Al-Anon Family Groups: Newcomers and Members

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ABSTRACT. Objective: Empirical knowledge is lacking about Al-Anon Family Groups (Al-Anon), the most widely used form of help by people concerned about another's drinking, partly because conducting research on 12-step groups is challenging. Our purpose was to describe a new method of obtaining survey data from 12-step group attendees and to examine influences on initial Al-Anon attendance and attendees' recent life contexts and functioning. **Method:** Al-Anon's World Service Office sent a mailing to a random sample of groups, which subsequently yielded surveys from newcomers (n = 359) and stable members (n = 264). **Results:** Reasons for groups' nonparticipation included having infrequent newcomers and the study being seen as either contrary to the 12 Traditions or too uncomfortable for newcomers. Main concerns prompting initial Al-Anon attendance were problems with overall quality of life and with the Al-Anon trigger (a significant drinking individual), and being stressed and angry. Goals for Al-Anon attendance were related to the following concerns: better quality of life, fewer trigger-related problems, and less stress. Members reported better functioning in some of these domains (quality of life, relationship with the trigger) but did not differ from newcomers on physical and psychological health. Newcomers were more likely to have recently drunk alcohol and to have obtained treatment for their own substance misuse problems. **Conclusions:** This method of collecting data from 12-step group attendees yielded valid data and also was seen by many in Al-Anon as consistent with the Traditions. Both newcomers and members had aimed to improve their overall quality of life and well-being through Al-Anon, and, indeed, members were more satisfied with their quality of life than were newcomers. (*J. Stud. Alcohol Drugs, 74,* 965–976, 2013)

ALCOHOL USE DISORDERS HAVE NEGATIVE consequences for both drinking individuals and their loved ones (Dawson et al., 2007; O'Farrell and Clements, 2012; Rowe, 2012). Poor functioning by the concerned other person (CO) has a negative impact on the drinking individual and may jeopardize recovery (Rowe, 2012). Al-Anon Family Groups (Al-Anon), 12-step mutual-help groups for families and friends of problem-drinking individuals, offer help to deal with the impact of another's drinking. Al-Anon is the most widely used form of help for COs in the United States (Miller et al., 1999; O'Farrell and Clements, 2012; O'Farrell and Fals-Stewart, 2001). Of approximately 24,000 Al-Anon groups in more than 130 countries, approximately 14,000 are in the United States and Canada (http://www.al-anon.alateen.org). Expanding knowledge of Al-Anon's benefits would be useful to providers of help to COs and to the drinkers in COs' lives.

Despite widespread use, empirical knowledge is lacking about Al-Anon, such as characteristics of newcomers and members, their reasons and goals for participation, and their life contexts, including their physical and mental health status, substance use, and functioning. To date, no published studies of Al-Anon have compared newcomers with members. Rather, prior studies examined Al-Anon attendees with a broad range of membership duration (e.g., 1 month to >20 years; Keinz et al., 1995), or with long-term, stable membership (e.g., participants in Al-Anon's most recent membership survey [N = 1,775] averaged 13 years of continuous attendance [http://www.al-anon.alateen.org]). Studies of Al-Anon tend to be outdated.

Al-Anon members

Al-Anon members are 84% female and 93% White, with an average age of 56 years; 58% are married, 56% have at least a college degree, and 60% are employed (http://www.al-anon.alateen.org). The main reason for initiating Al-Anon participation is accumulated life stressors, such as the family's financial problems and poor relationships, the drinker's legal problems, and COs' neglect of their physical health and work responsibilities while coping with drinkers (Roth, 2004; Roth and Tan, 2007, 2008). The distress of cumulative problems becomes too much to bear (Ablon, 1974). One problem attributable to drinking is violence; wives in Al-Anon had often been beaten by their husbands and had witnessed their destructive acts (Gorman and Rooney, 1979).

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Table 1. Al-Anon's 12 traditions

1.	Our common welfare should come first; personal progress for the greatest number depends upon unity.
2.	For our group purpose there is but one authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants—they do not govern.
3.	The relatives of alcoholics, when gathered together for mutual aid, may call themselves an Al-Anon Family group, provided that, as a group, they have no other affiliation. The only requirement for membership is that there be a problem of alcoholism in a relative or friend.
4.	Each group should be autonomous, except in matters affecting another group or Al-Anon or AA as a whole.
5.	Each Al-Anon Family Group has but one purpose: to help families of alcoholics. We do this by practicing the Twelve Steps of AA ourselves, by encouraging and understanding our alcoholic relatives, and by welcoming and giving comfort to families of alcoholics.
6.	Our Family Groups ought never endorse, finance or lend our name to any outside enterprise, lest problems of money, property and prestige divert us from our primary spiritual aim. Although a separate entity, we should always co-operate with Alcoholics Anonymous.
7.	Every group ought to be fully self-supporting, declining outside contributions.
8.	Al-Anon Twelfth Step work should remain forever non-professional, but our service centers may employ special workers.
9.	Our groups, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10.	The Al-Anon Family Groups have no opinion on outside issues; hence our name ought never be drawn into public controversy.
11.	Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, films, and TV. We need guard with special care the anonymity of all AA members.
12.	Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles above personalities.

Notes: From the Al-Anon Family Groups website (http://www.al-anon.alateen.org/the-twelve-traditions). Al-Anon's Twelve Traditions are copyrighted by Al-Anon Family Group Headquarters, Inc. Reprinted by permission of Al-Anon Family Group Headquarters, Inc. Permission to reprint this excerpt does not mean that Al-Anon Family Group Headquarters, Inc., has reviewed or approved the contents of this publication or that Al-Anon Family Group Headquarters, Inc., necessarily agrees with the views expressed herein. Al-Anon is a program of recovery for families and friends of alcoholics—use of this excerpt in any non–Al-Anon context does not imply endorsement or affiliation by Al-Anon.

Potential benefits of Al-Anon attendance involve better health and functioning. Members attribute improved psychological health (less depression, anger) and relationship and family satisfaction to Al-Anon attendance (Cutter and Cutter, 1987; Dittrich and Trapold, 1984; Keinz et al., 1995; Miller et al., 1999). Al-Anon may help COs cope more adaptively with the loved one's drinking and with life stressors related or unrelated to the drinking (Gorman and Rooney, 1979; McGregor, 1990; O'Farrell and Fals-Stewart, 2001).

As reviewed by O'Farrell and Fals-Stewart (2003), when drinkers are unwilling to seek help, Al-Anon facilitation (structured encouragement of participation) and referral help family members cope better. This conclusion is based on equivalent or greater improvement in COs' functioning following Al-Anon facilitation or referral than that of wait-list control groups or family-involved treatments. However, no new studies of Al-Anon facilitation and referral have been conducted since 2003 (O'Farrell and Clements, 2012). In addition, no previous study has compared the health and coping of Al-Anon newcomers and members, as we did.

Study purpose

This study's purpose was to fill gaps in what is known about Al-Anon by describing and comparing newcomers' and members' demographic characteristics, initial reasons for coming to Al-Anon and goals of participation, and current health status and functioning. We examined life stressors and psychological symptoms that influenced newcomers' and members' decisions to attend Al-Anon. To broaden understanding of why COs choose Al-Anon, we examined newcomers' and members' referral sources and reasons Al-Anon was selected as a help source.

Comparisons of newcomers' and members' reasons and goals for initiating attendance indicate the extent to which newcomers, who may or may not continue attending meetings, are influenced by reasons to try Al-Anon that are similar to those of people who have become stable members. Possibly, newcomers have reasons and goals for initiating participation that differ from those of individuals who have chosen to sustain membership. Information about what newcomers hope to gain from participation, in comparison with stable members' initial hopes, will help professionals and others who refer individuals to Al-Anon be better prepared about expectations of people who have never been to a meeting regarding possible attendance. Comparison of newcomers' and members' health status and functioning can help inform the extent to which stable membership may be associated with better life contexts and in what domains.

One reason for the lack of information about Al-Anon is the challenge of conducting research on 12-step groups that does not use treatment samples (Brigham, 2003). Research is controversial in the 12-step community. Because 12-step programs such as Al-Anon have Traditions (group governance guidelines; Table 1) of maintaining members' personal anonymity and groups' nonaffiliation with outside organizations, some individuals believe that attendees should not participate in research (Timko et al., 2012). In this study, we report a method of recruiting individuals attending Al-Anon meetings that was designed to uphold 12-step Traditions and achieve scientific validity.

Table 2. Demographic characteristics of Al-Anon newcomers (n = 359) and members (n = 264)

Variable	Newcomers M (SD) or % (n)	Members M (SD) or % (n)	t or χ^2
Female	86.5% (310)	83.9% (222)	0.79
Race and ethnicity			4.50
Hispanic or Latino	4.5% (16)	3.2% (8)	
American Indian/Alaskan Native	1.7% (6)	3.1% (8)	
Asian	1.7% (6)	1.2% (3)	
Black, African American	2.5% (9)	3.1% (8)	
Native Hawaiian/Pacific Islander	0.6% (2)	0.4% (1)	
White	94.1% (335)	92.9% (237)	
Marital status			1.81
Single, never married	15.2% (54)	11.7% (30)	
Married or living with partner	61.4% (223)	62.7% (136)	
Separated or divorced	20.4% (74)	23.0% (50)	
Widowed	3.1% (11)	3.9% (10)	
Age, in years	46.8 (13.4)	51.0 (12.6)	-3.98***
Years of education	14.9 (2.0)	14.9 (2.0)	-0.16
Employed	67.9% (237)	58.6% (146)	5.41*
Personal income	$52.7K ($62.8K)	$48.5K ($60.2K)	0.76
You and family have health insurance	86.6% (305)	81.3% (204)	3.18
Any children under age 18	31.8% (114)	29.0% (95)	0.55
Any children 18 years old or older	49.6% (178)	60.2% (156)	6.89**
No. years living where you are now	9.2 (10.2)	10.3 (10.7)	-1.29
Usually live with family	70.2% (247)	68.6% (175)	1.12
Religious practices			15.70**
Atheist	1.1% (4)	1.2% (3)	
Agnostic	4.8% (17)	1.2% (3)	
Unsure	2.8% (10)	7.8% (20)	
Spiritual	47.0% (166)	44.2% (156)	
Religious	41.6% (107)	48.2% (124)	

Notes: K = 1,000; no. = number.
*p < .05; **p < .01; ***p < .001.

In summary, the purpose of this study was twofold: (a) to describe a new method of obtaining survey data from 12-step group attendees and (b) to examine influences on initial Al-Anon attendance, and current functioning, among Al-Anon newcomers and members.

Method

Sample

Although procedures were designed to survey Al-Anon newcomers, we received 623 surveys from both newcomers (n = 359, 62.5%) and members (n = 264, 37.5%). Conforming to Al-Anon convention, *newcomers* were defined as having attended six or fewer, and *members* as having attended more than six, Al-Anon meetings (lifetime). Newcomers and members had attended an average of 3.3 (SD = 1.7) and 62.8 (SD = 152.0) Al-Anon meetings, respectively. In the 6 months before the survey, newcomers had attended an average of 0.2 meetings per week, compared with members' average of 1.5 meetings per week.

Procedure

Al-Anon Family Group Headquarters, Inc. World Service Office (WSO) sent (but did not pay for) a postal mailing to a random sample of 4,500 Al-Anon groups. (WSO uses mail to communicate with Al-Anon groups.) It is unknown how many mailed letters were received, or received and opened, by people in Al-Anon groups to which they were sent. The mailing introduced the study, asked permission for research staff to contact the group, and clarified that the group was free to accept or refuse to participate in the study. Group representatives were asked to return directly to the researchers (in prepaid envelopes) their group's permission to be contacted, contact information, and an estimate of the number of newcomers attending their group per month; the letters included the previously mentioned definition of *newcomer.* Of 979 groups responding (22%), 853 (87%) permitted contact.

Researchers mailed the representatives of each group permitting contact a cover letter explaining procedures to hand out surveys to newcomers, describing the purpose and potential benefits of the survey, and inviting them to call and discuss any questions or concerns. This mailing included the number of survey packets corresponding to the estimated number of newcomers to the group per month. Representatives were asked to give the survey to the next newcomer encountered at meetings, without regard to demographic or other characteristics. They were given a standard script to follow when giving newcomers the survey. If the newcomer declined the survey, representatives were

TABLE 3. Al-Anon newcomers (n = 359) and members (n = 264): Influences on the initial decision to come to an Al-Anon meeting

Variable	Newcomers % (n)	Members % (n)	χ^2
Problems with:			
Your overall quality of life and well-being	91.8 (326)	92.9 (236)	0.24
Your relationship with your:			
Trigger	90.4 (321)	92.9 (237)	1.23
Spouse/partner	68.5 (243)	66.7 (170)	0.21
Relatives (other family members)	57.5 (205)	64.3 (162)	2.91
Children	47.8 (171)	55.7 (142)	3.74
Friends	33.7 (120)	42.1 (106)	4.39*
Your home and/or finances[a]	74.7 (239)	76.8 (139)	0.28
Your work or school	23.3 (83)	27.9 (70)	1.62
The police, law, or criminal justice system	13.4 (48)	12.6 (32)	0.08
You were concerned that you:			
Can't handle or help Al-Anon trigger[a]	93.5 (333)	94.0 (202)	0.04
Are stressed, anxious, unable to relax	85.2 (299)	88.5 (224)	1.44
Are hopeless and/or depressed or moody[a]	82.4 (294)	84.6 (176)	0.48
Are angry	78.6 (276)	77.6 (197)	0.09
Are confused on coping with life problems	70.5 (248)	75.4 (190)	1.81
Feel lonely and isolated	66.9 (234)	72.3 (183)	2.07
Are missing what's important in life	57.1 (200)	59.3 (150)	0.27
Feel bad about yourself (low self-esteem)	53.8 (189)	64.3 (162)	6.61**
Receive verbal and/or physical abuse	48.3 (169)	52.8 (133)	1.18
Do not have a satisfying spiritual life	36.5 (128)	38.6 (95)	0.28
Are neglecting your responsibilities	28.5 (100)	31.0 (78)	0.42
Have physical health problems	24.7 (87)	29.9 (76)	2.02
Have a problem with alcohol and/or drugs	10.0 (35)	7.3 (18)	1.2
People who advised or encouraged you to try Al-Anon:			
Family, friends, or co-workers[a]	62.4 (227)	56.9 (123)	1.66
People you know who are in Al-Anon	37.3 (133)	37.8 (96)	0.01
People you know who are in AA	30.8 (110)	39.6 (101)	5.07*
Your Al-Anon trigger's health provider(s)	28.9 (103)	32.7 (83)	0.97
Your Al-Anon trigger	27.0 (96)	23.1 (58)	1.20
Your own doctor or other provider	26.3 (94)	27.2 (69)	0.06
Reason you came to Al-Anon:			
You agree that alcoholism is a disease	86.5 (310)	83.8 (212)	0.84
You like the anonymity of Al-Anon	80.6 (283)	78.3 (199)	0.47
You want circle of friends you can relate to	80.0 (280)	82.7 (211)	0.73
Meetings are at convenient times, places	77.4 (271)	81.1 (206)	1.20
Meetings are free of charge	74.9 (263)	70.9 (180)	1.23
Meet people who may be role models	73.4 (256)	71.8 (183)	0.19
You like Al-Anon's spiritual orientation	63.8 (224)	69.3 (178)	1.90
People you know benefitted from Al-Anon	63.2 (222)	63.9 (163)	0.02
You like Al-Anon's group format	60.9 (213)	70.0 (177)	5.37*
Want Al-Anon trigger to go to AA	56.5 (197)	46.0 (116)	6.56**
Want Al-Anon trigger to get professional treatment	56.2 (198)	46.6 (117)	5.34*

Notes: AA = Alcoholics Anonymous. [a]Two items were combined such that endorsement of one or both was counted as an endorsement.
*p < .05; **p < .01.

asked to offer it to the next newcomer. Representatives were asked to send a notice to research staff in a prepaid, preaddressed envelope, indicating how many newcomers who were approached declined. Of 853 groups contacted, 784 (91.9%) returned notices. Of the 784 groups, 672 (85.7%) participated in the project and, on average, obtained a survey refusal from less than one newcomer (M = 0.4, SD = 1.2).

A cover letter with the consent form and questionnaire provided a study summary (aims, methods, the survey's voluntary and confidential nature, time requirements, how to contact project staff, and a request to complete the survey within 2 weeks). Surveys were received from attendees of 54% (n = 360) of groups that agreed to participate. Respondents (mean number per group = 1.7; SD = 1.2) were offered a $25 gift card. They returned their consent form and questionnaire in separate envelopes to protect confidentiality. Respondents lived in 49 of the 50 United States (55% in suburban, 20% in rural, and 25% in urban areas).

Survey

Survey items were mainly from the Health and Daily Living Form (Moos et al., 1992), which has demonstrated strong

Table 4. Goals of Al-Anon attendance reported by newcomers (n = 359) and members (n = 264)

Variable	Newcomers % (n)	Members % (n)	χ^2
Better:			
Overall quality of life and well-being	96.3 (343)	96.5 (248)	0.01
Relationship with your:			
Al-Anon trigger	87.1 (310)	86.3 (221)	0.07
Spouse or partner	71.2 (252)	71.2 (183)	0.00
Other family members (relatives)	68.3 (243)	75.4 (193)	3.74
Children	58.9 (209)	68.4 (175)	5.78*
Friends	57.0 (203)	70.8 (182)	12.32***
Home and/or finances[a]	74.4 (239)	76.8 (139)	0.28
Work or school performance	34.0 (121)	44.9 (115)	7.49**
Police, law, criminal justice problems	11.6 (41)	11.7 (30)	0.00
What you hope to gain:			
Learn how to handle trigger problems	94.6 (334)	94.5 (239)	0.00
Less stress, anxiety; learn to relax	91.5 (324)	94.9 (241)	2.62
More hope and/or less depression[a]	88.5 (316)	93.4 (199)	3.69*
Less anger	83.0 (293)	84.1 (212)	0.13
Less confused on coping with life problems	79.4 (281)	87.0 (221)	6.14**
Involved more in what's important in life	76.8 (272)	81.6 (208)	2.01
Learn how to help your Al-Anon trigger	72.2 (254)	62.9 (158)	5.71*
Feel better about self (more self-esteem)	69.7 (246)	82.3 (209)	12.83***
Less loneliness and isolation	69.2 (245)	78.0 (198)	5.80*
More satisfying spiritual life	68.3 (241)	77.2 (196)	5.87**
Better physical health	53.4 (187)	66.0 (167)	9.67**
Stop receiving verbal, physical abuse	48.7 (172)	50.8 (127)	0.25
Better at meeting your responsibilities	43.5 (154)	51.2 (130)	3.50
Less drinking and/or drug use	13.9 (49)	12.1 (30)	0.40

[a]Two items were combined such that endorsement of one or both was counted as an endorsement
*p < .05; **p < .01; ***p < .001.

psychometric characteristics in family studies of alcohol use or other mental health disorders (Brennan et al., 2010; Timko et al., 2009). We added items on who advised or encouraged Al-Anon attendance and reasons for coming to Al-Anon (Table 3). The survey was pretested with an Al-Anon group secretary, a long-term member, a newcomer, and a dropout.

The survey ascertained newcomers' and members' demographic characteristics (Table 2). It asked what influenced the individual to initially decide to come to an Al-Anon meeting in terms of specific (a) problems, (b) concerns, (c) people or groups' advice or encouragement, and (d) aspects of Al-Anon (Table 3). Respondents reported whether each possible goal of Al-Anon attendance was a goal for them and what they hoped to gain by attending Al-Anon (Table 4).

The survey asked attendees to describe their health (Table 5), including whether they recently had experienced (a) any medical conditions ever diagnosed by a physician, (b) any psychological conditions ever diagnosed by a physician or psychologist, (c) physical abuse, (d) sexual abuse, and (e) psychological symptoms, often (Table 5). It asked about alcohol, prescription drug, and nonprescription drug use, and about help obtained for medical, psychological, couples/family, and alcohol or other drug problems (Table 5). To assess recent functioning, the survey asked whether respondents had been satisfied with aspects of their life context and how they had coped when important problems or crises arose (Table 6).

Data analysis

We compared newcomers with members, using t tests for continuous variables and chi-square tests for categorical variables.

Results

Group refusals

Of 126 groups refusing permission to be contacted (reasons were provided in open-ended format), 56 (44.4%) infrequently had newcomers, 23 (18.2%) said the study was contrary to the Traditions (Table 1), and 23 (18.2%) gave no reason. In addition, 14 (11.1%) stated that the survey would be too uncomfortable for newcomers, 5 (3.9%) gave miscellaneous reasons ("too busy"), 3 (2.8%) stated that science should not be used to study Al-Anon ("You can't scientifically quantify spirituality"), and 2 (1.4%) were located in jails.

Regarding lack of newcomers, representative statements were: (1) "We are a new, small group. Not enough newcomers to help you. Sorry." (2) "In the last year, I am the group. No newcomers." (3) "Sorry we cannot help—live in a small town and haven't had any new members for a long time." (4) "Of 3 newcomers in the past several months, two only came once to get a court-ordered form signed so they could

TABLE 5. Health status of Al-Anon newcomers (n = 359) and members (n = 264)

Variable	Newcomers % (n)	Members % (n)	χ^2
Health is good or excellent	82.2 (296)	77.3 (207)	2.44
In the past 6 months, have you had:			
Diagnosed medical condition	36.6 (129)	39.1 (99)	0.38
Diagnosed psychological condition	41.0 (146)	41.1 (104)	0.00
Physical and/or sexual abuse[a]	12.1 (41)	13.7 (27)	0.31
In the past 6 months, have you often experienced:			
Feeling:			
Anxious (tense)	87.5 (308)	88.4 (222)	0.12
Depressed (sad or blue)	76.4 (269)	74.9 (188)	0.18
Guilty	71.1 (249)	66.7 (168)	1.37
Happy	70.7 (245)	70.4 (175)	0.00
Hopeless	67.5 (237)	64.7 (161)	0.53
Having:			
Positive attitude toward yourself	59.7 (206)	64.5 (162)	1.44
A lot of control over what happens	36.6 (127)	37.2 (92)	0.02
In the past month (30 days):			
Had a drink containing alcohol	60.6 (208)	52.7 (128)	3.69*
Drank 5 or more drinks on single occasion	14.0 (48)	9.9 (24)	2.23
Used prescription drugs	57.5 (203)	60.9 (151)	0.68
Used nonprescription drugs	3.5 (12)	3.3 (8)	0.01
Help obtained in the past 6 months (not including Al-Anon):			
Medical:			
Outpatient	28.9 (103)	34.6 (88)	2.30
Self-help	7.6 (27)	7.1 (18)	0.05
Psychological:			
Outpatient	25.8 (92)	31.9 (81)	2.72
Self-help	14.6 (52)	21.7 (55)	5.10*
Couples/family:			
Outpatient	18.5 (66)	15.0 (38)	1.32
Self-help	14.6 (52)	15.4 (39)	0.07
Alcohol, other drug:			
Outpatient	3.9 (14)	1.2 (3)	4.58*
Self-help	16.2 (58)	13.4 (34)	0.95

[a]Two items were combined such that endorsement of one or both was counted as an endorsement.
*$p < .05$.

visit their son/husband in a treatment facility." (5) "We are a step-study group and rarely if ever receive a new person."

When refusing because of the Traditions (Table 1), those cited were 3, 5, 6, 7, 10, 11, and "all 12." For example: (1) "Our group feels this is against traditions. It is an outside entity." (2) "This breaks all the 12 traditions." (3) "Violates Tradition 10." (4) "Anonymity—do not feel comfortable telling stories to non-Al-Anon."

When indicating that the survey was too intrusive for newcomers, groups stated, for example: (1) "Giving a survey to a newcomer would impose a burden on someone who is already experiencing a hardship." (2) "The newcomer is already overwhelmed and this would simply add to that." (3) "Newcomers are often so fragile that these kinds of questions would appear obtrusive." (4) "While old-timers would be happy to do a survey, we do not feel right about asking newcomers."

Of 112 groups refusing study participation after having received additional information, reasons were as follows: survey too uncomfortable for newcomers (n = 48, 42.9%), lack of newcomers (n = 38, 33.9%), contrary to Traditions (n = 19, 17.0%), miscellaneous or no reason (n = 6, 5.4%), and "not in line with our spiritual aim" (n = 1, 0.8%).

Newcomers and members

Demographics. Most newcomers and members were female (85.5%; percentages and means in the text pertain to the full sample), were White (93.7%), and had health insurance (84.7%); 61.7% were currently married or with an intimate partner, and, on average, they had 14.9 (SD = 2.0) years of education, had $51,749 ($SD$ = $61,658) of annual personal income, and had lived 9.6 years (SD = 10.3) in their present home, with 69.3% living with family. On average, newcomers were somewhat younger, less likely to have adult children, more likely to be employed and to be spiritual or agnostic, and less likely to be religious or unsure about their beliefs, compared with members (Table 2).

Participation influences. The main stressors influencing newcomers' and members' initially attending an Al-Anon meeting were problems with their overall quality of life and home and relationships with their Al-Anon trigger ("the

Table 6. Current personal functioning of Al-Anon newcomers (n = 359) and members (n = 264)

Variable	Newcomers % (n)	Members % (n)	t or χ^2
Currently satisfied with your:			
Relationship with friends	72.9 (248)	76.0 (187)	0.70
Home and/or finances[a]	74.7 (239)	76.8 (139)	0.28
Work or school	65.2 (172)	67.2 (121)	0.20
Relationship with other family members	62.7 (212)	63.9 (154)	0.08
Relationship with your children	62.2 (155)	64.0 (119)	0.14
Overall quality of life and well-being	39.0 (136)	49.8 (122)	6.86**
Relationship with your spouse or partner	31.9 (91)	40.2 (78)	3.55
Relationship with your Al-Anon trigger	17.7 (59)	28.8 (67)	9.64**
When you had an important problem or crisis to deal with, did you:			
Talk with family, friends about the problem	90.7(323)	88.2 (224)	1.02
Try to see the good side of the situation	66.6 (235)	71.9 (182)	1.98
Step back from situation, be more objective	65.3 (230)	72.1 (181)	3.11
Seek help from people, groups with problem	62.6 (223)	79.1 (200)	19.30***
Try not to think about the problem	57.5 (203)	52.0 (131)	1.81
Talk with professional (e.g., doctor) about it	53.1 (189)	53.5 (136)	0.01
Make a plan of action and follow it	52.7 (186)	61.5 (155)	4.66*
Take upset feelings out on other people	50.4 (180)	48.2 (121)	0.28
Do more work, leisure, social activity	45.6 (163)	51.2 (130)	1.64
Try to help others with a similar problem	37.6 (133)	46.6 (117)	4.94*
Accept it: nothing can be done	35.7 (125)	36.4 (91)	0.03

[a]Two items were combined such that endorsement of one or both was counted as an endorsement
*p < .05; **p < .01; ***p < .001.

person in your life who is the main reason you're going to Al-Anon," sometimes called the *qualifier*), spouse/partner, and other family members (Table 3). Members were more likely than newcomers to cite problems with friends as an influence on meeting attendance.

The main concerns that influenced Al-Anon attendance (Table 3) were not knowing how to handle problems due to the trigger and/or how to help the trigger, and feeling stressed, hopeless, and angry (77.9%–93.5%). Other common concerns were being confused about how to cope, loneliness, missing what's important in life, and low self-esteem (55.7%–72.0%). A total of 49.8% of respondents were concerned about receiving verbal and/or physical abuse. Members cited low self-esteem as influencing Al-Anon attendance more frequently than did newcomers.

Regarding advice or encouragement to try Al-Anon, family, friends, or coworkers were cited most (Table 3). Members were more likely than newcomers to report that people in Alcoholics Anonymous (AA) had advised trying Al-Anon. Most newcomers and members endorsed most of the reasons considered for coming to Al-Anon (Table 3). However, newcomers less often liked Al-Anon's group format and more often wanted their Al-Anon trigger to go to AA and get professional treatment.

Attendance goals. Most newcomers and members endorsed goals of Al-Anon attendance to be improved life circumstances: better quality of life and well-being, and better relationships with the Al-Anon trigger, spouse or partner, other family members, children, and friends (Table 4). Members were more likely than newcomers to endorse the goals of better relationships with children and friends and doing better at work or school.

Most newcomers and members also endorsed other hoped-for gains by Al-Anon attendance: learning how to handle problems due to the Al-Anon trigger, having less stress and more relaxation, and having more hope and less anger and confusion about how to cope (82.3%–94.5%). Other commonly endorsed goals were being more involved in what is important in life; learning how to help the Al-Anon trigger; and having more self-esteem, less loneliness, and a more satisfying spiritual life (68.6%–78.5%). Members were more likely than newcomers to endorse the goals of feeling more hope and less depression, less confusion about how to cope, less loneliness, more self-esteem, more satisfied spiritually, and better physically. Newcomers were more likely to endorse the goal of learning how to help the Al-Anon trigger.

Membership's association with outcomes

Health. Of newcomers and members, 80.3% had good or excellent health (Table 5). Nevertheless, 58.9% of both groups had recently experienced a medical condition (most commonly, back pain [25.4%], high blood pressure [14.1%], and diabetes [12.1%]; not shown in a table) and/or a psychological condition (most commonly, depression [69.4%] and anxiety [52.8%]). Newcomers and members did not differ on medical and psychological conditions or on frequency of recent physical and/or sexual abuse, which had been experienced by 12.2%. Most newcomers and members re-

cently had often felt anxious, depressed, guilty, and hopeless (65.9%–87.9%). Nevertheless, most often felt happy (70.6%) and had a positive attitude toward themselves (62.1%). In contrast, only 37.1% of attendees often experienced having control over what happened to them.

Substance use. Newcomers were more likely than members to have had an alcoholic drink in the past month (Table 5). Relatively few respondents had engaged in heavy episodic drinking (12.3%) or used nonprescription drugs (3.4%), but most had used prescription drugs (58.8%). Respondents reported having psychological problems (24.1%), family arguments (23.6%), money problems (18.8%), physical health problems (14.2%), or problems with their job or school (10.9%) because of their own alcohol or other drug use (not shown in a table). Newcomers and members did not differ on these personal substance use–related problems.

Use of help. Within the past 6 months, outpatient care had been used by 31.1% of newcomers and members for medical problems and by 28.3% for psychological problems (Table 5). Members were more likely than newcomers to have attended a self-help group for psychological problems. In addition, 17.3% had obtained outpatient treatment, and 15.0% self-help, for couples and family problems. A small percentage had obtained outpatient treatment for substance problems (2.7%), but such help was more common among newcomers, and 15.0% had participated in self-help groups for their own substance use problems.

Functioning. Most newcomers and members were satisfied with their home and/or finances, friends, work or school, and relationships with children and other family members (63.2%–76.7%; Table 6). Fewer were satisfied with their quality of life and relationships with their spouse or partner and Al-Anon trigger (22.2%–43.7%). Members were more satisfied than newcomers with their quality of life and well-being as well as their relationship with the Al-Anon trigger.

The most commonly used coping method was talking with family or friends about problems or crises (89.8%). Other common methods were trying to see the good side of the situation, stepping back from the situation to be more objective, seeking help from others with the same problem, trying not to think about it, talking with a professional, and making a plan of action (53.5%–68.8%). Less commonly used were taking feelings out on others, spending more time on activities, helping others with similar problems, and acceptance (35.7%–49.2%). Members were more likely than newcomers to seek help from others, make a plan of action, and try to help others with similar problems.

Discussion

This study used an innovative method to accrue a national sample of 12-step group members: The first stage was a mailing by the Al-Anon WSO to groups, and, in the second stage, group representatives offered surveys to meeting attendees. In keeping with Al-Anon's philosophy of focusing on personal recovery, the most frequently endorsed goal of initial meeting attendance was achieving a better quality of life and well-being. Members were more likely than newcomers to be satisfied with their quality of life, but even so, only one half of members were satisfied. Although members were older than newcomers, they were as likely to report good or excellent health, perhaps because members were in relatively good health for their age, or newcomers were in relatively poor health, or both.

Methodology

Response rate. Twenty-two percent of groups who were initially sent a letter about the study by Al-Anon WSO responded. Assuming that some letters were undeliverable or unopened, the response rate was probably somewhat higher. Even so, it is comparable to that of other mail surveys that involved a one-time mailing without follow-up or group incentive (Dillman et al., 2009; Price and Rosenbaum, 2009). The response rate might have been higher had we been able to send reminder letters to nonresponding groups (Asch et al., 1997). Among responding groups, we obtained a high initial acceptance rate (87%) and, of groups sent more information, a high response rate (92%). In the end, we obtained surveys from 54% of the groups agreeing to participate, which is acceptable and normative (Hager et al., 2003). However, studies having direct contact with potential participants tend to have higher response rates than those initiating contact through the organizations with which individuals are affiliated (Baruch and Holtom, 2008).

Refusals. The main reasons for groups refusing participation were the infrequency of newcomers, the study being perceived as inconsistent with the Traditions, and the survey being too uncomfortable for newcomers. In future studies of specific attendee subgroups, it may help to work with the 12-step program's organizing offices to target those subgroups more efficiently from the outset. Other approaches would be to survey all attendees and select specific groups such as newcomers based on responses to survey items, or to first collect data from less vulnerable members and then work with groups to approach attendees who might need more protection.

Some, but not all, 12-step group members view research participation as inconsistent with one or more of the Traditions (3, 5, and 6, in particular) (Timko et al., 2012). Concerning Traditions 11 and 12, which emphasize anonymity, some members view revealing Al-Anon attendance to researchers as conflicting with this foundation of 12-step programs. In this regard, AA (2011) states, "A.A. as a whole seeks to ensure that individual members stay as private and protected as they wish, or as open as they wish, about belonging to the Fellowship; but always with the understanding that anonymity at the level of press, radio, TV, films, and

other media technologies such as the Internet is crucial . . . " (p. 6). This study's methods took precautions to preserve respondents' anonymity and confidentiality. For example, participants returned consent forms and surveys in separate envelopes, the survey contained no information to identify the respondent or trigger, and reports of the study will not identify any individual as an Al-Anon attendee.

In disagreements about offering newcomers a survey, some groups stated that doing so would place an undue burden at an already difficult time, but some viewed refusals to approach newcomers as over-caretaking of others (Hurcom et al., 2000; Rotunda et al., 2004). One representative stated, "Instructions were quite clear that newcomers were free to not answer any questions they felt were difficult for them. Objections [to participation] were based on the tendency of Al-Anon to be overly invasive in trying to control or protect others." We did not receive any comments from newcomers that the survey was too difficult; rather, spontaneous comments were uniformly positive (e.g., "Thank you for this study that allows me to get it all out of my system," "Thank you for the opportunity to let me share a little of my story."). These results agree with prior studies (Baddeley and Pennebaker, 2011; Danoff-Burg et al., 2010) showing that distressed participants may perceive benefits from sharing their experiences, often in the hope of helping other people with similar struggles.

Even though multiple sources were concerned with participant safety (study team, funding agency, institutional review board, WSO, Al-Anon groups taking a "group conscience"), our method raises questions: should researchers ask mutual-help group members to help implement data collection, and could there be some perceived coercion when a newcomer is approached by a group member about a study? This situation seems similar to snowball sampling (Chromy, 2008) and to recruitment in health care settings, where providers ask patients presenting for help to consider study participation. In this sense, it seems reasonable and ethical for researchers to enlist the voluntary help of group representatives to assist with recruiting potential voluntary participants. In addition, it is common in 12-step groups for experienced members to offer suggestions (obtain a sponsor, take a service position) to less experienced members while being clear that taking the suggestion is the newcomer's choice. Despite these considerations, researchers, providers, and group members need to have ongoing discussions to maintain ethical principles of conducting studies with mutual-help organizations.

Newcomers and members

Consistent with Al-Anon membership surveys (http://www.al-anon.alateen.org), respondents were mainly female and White. Although Al-Anon is open to everyone, the pattern of mainly White women seeking help has persisted over decades (Rosenqvist, 1991). Individuals who share predominant characteristics of members are more likely to initiate mutual-help group attendance (Humphreys and Woods, 1993). The Al-Anon membership may change as alcohol use disorders become more common among women (Rice et al., 2003), affecting their partners, and with increasing racial and ethnic diversity in the United States (Lee et al., 2012). Our results suggest that Al-Anon newcomers may need more flexibility than stable members to access meetings because of a higher likelihood of employment. Notably, the majority of both newcomers and members described themselves as religious or spiritual, which fits with Al-Anon's spiritual foundation.

Initial attendance

Newcomers and members differed little in terms of influences on their initial decision to attend Al-Anon, the most common of which were the individual's quality of life and well-being and relationship with the Al-Anon trigger. Consistently, the most common concerns motivating attendance were the lack of knowing how to handle problems due to the trigger, how to help the trigger, and feeling stressed, anxious, and unable to relax. In Al-Anon membership surveys, members frequently reported negative emotions before attending meetings (http://www.al-anon.alateen.org), but those surveys did not identify these symptoms as reasons for attendance. We found that newcomers were less likely than members to identify problems with friends and poor self-esteem as reasons for Al-Anon attendance. In the context of being more likely to be employed, perhaps newcomers have more work-based friendships and sources of self-confidence (Markiewicz et al., 2000; Mendes et al., 2012).

Whereas the Al-Anon membership survey reported that 44% of members had Al-Anon recommended to them by a professional (http://www.al-anon.alateen.org), our survey specified that 25%–30% of newcomers and members were advised or encouraged to attend Al-Anon by their own or the trigger's professional health care provider. Newcomers were less likely than members to have been advised to try Al-Anon by someone in AA but were more likely to have come to Al-Anon because they wanted their trigger to go to AA and obtain professional treatment. Although there may be reciprocity between a CO's Al-Anon participation and the trigger's AA participation (Roth and Tan, 2007, 2008), Al-Anon discourages COs from trying to change the trigger's drinking and related behaviors. Instead, COs are advised to detach from the trigger, focus on themselves, and obtain help for their own distress and to increase coping skills. This philosophy may be more familiar to members than to newcomers.

Newcomers' and members' goals for Al-Anon attendance were directly related to the problems and concerns that brought them to Al-Anon. That is, primary goals were better quality of life and relationship with the trigger, and primary

gains hoped for were learning how to handle trigger-related problems and less stress and anxiety. Newcomers were more focused on learning how to help the trigger, whereas members were more focused on gaining coping skills, self-esteem, physical health, less loneliness, and more spirituality. Again, Al-Anon's philosophy of focusing on the self rather than on the trigger may be more familiar to members than to newcomers, influencing their recall of goals of initial attendance.

Health and functioning

Compared with newcomers, members were more likely to be satisfied with their quality of life and their relationship with their Al-Anon trigger—that is, the primary problem areas that influenced initial attendance. Even so, one half or less of members were satisfied with their quality of life, spouse/partner, or trigger. Considering that substance use disorders may be associated with severe impairments in multiple areas and that recovery may be a lengthy process (el-Guebaly, 2012; Laudet and White, 2010), achievement of life satisfaction may be difficult, even with Al-Anon as a source of support.

In contrast, on psychological health, members did not differ from newcomers. Among both groups, 41% had recently experienced a diagnosed psychological condition. This is higher than the rate of 20% of U.S. adults with past-year diagnosable mental disorders (Substance Abuse and Mental Health Services Administration, 2012), which underscores the difficulties associated with being a CO. In particular, newcomers and members had recently experienced frequent feelings of anxiety and depression, and only about one third thought that they had control over what happened to them (Benishek et al., 2011; Klostermann et al., 2011; Tempier et al., 2006). Regarding emotional health, Al-Anon members were more likely to have obtained psychological self-help than newcomers. Newcomers were more likely than members to have recently had an alcoholic drink and obtained outpatient treatment for substance use problems. Perhaps COs decrease their own drinking as they proceed through recovery (Smith et al., 2012). In principle, Al-Anon and other sources of help could contribute independently to better outcomes or either bolster or detract from each other (Fiorentine and Hillhouse, 2000; Moos and Moos, 2005).

As might be expected among mutual-help group attendees, the most common coping method was talking with family and friends about problems or crises. In keeping with their longer Al-Anon tenure, members were more likely than newcomers to endorse the method of seeking help from people or groups with the same problem. Both groups were more likely to use approach (talking, seeing the good side, stepping back and being objective) than avoidance (trying not to think about it, taking upset feelings out on others) methods (Moos, 1993). Research findings are strong and consistent that approach methods are associated with better adjustment than are avoidance methods (Taylor and Stanton, 2007). Interestingly, despite the Serenity Prayer being the heart of the 12-step ethos ("God, grant me the Serenity to accept the things I cannot change . . . "), acceptance was the least frequently used coping method, endorsed by about one third of newcomers and members.

Limitations and directions

One limitation of this study was that members reported on their reasons for and goals of initial Al-Anon attendance retrospectively. Their experiences as Al-Anon members may have affected their reports of past influences and goals. In addition, because newcomers and members were not randomized, confirmed as equivalent at baseline, and followed prospectively, we cannot attribute group differences in functioning as attributable to Al-Anon attendance or any other factors rather than self-selection. However, studies of AA addressing selection bias have yielded consistent evidence that attendance improves drinking outcomes (Magura et al., 2013; Ye and Kaskutas, 2009). We conducted multiple comparisons without adjustment, and when comparisons of members and newcomers were significant, effect sizes tended to be small (i.e., about .20, ranging from .18 to 1.20).

The rarest source of referral to Al-Anon was the individual's own professional health care provider. Lack of referral may contribute to long delays between the beginning of COs' difficulties and their seeking help through Al-Anon (Ablon, 1974; Gorman and Rooney, 1979). Studies are needed of how providers might play a larger role in referring COs to mutual help (Laudet et al., 2002). Providers can inform and educate clients about Al-Anon, redress misunderstandings about meetings, and help find a good fit between clients' needs and preferences and the tools and support offered by the fellowship. Continued and expanded cooperation among the 12-step, research, and professional provider communities may help to improve the quality of life and relationships of people coping with another's alcohol use disorder.

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