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Al-Anon Newcomers: Benefits of Continuing Attendance for Six Months

Christine Timko, PhD¹, Alexandre Laudet, PhD², and Rudolf H Moos, PhD¹

Christine Timko: ctimko@stanford.edu; Alexandre Laudet: AlexandreLaudet@gmail.com; Rudolf H Moos: rmoos@stanford.edu

¹Center for Innovation to Implementation, Department of Veterans Affairs Health Care System and Stanford University School of Medicine, Palo Alto, CA (Postal address: 795 Willow Rd (152-MPD), Menlo Park, CA 94025 USA)

²National Development and Research Institutes, New York, NY (Postal address: 71 West 23rd St. (8th floor), New York, NY 10010 USA)

Abstract

Background—Al-Anon Family Groups, a 12-step mutual-help program for people concerned about another person's drinking, is the most widely used form of help by Concerned Others.

Objectives—This longitudinal study examined newcomers' outcomes of attending Al-Anon. Aims were to better understand early gains from Al-Anon to inform efforts in the professional community to facilitate Concerned Others' attendance of and engagement in Al-Anon.

Methods—We compared two groups of Al-Anon newcomers who completed surveys at baseline and six months later: those who discontinued attendance by the 6-month follow-up (N=133), and those who were still attending Al-Anon meetings (N=97); baseline characteristics were controlled in these comparisons.

Results—Newcomers who sustained participation in Al-Anon over the first six months of attendance were more likely than those who discontinued participation during the same period to report gains in a variety of domains, such as learning how to handle problems due to the drinker, and increased well-being and functioning, including reduced verbal or physical abuse victimization. Newcomers to Al-Anon reported more personal gains than drinker-related gains. The most frequent drinker gain was a better relationship with the Concerned Other; attendees were more likely to report this, as well as daily, in-person contact with the drinker.

Conclusion—Al-Anon participation may facilitate ongoing interaction between Concerned Others and drinkers, and help Concerned Others function and feel better. Thus, short-term participation may be beneficial. Health care professionals should consider providing referrals to Al-Anon and monitoring early attendance.

Keywords

Al-Anon Family Groups; mutual-help; 12-step groups; alcohol use disorders; addiction; family

Introduction

Family members of individuals with alcohol and drug problems incur greater health care costs and are more likely to be diagnosed with a number of conditions, including substance use disorders, depression, and trauma, than family members of similar persons without such problems, including persons with chronic medical disorders such as diabetes or asthma (1–3). Al-Anon Family Groups (Al-Anon), a 12-step mutual-help program for people concerned about another's drinking, is the most widely used form of help by Concerned Others in the United States (4–6). This study compared two groups of Al-Anon newcomers who completed surveys at baseline and six months later: those no longer attending meetings by the 6-month follow-up, and those who were still attending Al-Anon meetings. The groups were compared on perceived gains for themselves and for the drinker due to Al-Anon attendance, and the Al-Anon attendee's health status (medical, substance use, psychological, and coping strategies) and reports of the drinker's health status.

Al-Anon Outcomes

The main source of information about Al-Anon has been its internal triennial membership survey, the most recent of which was conducted in 2015 (N=8,517 Al-Anon members, most with 5 years of continuous membership) (7). The survey asked members to rate their mental and physical health and daily functioning before they began attending Al-Anon meetings and currently. Members also reported experiences related to the problem drinker: emotions and feelings (e.g., loving, proud, anxious, disappointed), problem areas (e.g., stress, depression, sleeping, headaches), and behaviors (i.e., procrastinating, concentrating, lacking productivity at home, exercising, work over-involvement). In all these domains, members reported improved well-being for themselves and for the problem drinker. In addition, 95% of members reported that their spiritual life had improved. When asked how being a member of Al-Anon has affected their life, 94% said "very positively," and 5% said "somewhat positively."

Early empirical studies of Al-Anon support these findings. Among Al-Anon members who were wives of alcoholic husbands, a longer duration of Al-Anon membership was associated with greater decreases in negative coping (e.g., threaten actions without follow-through; have emotional outbursts); and, in turn, decreases in negative coping were associated with a longer duration of the husband's abstinence (8). The greatest improvements in coping may occur early in Al-Anon membership, although they may continue for seven years or more (8). Al-Anon members also reported improvements in understanding alcoholism, and in levels of depression, assertiveness, self-acceptance, and relationship satisfaction (9).

In a randomized controlled trial, in comparison to wait-list controls, spouses of heavy drinkers referred to Al-Anon reported reduced personal problems related to the drinker's alcohol use (e.g., money shortages, self-blame for drinker's alcohol use, loneliness,

irritability) (10). Similarly, among spouses of treatment-resistant alcoholics, Al-Anon Facilitation Therapy (a manual-guided, therapist-delivered counseling method designed to encourage participation in Al-Anon) (11) reduced emotional distress and increased coping behaviors to a larger extent than a wait-list control condition (12). Facilitation also yielded reductions in depression, anger, and family conflict, and increases in family cohesion and relationship happiness among Concerned Others of treatment-resistant alcoholics (4). Dittrich and Trapold (13) found greater reductions in anxiety and depression and increases in self-concept at a 4-month follow-up among wives of treatment-resistant alcoholics randomly assigned to therapy based on Al-Anon concepts than among those assigned to a wait-list control condition. Recent studies support these findings in that stable members in Al-Anon reported a better quality of life, less concern about the drinker's alcohol use, and a better relationship with the drinker than did newcomers to Al-Anon (14).

Present Study

Previous studies of Al-Anon's benefits have tended to focus on long-term members or Concerned Others referred to Al-Anon by a study therapist. The present study focused on a unique sample in that it utilized a national sample of newcomers to Al-Anon rather than of long-term Al-Anon members. Moreover, participants were followed prospectively for 6 months, and did not receive professional counseling as part of the study. The study design enables comparisons of two naturally-occurring groups of Al-Anon newcomers -- those who were still attending meetings at the 6-month follow-up, and those who were not -- on perceived gains due to Al-Anon and current health status, with respect to both the Al-Anon newcomer and his or her drinker. Better understanding of early gains from Al-Anon will inform efforts in the professional community to facilitate Concerned Others' attendance of and engagement in Al-Anon.

Method

Sample

Participants were Al-Anon newcomers at baseline who, in accordance with Al-Anon convention, had attended 6 Al-Anon meetings or fewer in their lifetime. The sample was composed of 230 individuals who completed surveys at baseline and 6 months later, and whose status as discontinued, or retained in, Al-Anon at follow-up could be determined (see Results). Specifically, at the 6-month follow-up, discontinuation was defined as not having attended any Al-Anon meetings during the past month; retention was defined as having attended at least one meeting during the past month. Using these definitions, 133 (57.8%) newcomers at baseline had discontinued at 6 months, and 97 (42.2%) were still attending Al-Anon. The 97 still attending at 6 months had attended a mean of 23.5 meetings (SD=19.5) in the past 6 months and 3.8 (SD=3.0) in the past month, compared to means of 6.4 (SD=10.5) in the past 6 months and 0 in the past month for those who discontinued attendance ($t = -8.47$ and -14.77 , respectively, $p < .001$).

At baseline, participants were mostly women (86.5%, $N=199$), white (93.9%, $N=216$), married or partnered (62.3%, $N=142$), and employed (69.1%, $N=159$), with a mean age of 46.1 years (SD=13.0) and a mean of 15.2 years of education (SD=2.1). At baseline,

newcomers who discontinued or were still attending Al-Anon 6 months later did not differ on these demographic characteristics of gender, race, marital status, employment, age, and education ($p>.05$).

Procedure

Recruitment—To acquire the sample, Al-Anon Family Groups World Service Office mailed (but did not pay for) a random sample of 4,500 Al-Anon groups. The mailing introduced the study, asked permission for research staff to contact the group, and stated that the group was free to accept or refuse. Representatives were asked to return their group's permission to be contacted, their contact information, and an estimate of the number of newcomers attending their group per month directly to the researchers in prepaid envelopes; "newcomer" was defined. Of 979 groups (22%) responding, 853 (87%) gave permission, and 126 (13%) refused (15).

Research staff mailed responding Representatives a cover letter explaining procedures to hand out surveys to newcomers and the purpose and potential benefits of the survey, and inviting them to call and discuss questions or concerns. The mailing included the number of survey packets corresponding to the estimated number of newcomers per month. Representatives were given a standard script to follow and asked to give the survey to the next newcomer at their meetings, without regard to demographic or other characteristics. If newcomers declined the survey, Representatives offered it to the next newcomer. Representatives were asked to send a notice to research staff (envelope provided), indicating how many newcomers who were approached declined. Of 853 groups contacted, 784 (91.9%) returned notices; of these, 672 (85.7%) participated, and, on average, had obtained a refusal from <1 newcomer ($M=.48$, $SD=1.2$).

A cover letter with the newcomer questionnaire and consent form provided a study summary (aims; methods; the survey's voluntary and confidential nature, basic content, and time requirements; how to contact project staff; request to complete the survey within two weeks). Surveys were received from 54% ($N=360$) of groups that agreed to participate. Respondents ($N=631$; mean number per group= 1.9 ; $SD=1.2$) were offered a \$25 gift card, and returned their consent form and questionnaire in separate envelopes to protect confidentiality. They lived in 49 of the 50 United States.

Follow-up—Of the 631 respondents, 365 were newcomers (57.8%; the others did not meet our definition). Of the 365 newcomers, 305 (83.6%) agreed, at the time of the baseline survey, to be contacted about the 6-month follow-up survey. After 6 months, participants were mailed a copy of the follow-up survey and contacted by email to let them know the follow-up survey had been mailed to them. Participants again returned their survey and payment information separately to protect their confidentiality, and received \$25 as compensation for participating. Of the 305 agreeing to the follow-up survey at baseline, 253 (83%) returned it. Of those who did not return the follow-up survey, 4 (8%) could not be located, and 48 (92%) were located but did not return the questionnaire.

Surveys—The baseline and 6-month survey items were quite similar and drawn mainly from the Health and Daily Living Form (16), which has demonstrated strong psychometric

characteristics in family studies of alcohol use and other mental health disorders (17–18). The baseline survey was pretested with four individuals (Al-Anon group secretary, long-term member, newcomer, former attendee), and was used to ascertain newcomers' demographic characteristics.

Gains from Al-Anon—The baseline survey asked what the participant hoped to gain for him or herself by attending Al-Anon. Specifically, for each of 25 potential goals, the participant checked “yes, a goal” or “no, not a goal.” The 6-month follow-up asked the participant, for each of the 25 potential goals on the baseline survey, whether or not it was a benefit for him or herself of attending Al-Anon. Table 1 lists the potential gains on the 6-month follow-up survey with respect to Al-Anon attendance; these were the same as the goals asked about at baseline.

Health status—At baseline and the 6-month follow-up, participants reported on their own health, substance use, psychological functioning, health care utilization, and coping strategies. These items are listed in Table 2.

Drinker—At both time points, participants were asked about daily contact with the drinker, concern about the drinker's alcohol and drug use, amount of the drinker's alcohol and drug use, and the drinker's help for alcohol and drug problems. These items are listed in Table 3. In addition, the baseline survey asked what the participant hoped to gain for the drinker by attending Al-Anon, using the same 25 potential goals listed on Table 1. The 6-month follow-up asked the participant, for each of the 25 potential goals on the baseline survey, whether or not it was a benefit for the drinker of attending Al-Anon.

Data Analysis

We compared the Al-Anon discontinued and current attendees at 6 months using analyses of covariance (ANCOVAs) that controlled for the corresponding item at baseline. For example, on Table 1, the first comparison is on whether or not the respondent benefitted from Al-Anon attendance at follow-up in terms of having learned how to handle problems due to the drinker. This comparison controlled for whether or not, at baseline, learning how to handle problems due to the drinker was a goal of Al-Anon attendance. On Table 2, the first comparison is on whether respondents described their health as good or excellent at the 6-month follow-up, controlling for responses to the same item at baseline. All follow-up findings on Tables 2 and 3 controlled for the same corresponding item at baseline.

Results

Personal Gains from Al-Anon

A total of 23 of the 253 newcomers did not answer the follow-up survey's question of how many meetings they had attended in the past month, leaving 230 respondents for analyses. Table 1 compares discontinued and current attendees on what they gained by attending Al-Anon, controlling for baseline goals of Al-Anon attendance. Current attendees were especially more likely than dropouts to report gains in terms of: learning how to handle problems due to the drinker; better overall quality of life and well-being; feeling more

hopeful; having better relationships with relatives and friends; being more involved in what's important in life; feeling less confused, stressed, angry, and depressed; and having more self-esteem and a more satisfying spiritual life. In addition, current attendees were more likely to report that their psychological frame of mind had improved during the past 6 months (78.4% [N=76] vs. 62.0% [N=80], $X^2=8.89$, $p<.01$); this item is not tabled because it was asked only at the 6-month follow-up and did not have a baseline covariate.

Health Status Improvements

Table 2 shows that current attendees and those who discontinued attendance did not differ significantly on improvements in their health, or use of alcohol and drugs. Current attendees were more likely to show improvements in often feeling positively about themselves and having a lot of control over things that happened to them. They were less likely to report having obtained medical care in the past 6 months. An item helping to explain this difference (not tabled because it was asked only at follow-up and did not have a baseline covariate) showed that current attendees were less likely to report that in the past 6 months they had been newly diagnosed with a medical condition (10.3% [N=10] vs. 19.1% [N=25], $X^2=3.43$, $p<.05$). Finally, there were few differences between groups on coping strategies. In keeping with their AI-Anon attendance, current attendees were more likely to cope with problems or crises by seeking help from others with the same problem, and by trying to help others with the problem.

Drinker Characteristics

Current attendees were more likely to report increases in daily, in-person contact with the drinker than were those who discontinued attendance (Table 3). The groups did not differ on concern about the drinker's alcohol and other drug use, or on amounts of substance use by the drinker. However, current attendees reported that drinkers were more likely to have received residential or outpatient treatment for their substance-related problems.

As noted in the methods, the baseline and follow-up surveys asked about goals and gains for the drinker by the participant's attending AI-Anon (listed on Table 1). Current attendees were more likely than discontinued attendees ($p<.01$) to report that the drinker had benefitted by having a better relationship with the Concerned Other (72.5% vs. 55.3%, $X^2=6.96$) and less anger (49.2% vs. 32.3%, $X^2=6.52$). Other gains for drinkers ($p<.05$) were better relationships with spouses/partners (43.7% vs. 31.4%, $X^2=3.46$) and overall quality of life and well-being (53.5% vs. 39.9%, $X^2=3.81$), and less stress (44.9% vs. 31.1%, $X^2=4.10$) and depression (36.0% vs. 25.7%, $X^2=2.67$).

Discussion

We found that individuals who sustained participation in AI-Anon over the first six months were more likely than those who discontinued participation during the same period to report gains in a variety of domains. Reported gains from AI-Anon attendance were more frequent with regard to personal benefits rather than benefits achieved for the drinker.

One key domain in which sustained attendees gained more than discontinued attendees did was learning how to handle problems due to the drinker. This finding is important because

the most frequent concern influencing initial Al-Anon attendance, endorsed by 94% of participants at baseline, was not knowing how to handle problems due to the drinker (15). However, in the follow-up results reported here, sustained attendees were no more likely than discontinued attendees to report that they had gained a better relationship with the drinker, or learned how to help the drinker. Perhaps this is because Al-Anon advises Concerned Others to focus on their own problems, rather than try to change the drinker and related behaviors (19). Nevertheless, almost two-thirds of sustained attendees and about one-half of discontinued attendees reported that the drinker had benefitted by developing a better relationship with them. This is consistent with the finding that about two-thirds of sustained, and one-half of discontinued, attendees reported that they had gained from Al-Anon by having stopped the receipt of verbal or physical abuse.

Compared to discontinued attendees, sustained attendees reported more gains from Al-Anon in the individual's general welfare: having a better overall quality of life and well-being, being more involved in what's important in life, and having a better spiritual life. Indeed, having a better overall quality of life was the most frequently endorsed goal of initial Al-Anon attendance at baseline (endorsed by 96%) (15). Sustained attendees also reported more functional gains than discontinued attendees did in that they had better relationships with relatives and friends. Gains reported by sustained attendees also included a number of psychological benefits, such as feeling more hope and self-esteem, and less confusion, stress, anger, and depression. Our prospective results for newcomers' gains across domains are consistent with and extend the findings of retrospective reports of long-term members' benefits found in Al-Anon's membership survey (7).

Thus far, we have highlighted domains in which sustained attendees reported more personal gains than discontinued attendees did, but the latter group frequently reported gains from Al-Anon attendance in the same domains. Short-term and less intensive participation in Al-Anon may be beneficial, even if it is not as helpful as more sustained and intensive participation. These perceived gains from short-term, less intensive participation may encourage former attendees to return to Al-Anon later.

We previously identified several reasons for discontinuation of Al-Anon, including lack of initial referral by health care providers, milder initial difficulties, and goals that are less compatible with Al-Anon's philosophy, such as addressing concerns about the drinker's psychological symptoms (20). However, as with people seeking therapy, discontinuation may also occur because the Concerned Other, although struggling with life stressors and wanting some relief from emotional pain, may choose not to address these issues further at a given time (21). Eventual return to Al-Anon may be prompted by suggestions from the Concerned Other's health care providers, a worsening of problems due to the drinker, or a change in willingness and ability to confront challenges. Health care providers could advise former attendees that they may need to "shop around" to different Al-Anon groups to find a home group with the best fit. Longer-term prospective studies are needed to inform common patterns of Al-Anon attendance, discontinuation, and benefits over time.

Comparing Improvements Between Sustained and Discontinued Attendees

When baseline status was controlled, the groups did not differ on improvement in ratings of their health as good or excellent, or on use of alcohol and drugs. However, at follow-up, sustained attendees were more likely to report better physical health as an AI-Anon-related gain, were less likely to have been newly diagnosed with a medical condition, and, when baseline status was controlled, were less likely to have obtained medical care between baseline and follow-up. These results reinforce the importance of gauging progress by obtaining both self-attributions of gains, and prospective data using the same measures across time (22). In agreement with prior studies of gains from AI-Anon attendance, current attendees were more likely to report that their psychological frame of mind had improved since baseline, and, with baseline status controlled, to have improved on often feeling positively about themselves and having a lot of control over things that happened to them.

Current attendees increased their likelihood of coping with problems or crises by seeking help from others with the same problem, and by trying to help others with the problem. This strategy of help-seeking by current attendees is consistent with their more sustained and intensive AI-Anon participation, and generally, seeking help for personal and family problems tends to be associated with better outcomes than trying to solve problems alone (23). Helping other Concerned Others may have its own benefits. Generally, volitional or autonomous helping yields benefits for both the helper and the recipient through greater need satisfaction (24). More specifically, helping others is associated with recovery by members of Alcoholics Anonymous, and with better outcomes by members of diverse mutual-help groups (25). Nevertheless, helping may sometimes harm the intended recipients. “Over-helping” by a Concerned Other may involve trying to control the drinker to one’s own detriment, which is closely tied to the concept of codependency addressed within AI-Anon (19, 26). Research examining benefits of helping should clearly differentiate Concerned Others’ possible codependence, involving unhealthy self-sacrifice, needs for external validation, and reactivity toward recipients (27), from a Concerned Other’s assistance of others sharing the same predicament of involvement with a drinker.

Drinker Characteristics

In keeping with AI-Anon’s focus on the self rather than the drinker, respondents reported fewer drinker-than self-related gains from attending AI-Anon. The most frequent gain for the drinker reported by both sustained and discontinued attendees was a better relationship with the Concerned Other; sustained attendees were more likely to report this gain. Indeed, when amount of contact at baseline was controlled, sustained attendees were more likely to report increases in daily, in-person contact with the drinker. More contact with the drinker may reflect the Concerned Other’s hope for improvement in the behavior of those drinkers who initiated residential or outpatient treatment. It is also possible, as Young and Timko (26) suggested, that continuing relationships with drinkers may benefit Concerned Others by preserving their self-identity, social identity, values, security, stability, and hope (28). Research is needed to identify factors that influence Concerned Others’ decisions to sustain or end their relationship with the drinker and the role, if any, that AI-Anon attendance plays in these decisions.

Among sustained and discontinued attendees, 69% and 73%, respectively, had a lot of concern about the drinker consuming alcohol, even though only 48% and 52% of drinkers, respectively, had consumed alcohol in the past month, and even though drinkers of sustained attendees were more likely to have obtained treatment (37% and 33% of sustained and discontinued attendees' drinkers, respectively, had obtained inpatient, residential, and/or outpatient treatment). Although it is important for the drinker to obtain treatment, Miller et al. (4) found that, in the short-term, Concerned Others improved when they obtained help for themselves, even if their drinker did not enter treatment. Obtaining help may be associated initially with the Concerned Other's improvement, and extend to a meaningfully better relationship with the drinker and the drinker's better outcomes. This is in line with therapy models in which strengthened self-efficacy and personal agency have positive impacts on social relationships and recovery (29), and with Al-Anon's suggestions that taking care of oneself first may lead to the consequences of more peaceful relationships and a better quality of life.

Limitations

A limitation of this study is that there is an unknown amount of self-selection due to Al-Anon groups and newcomers' deciding whether or not to participate. Although only about one-quarter of groups responded to the initial study letter, this is comparable to that of other mail surveys that involved a one-time mailing without follow-up or incentive, conducted through the organization rather than through direct contact with potential participants (15). The provision of compensation could have biased the sample toward less affluent participants; however, aside from economic gain, more common motivators of research participation are citizenship, altruism, and personal satisfaction (30). Another limitation is that participants' reports about their drinkers reflect the reporter's perceptions. These perceptions may be inaccurate, especially among participants who had less contact with their drinker. Finally, we conducted multiple comparisons without adjustment, such that our findings require replication.

Conclusions

Results from this prospective, longitudinal study of newcomers to Al-Anon suggest that more intensive, sustained attendance over the first six months is more helpful than less intensive and discontinued attendance to improve functioning and psychological status, as well as ongoing contact with the drinker. In analyses of survey respondents at baseline, we found that the rarest source of referral to Al-Anon was the Concerned Other's health care provider, and that when respondents were referred to Al-Anon by their drinker's health care provider, they were less likely to discontinue with meetings (20). Therefore, we recommended that providers, when discussing the problematic drinking of close friends and relatives with their patients, refer concerned patients to Al-Anon to facilitate attendance. The current study supports that recommendation, but also suggests that providers consider monitoring patients' follow-through with such referrals to optimize outcomes. As research on Al-Anon continues, evidence-based referral and monitoring practices that are feasible for providers and beneficial to Concerned Others should be developed, implemented, and evaluated.

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ANCOVAs comparing Al-Anon newcomers on personal gains due to Al-Anon attendance at 6-month follow-up: Discontinued vs. sustained attendees.

Table 1

	Discontinued		Sustained		F
	%	(N)	%	(N)	
Learn how to handle problems due to drinker	77.4	(103)	93.4	(91)	11.56 ^{***}
Better overall quality of life and well-being	73.2	(97)	88.0	(85)	7.68 ^{**}
Feel more hopeful	70.2	(93)	88.3	(86)	10.85 ^{***}
Better relationship with: Drinker	67.8	(90)	71.6	(69)	.37
Relatives	64.3	(85)	81.6	(79)	8.36 ^{**}
Friends	64.0	(85)	81.2	(79)	8.20 ^{**}
Spouse or partner	56.8	(76)	68.2	(66)	3.36
Children	57.1	(76)	65.4	(63)	1.78
Involved more in what's important in life	68.3	(91)	88.2	(86)	12.63 ^{***}
Less confused on how to cope with life problems	66.6	(89)	90.1	(87)	17.82 ^{***}
Less loneliness and isolation	66.0	(88)	74.9	(73)	1.98
Less stress, tension, anxiety; learn how to relax	64.1	(85)	87.6	(85)	16.54 ^{***}
Less anger	63.6	(85)	88.2	(86)	19.50 ^{***}
More self-esteem, confidence	62.3	(83)	86.1	(84)	16.04 ^{***}
Less depressed, moody	60.0	(80)	79.8	(77)	10.58 ^{***}
More satisfying spiritual life	59.9	(80)	88.7	(86)	25.78 ^{***}
Better at meeting your responsibilities	57.2	(76)	68.2	(66)	2.78
Learn how to help drinker	55.4	(74)	58.6	(57)	.23
Stop receiving verbal and/or physical abuse	51.6	(69)	65.6	(64)	4.87 [*]
Doing better at work or school	50.0	(67)	63.1	(61)	3.96 [*]
Better physical health	49.4	(66)	65.5	(64)	5.86 [*]
Less drinking and/or drug use	43.8	(58)	49.4	(48)	0.67
Better home or neighborhood	40.3	(54)	54.9	(53)	5.13 [*]
Fewer problems with police, criminal justice	30.4	(40)	34.1	(33)	0.33
Better financial situation	27.8	(37)	40.0	(39)	3.71

100>d

;10>d
**
;50>d
*

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ANCOVAs comparing Al-Anon newcomers on health-related indices at 6-month follow-up: Discontinued vs. sustained attendees.

Table 2

	Discontinued		Sustained		F
	%/M	(N/SD)	%/M	(N/SD)	
Health is excellent or good	83.4	(110)	87.8	(85)	1.01
Past month: Drank alcohol	65.2	(87)	62.6	(61)	0.25
Number of days drank	5.2	(7.6)	4.6	(6.6)	0.62
Number of drinks in typical drinking day	1.5	(1.0)	1.6	(0.8)	0.74
Largest number of drinks in one day	3.0	(2.2)	3.4	(2.4)	1.08
Number of times had 5 or more drinks	0.4	(1.0)	0.5	(2.2)	0.22
Used prescription drugs	51.0	(68)	57.8	(56)	1.56
Used non-prescribed drugs	2.4	(3)	2.1	(2)	0.04
Past 6 months, often felt:					
Happy	85.0	(113)	87.2	(85)	0.24
Positive attitude toward self	84.0	(112)	91.5	(89)	2.98 *
A lot of control over things that happened	64.8	(86)	75.4	(73)	2.83 *
Anxious	63.4	(84)	70.7	(69)	1.36
Depressed	53.4	(71)	56.7	(55)	0.28
Guilty	39.4	(52)	41.5	(40)	0.11
Hopeless	36.2	(48)	30.7	(39)	0.77
Past 6 months: Obtained outpatient care					
Medical	28.7	(38)	17.1	(17)	4.44 *
Psychological	28.0	(37)	26.4	(26)	0.08
Couples/family	16.8	(22)	20.8	(20)	0.64
Alcohol/drug	4.6	(6)	2.0	(2)	1.42
Attended self-help for alcohol/drug problems	14.4	(19)	14.8	(14)	0.01
When you had an important problem or crisis to deal with, did you:					
Try to see the good side of the situation	93.6	(124)	87.2	(85)	2.76
Talk with family, friends about the problem	92.5	(123)	92.3	(90)	0.01
Step back and be more objective	88.3	(117)	90.4	(88)	0.25
Make a plan of action and follow it	74.4	(99)	73.1	(71)	0.05

	Discontinued		Sustained		F
	%/M	(N/SD)	%/M	(N/SD)	
Increase work, leisure, social activities	67.4	(90)	73.5	(71)	1.02
Talk with a professional (e.g., doctor)	52.0	(69)	49.4	(48)	0.17
Try not to think about the problem	49.3	(66)	46.1	(45)	0.25
Seek help from people or groups with the same problem	49.1	(65)	77.6	(75)	7.03**
Accept it: Nothing can be done	48.8	(65)	44.0	(43)	0.50
Try to help others with a similar problem	42.3	(56)	56.9	(55)	4.89*
Take upset feelings out on other people	32.3	(43)	33.3	(32)	0.03

* p<.05;

** p<.01

Note: M=Mean; SD=Standard Deviation

ANCOVAs comparing Al-Anon newcomers on drinker characteristics at 6-month follow-up: Discontinued vs. sustained attendees.

Table 3

	Discontinued		Sustained		F
	%/M	(N/SD)	%/M	(N/SD)	
Daily contact with drinker					
In person	40.6	(54)	53.9	(52)	6.16*
By phone or email	40.2	(53)	45.7	(44)	0.87
A lot of concern about drinker's:					
Drinking alcohol	73.2	(97)	68.9	(67)	0.61
Use of prescription drugs	36.9	(49)	32.0	(31)	0.67
Use of non-prescribed drugs	36.8	(49)	37.1	(36)	0.00
Drinker, past month: Drank alcohol	51.8	(69)	48.2	(47)	0.24
Number of days drank	9.2	(12.0)	8.5	(11.8)	0.14
Number of drinks in typical drinking day	6.4	(3.9)	6.9	(4.7)	0.20
Number of times had 5 or more drinks	10.8	(10.3)	11.6	(11.2)	0.07
Largest number of drinks on one occasion	11.1	(9.6)	12.7	(6.3)	0.58
Used prescription drugs	40.8	(54)	43.3	(42)	0.12
Used non-prescription drugs	12.5	(17)	15.4	(15)	0.25
Past 6 months: Drinker's help for alcohol and drug problems					
Detoxification	14.8	(20)	19.3	(19)	0.89
Hospital inpatient or residential program	15.7	(21)	27.5	(27)	5.13*
Outpatient program	25.1	(33)	36.2	(35)	2.99*
12-step mutual-help groups	41.4	(55)	44.8	(43)	0.38

* p<.05

Note: M=Mean; SD=Standard Deviation