This analysis may also be biased toward higher socio-economic and educated subjects. "Research comparing multiple functions of support has found associations between support and well being for some functions but not others, depending

on the population and the situation" (Cohen & Syme, 1985, p. 17). Surveying A.A. members without Internet access, and/or A.A. members from outside the greater Los Angeles area may provide more generalized information on the shame and guilt experience of dually diagnosed A.A. members. Future qualitative studies could also be help to illuminate some of the more elusive conceptual issues not captured by the quantitative approach utilized in this paper.

A second limitation of this study was that results were based on self-reported data. A major limitation of self-report data is memory biases. Unlike many studies that require participants to think back over long periods of time, the participants are attending meetings regularly and can frame their answers within a day or two of memory recall, which should have reduced much of the memory bias associated with self-report measures. However, mood and other factors may bias participants reporting on internal experiences. As there was no way to control for how soon a subject was taking the online survey after going to a meeting, memory bias may have affected the results of this study.

Third, this research was conducted with subjects who possess a concealable stigma. The population of clinically depressed A.A. members who are taking antidepressants can only be identified through self-report; therefore it is impossible to conclude that this sample represents all dually diagnosed A.A. members. This study can only comment

on the sub-population of people who identify themselves as dually diagnosed and taking antidepressant medication and who are willing to participate in this study. This sub-population may be comprised of people who are most comfortable with their diagnoses, most involved in the A.A. community, or who are most amenable to research.

Fourth, A.A. has been available to the public for over 50 years and offers over 3000 meetings per week in the Los Angeles area alone. DRA is a much younger organization and currently offers, at best, 30 meetings per week in the Los Angeles area. This fact may be a very significant limitation. A future study comparing two support groups that offer comparable numbers of meetings would control for internal validity on this variable.

Finally, this study limited its population to A.A. members in the Los Angeles area only. This choice was made to remove confounds associated with differences between geographic regions. Future studies should consider expanding the sample selection to include a cross-section of participants in urban and non-urban settings to increase external validity, provide more diversity in demographic characteristics, and generalize to all A.A. meetings.

Conclusions and Future Research

This study examined the social and psychological ramifications of affiliation with A.A. and DRA. Evidence revealed that dually diagnosed individuals who attend only

A.A. meetings are not experiencing meetings as a shame-free atmosphere in which to freely admit and discuss their need to treat depression pharmaceutically with antidepressant medication. In addition to inherent differences in shame levels, this study found differences in levels of depression between the two subject groups even while medicated. Perhaps AA/DRA members are suffering with their depression in a different way than those who only go to A.A., and subsequently feel driven to seek out more support. Again, qualitative study through interviews with subjects at a more in-depth level around their experience of their depression would enhance future studies.

This study provides evidence that dually diagnosed individuals who attend DRA meetings receive the kind of support that enables members to dismiss the negative evaluation of A.A. members who stigmatize against antidepressant medication users.

In conclusion, the author recommends that future research on support groups examine all possible characteristics of the recovering dually diagnosed. Further, the author hopes that the respective scientific studies of alcohol addiction and mental illness will find a way to cooperate in researching the combined effects of their areas of expertise.

During the course of the author’s study, there has been an increase in the number of studies done on dual diagnosis and appropriate treatment regimes for people suffering from

alcoholism and depression. In addition, the number of dual recovery meetings has increased in the Los Angeles area with the introduction of the Dual Diagnosis Anonymous program. This study provides a valid contribution to the field of dual diagnosis research, and concludes that there are effective treatment options to be discovered for the dually diagnosed.

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APPENDIX A

Personal Survey

1. Are you male or female?
2. Are you between the ages of 35 and 65?
3. Are you between one and fives years of sobriety in Alcoholics Anonymous up to and including the present?
4. Are you currently taking antidepressant medication?
5. How long have you taken this medication?
6. What medication are you taking and what is your daily dosage?
7. On average, how many times per week do you attend Alcoholics Anonymous meetings?
8. Do you attend Dual Recovery Anonymous meetings?
9. If yes, how many times per month do you attend a Dual Recovery Anonymous meeting?
10. What is your home address zip code?

APPENDIX B

The advertisement placed to solicit subjects.

HOW CAN YOU BE OF SERVICE TODAY?

IF YOU ARE A MEMBER OF ALCOHOLICS ANONYMOUS AND/OR DUAL RECOVERY ANONYMOUS WHO IS:

1) TAKING ANTI-DEPRESSANTS PRESCRIBED BY MEDICAL DOCTOR
2) HAVE ACCESS TO THE INTERNET
3) LIVE IN THE LOS ANGELES AREA

PLEASE LOG ONTO: WWW.AAWEBSURVEY.COM AND TAKE A 10-MINUTE SURVEY!

THIS RESEARCH IS FOR A PHD DISSERTATION COLLECTING DATA ON UNDERSTANDING MORE ABOUT ALCOHOLISM, DUAL DIAGNOSIS, AND ALCOHOLICS ANONYMOUS AND DUAL RECOVERY MEETINGS.

THANK YOU SO MUCH FOR LETTING US KNOW ABOUT YOU!

APPENDIX C

The Author’s amended version of Harder and Zalma’s Personal Feelings Questionnaire 2.

For each of the following listed feelings please check a number from 0 to 4, reflecting how common the feeling is for you ***in meeting of A.A.***:

4 = you experience the feeling continuously or almost continuously
3 = you experience the feeling frequently but not continuously
2 = you experience the feeling some of the time
1 = you experience the feeling rarely
0 = you never experience the feeling

____1. embarrassment
____2. mild guilt
____3. feeling ridiculous
____4. worry about hurting or injuring someone
____5. sadness
____6. self-consciousness
____7. feeling humiliated
____8. intense guilt
____9. euphoria
____10. feeling "stupid"
____11. regret
____12. feeling "childish”
____13. mild happiness
____14. feeling helpless, paralyzed
____15. depression
____16. feelings of blushing
____17. feeling you deserve criticism for what you did
____18. feeling laughable
____19. rage
____20. enjoyment
____21. feeling disgusting to others
____22. Remorse

APPENDIX D

The following is the debriefing paragraph that the participant will read at the conclusion of the study:

Thank you for participating in this study.

In order to maintain anonymity with others who share your computer, please remember to clear your history of websites accessed during this session.

Should you want to obtain a copy of the results of this survey, please contact the author at her e-mail address: aawebsurvey@mac.com. The results will be available after January 1st, 2005. If you know of other A.A. members who would be interested in participating in this study, please encourage them to access this website.

Your participation has been very helpful. Thank you for your time.

APPENDIX E

Ethics Committee Application

1. Participants:

   The participant population has over five years of sobriety as members of Alcoholics Anonymous, is between the ages of thirty-five and sixty-five, attends Alcoholics Anonymous meetings at least two times a week, is currently taking prescribed anti-depressant medication for a mental health disorder, and has been taking this medication for at least eight weeks. In addition to the aforementioned qualifiers, half of the subjects also attend Dual Recovery Anonymous meetings at least three times a month. The participants will be collected via the Internet, using both Internet advertisements and paper fliers distributed by the author at Alcoholics Anonymous meetings in the Los Angeles area.

2. Procedures:

   The participant will either respond to the A.A. Web Survey Google ad (see attached) by clicking on the survey link, or they will receive a flier handed out an Alcoholics Anonymous meeting which asks them to participate in a survey by going to www.aawebsurvey.com. Both links take them to the first page of the survey, which is the consent form.

3. Consent:

   After reading the consent form on the first page of the study, the participants will click “yes” or “no” to indicate whether they have understood the information given regarding the purpose of the study and consent to participating. Only participants who click “yes” will continue through to the next page, which is the personal survey.

   The first and last page of the survey provide an email contact address and the date that the study results will be available should the participants want to receive a copy of the results of the study. The contact email address will remain open for at least open for at least six months following the conclusion of the experiment.

4. Risks:

   One potential risk to the participants is if a participant emailed the author for the results of the study and inadvertently revealed his/her identity by using an identifying email address (for example, BillSmith@aol.com). In this case, only the author would have knowledge of the participant’s identify and clearly the participant would be aware that he/she has revealed his/her identity. Using the Internet to conduct this survey was decided upon specifically to ensure complete anonymity of the participants.

The only other potential risk to participants is if participants share their computer with others and do not realize that their Internet searches can be viewed by others if not deleted after use.

5. Safeguards:

Obtaining an anonymous email address is a simple and often cost-free solution for participants with identifying email addresses. The author obtained such an email address –aawebsurvey@mac.com- in five minutes through her Internet provider. The author also informs the participants that the results of the study will be available via email at the beginning of the survey, so subjects with identifying email addresses who do not wish to use their email address to obtain the results can choose not to participate.

In regards to the problem of maintaining anonymity from others who share the computer with participants, the author has included a reminder in the concluding statement of the survey that participants should "clear" their "history" of Internet websites.

6. Benefits:

As this survey intends to provide a deeper understanding of the effects of participation in Alcoholics Anonymous on individuals who suffer from comorbid disorders, the participants and their

Alcoholics Anonymous communities will ultimately benefit from this study through expanded knowledge about their chosen treatment regime. This study also hopes to encourage other researchers to probe farther into the unexplored problem of defining the best possible treatment options for dually diagnosed individuals.

7. Post-Implementation Interview:

   As this is an Internet survey, there is no direct contact with participants. However, the final page of the survey reiterates that participants can obtain a copy of the study at its completion via email and thanks for participants for their time.

8. Attachments:

   Consent Form and author's contact information (page 1 of survey)
   Personal Survey
   Beck Depression Inventory-II
   Harder and Zalma's Personal Feelings Questionnaire 2
   Amended Harder and Zalma's Personal Feelings Questionnaire 2
   Concluding page and author's contact information
   Google Advertisement for the survey
   Flier