

Physicians in Long-Term Recovery Who Are Members of Alcoholics Anonymous

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Background: There is little empirical literature on the experience in sobriety of long-term, committed members of Alcoholics Anonymous (AA).

Objective: Studies on the experience of long-term members, however, can yield a better understanding of the role of spirituality in AA membership, and how the program helps stabilize abstinence.

Methods: We studied 144 physicians at a conference of doctors in AA.

Results: Respondents had a mean period of sobriety of 140 months. Compared to normative populations, they scored higher on scales for depression and anxiety, and were more adherent to the spiritual character of AA, rather than a formally religious orientation. Those who reported “having a spiritual awakening” were more likely to “experience God’s presence” on most days (81% vs. 19%) and were less likely to report craving for alcohol (21% vs. 41%) than those who did not. Respondents who had a history of being enrolled in State Physicians’ Health Programs did not differ significantly on any of the aforesaid subjective variables from those who were not enrolled.

Conclusion: The experience of long-term AA members can be characterized in terms of abstinence, spirituality, and alcohol craving.

Scientific Significance: The study of long-term AA members can shed light on mechanisms of achieving abstinence in this fellowship. (*Am J Addict* 2013;22:323–328)

An important component of the fellowship of Alcoholics Anonymous (AA) is its long-term, committed membership. These members tend to be strong advocates of the Twelve-Step format, and regular attenders at AA meetings. According to AA’s own survey, conducted at a sample of its regular meetings, its member respondents had attended an average of 2.4 meetings weekly, with 47% indicating they had been sober for at least 5 years.¹

The peer-review literature on AA, on the other hand, does not typically reflect access to long-term members, as it generally describes substance abusers who were followed after

referral to AA by ongoing treatment programs. Many such patients do not attend AA with regularity, nor do they stay affiliated for the long term.^{2–4} Additionally, such studies typically do not include members who affiliated with AA independent of professional referral.

The current study was designed to characterize a cohort of long-term members, highly committed, and not exclusively referred from treatment or monitoring programs. These respondents are occupationally defined, in that they are all physicians. Although this limits the opportunity to generalize to other committed members, it does provide an understanding of the experience of certain well-rehabilitated AA members in long-term sobriety. Additionally, it characterizes a population of considerable interest from a public health perspective, given the role these physicians play in patient care.

In framing this study, we wanted to address additional issues that are salient to understanding long-term recovery among our respondents: What differences in recovery status might there be between those physicians who entered AA in conjunction with referral by physicians’ health programs, and those who did not? What are some aspects of alcohol craving and affective status (such as depression) as concomitants of the recovery experience? What role does spirituality play in the recovery process? Spirituality in particular is important to AA—a self-designated spiritual fellowship—but is an issue which merits some clarification because of the subjective nature of its experience, and the limited empirical literature on this issue.

METHOD

The study was designed to be in accord with the 12th AA tradition, the need to preserve members’ anonymity. This was done by not soliciting names of the participants, and surveying them in such a way that they could not be individually identified by the responses they gave to the research instrument we employed.

The study was carried out at a scientific session, providing continuing medical education, of an association of health professionals. Information on this association is publicly

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available, described on its website (www.aa.org; 2011) as an organization of recovering health professionals at a doctoral level who support AA as a basis for recovery from addiction. It is not directly affiliated with the fellowship of AA, nor does it represent that latter fellowship. AA itself does not retain the identity of its members, whereas this group does so in order to contact them about organizational activity. In this respect, it operates more like a professional affinity organization. It holds a convention each year, and our survey was conducted at its August 2010 convention in Buffalo, NY. Our survey was explained to attendees at one session as a vehicle for providing information that would enhance professional understanding of addiction recovery as experienced through affiliation with AA. In all, 239 professionals attended that session, and 196 elected to volunteer to complete the survey. We analyzed the data from 144 of the respondents who were physicians.

The survey instrument consisted of 71 computer-coded items. The topics addressed included demographics, substance abuse history, general psychological and addiction treatment, and experience in, and views of, AA. Depression and anxiety in the past week were assessed by a series of 12 items drawn from the Brief Symptom Inventory, with scores compared to a community sample, normed for men and women, respectively.⁵ Craving for alcohol was assessed by responses on a 10-point visual analog scale, similar to ones applied in other studies on substance abusers in treatment.⁶ Respondents' spiritual and religious orientation was assessed by comparison to items employed in surveys of US national probability samples.⁷⁻⁹

RESULTS

The respondent sample ($N = 144$) was 81% male and 83% employed, with a mean age of 57.8 ($SD = 9.9$) years. It was divided among those whose principal problem was alcohol only (46%), drugs alone (6%), or both drug and alcohol abuse (48%). The majority (66%) had received treatment for general psychological problems (ie, not substance abuse). They reported that they currently had not used alcohol or drugs of abuse for an average of 139.6 ($SD = 117.8$) months. Most respondents (69%) had been enrolled in a physicians' health program. Most (58%) had received outpatient substance abuse treatment and half (50%) had been hospitalized for this problem. Thirty-two percent of the sample reported receiving neither of these substance abuse treatments, but of these, almost half (15%) had received treatment for general psychological problems.

AA Engagement

The majority (77%) had been referred to AA by a professional, and had attended their first AA meeting at 40.2 ($SD = 10.5$) years of age. At some point, most (74%) had gone to 90 AA meetings in 90 days, a criterion considered by AA members as optimal for induction. Regarding current involvement in the AA program, they were frequent meeting

attenders ($\bar{x} = 155.1$, $SD = 120.5$, meetings in the last year) and the large majority (82%) indicated that they currently had a sponsor and were doing service (88%) for the fellowship (eg, making coffee at meetings) in the last year. Indeed, 72% had also served as sponsors of other AA members, with 25% of the overall sample having sponsored more than five other members.

The majority of respondents (69%) had been enrolled in State Physicians' Health Programs, and could be compared to those who had not been enrolled. These two groups were not significantly different regarding whether their problem was with alcohol alone or with drugs, or in the number of AA meetings attended in the last year. Those who had been enrolled in PHP, however, were younger ($\bar{x} = 56.03$, $SD = 9.24$, vs. 62.29, $SD = 10.24$, years, $t = 3.53$, $df = 134$, $p = .0001$) and more likely to have gone to 90 meetings in 90 days (84% vs. 54%, $\chi^2 = 14.48$, $df = 1$, $p = .0001$). At present, they had also been free of alcohol and drugs for a shorter period of time ($\bar{x} = 102.39$, $SD = 93.34$, vs. 219.09, $SD = 130.81$ months, $t = 5.25$, $df = 63$, $p = .0001$) than those who had no such history.

Affective Status

Mean item raw scores were calculated for responses to items on the Brief Symptom Inventory scales for both depression and anxiety. They were, for men, .640 and .678, respectively, reflecting T -scores of 62 and 59. For females, these scores were .573 and .480, respectively, reflecting T -scores of 63 and 54. Thus, respondents scored about one standard deviation higher than the mean of the community comparison groups for depression and anxiety.⁵ The majority of respondents (70%) indicated on the analog scale that they had no craving for alcohol in the past week, and there was a significant positive correlation between scores on that scale and the BSI depression ($r = .42$, $p < .001$) and anxiety ($r = .31$, $p < .001$) scales. Craving scores were inversely related to duration of current abstinence ($r = -.28$, $p < .01$).

Spirituality

Members' spiritual and religious orientations were evaluated by means of a number of questionnaire items. Regarding their belief in a deity, most (60%) indicated that they believed in a personal God as opposed to a Higher Power only (22%), or neither God nor a Higher Power (18%), but most (71%) indicated that they felt God's presence at least most days. Only a minority went to church at least monthly (36%), or designated themselves as religious (37%); 97%, however, designated themselves as spiritual.

Respondents could score statements reflecting their degree of agreement with the First and Third Steps of AA, respectively, on a scale of 1 (not at all) to 5 (very much). Ninety percent of them endorsed 5 for "I am powerless over alcohol" and 80% scored 5 for "I should turn my will and life over to the care of God as I understand him." Additionally, the large majority of respondents (81%) reported having had a spiritual awakening. On average, those who had experienced

a spiritual awakening reported a longer period of recent abstinence ($\bar{x} = 155.54$, $SD = 117.34$) than those who had not ($\bar{x} = 83$, $SD = 105.35$, $t = 2.94$, $df = 138$, $p = .004$), and were more likely to “experience God’s presence” on most days (81% vs. 19%, $\chi^2 = 23.31$, $df = 1$, $p < .001$). They were less likely to report experiencing any craving for alcohol (21%) than those who reported they had not (41%, $\chi^2 = 4.22$, $df = 1$, $p = .04$). Physicians who had been enrolled in State Physicians’ Health Programs were not significantly different from those who had not been in any of the spiritually related variables or on depression or anxiety.

DISCUSSION

Assessment of Long-Term AA Membership

One reason we undertook this study was because there is a paucity of information available on substance abusers who have long-term affiliation with AA and long-term abstinence. The findings presented here were obtained from a cross-sectional study on physicians in long-term Twelve-Step-based recovery who were attendees at a convention for doctoral level health professionals who were members of AA. Although the study is limited to a narrowly defined sample of abstinent substance abusers, it can augment the current understanding of long-term AA membership in a number of ways. It allows for a comparison of those referred by a system of careful monitoring (the physician health programs) to those who entered the fellowship by other means. It provides some basic information on prior use, treatment experience, and duration of abstinence not previously available for community-based long-term AA samples. It also characterizes respondents’ current status in abstinence regarding issues such as affective status and views related to AA and its spiritually oriented culture.

Although information on levels of AA attendance is available in numerous studies, most of these studies involve patients followed up after engagement in specific treatment programs.²⁻⁴ Community-based samples are less common, but do reflect an association between long-term AA attendance and positive outcome. One source of information on such members is the General Service Board of AA itself. AA’s Central Office conducts a triennial survey of members at a selected sample of meetings, most recently in 2007, and reported that 47% of attendees had been sober for at least 5 years.¹ Another source is the National Institute on Alcohol Abuse and Alcoholism, which conducted a large-scale survey (NESARC) weighted to be representative of the US adult population. Exposure to Twelve-Step programs (including Narcotics Anonymous, Cocaine Anonymous, and Alcoholics Anonymous) was queried, and 3.4% of respondents indicated exposure to these Twelve-Step programs at some point in their lives, and 24% of them had maintained continued Twelve-Step engagement. Most (74%) of those who had maintained engagement had undergone specialty treatment for their substance use disorder, with 36% having been abstinent for over 5 years.¹⁰

Some long-term follow-ups on treated populations are informative as well. One survey conducted in northern California⁴ followed up on individuals seeking treatment at alcohol programs. Those who were designated as high AA attenders had gone to meetings during the 12-month period prior to each of 1, 3, and 5 years out of treatment. Of them, 51% were abstinent at the 5-year follow-up.⁴ In another study, Moos and Moos¹¹ followed up a large sample of individuals over the course of 16 years who sought treatment for alcohol use disorders. A positive outcome after the first year was associated with both having obtained treatment and with attendance at AA. After 16 years, however, a better outcome was associated with subsequent AA involvement, but was not related to receiving subsequent treatment.

Our current study illustrates the variety of antecedent experiences that may be encountered by long-term members. It characterizes one group of long-term AA members who accessed AA independent of any treatment follow-up. A number of the long-term members we studied reported receiving no substance abuse treatment at all, but most of this latter group reported that they had received treatment for non-substance-related general psychological problems.

Physician Recovery Programs

Long-term abstinence among substance-abusing physicians is of considerable public health import due to the potential impact on medical errors of intoxication and chronic use on patient care. The majority of States therefore now provide support for programs of case-finding and monitoring of affected physicians. In both earlier and more recent reports, rehabilitation includes an emphasis on Twelve-Step attendance, even with a bias against “traditional psychiatric counseling.”¹² Because of this, physician recovery, although conducted in professionally directed programs, augmented by careful monitoring and varying degrees of counseling, can be a useful source for understanding Twelve-Step-based outcome.

Information on physician abstinence in the Twelve-Step context, in particular after State programs’ monitoring periods end, is limited. Early reports by program staff have provided outcomes of abstinence while physicians were monitored. These ranged from as low as 27%¹³ up to 92%.¹⁴ These reports also typically rely on program evaluation being conducted by investigators affiliated with the programs themselves. Two recent reports, however, were conducted by investigators unaffiliated with the programs themselves, and both illustrated how AA is employed as an important aspect of the programs. Both studies revealed positive outcomes. One¹⁵ drew on 16 programs, with review of records for outcome of 904 physicians admitted over a 6-year period, with alcohol (50%) and opiates (36%) being the most common primary problems. Of 802 physicians whose records were available at 5-year follow-up, 92% had been expected to attend Twelve-Step groups, and 79% were licensed and employed (largely in practice) after 5 years.

The second study¹⁶ was carried out on New York State’s program, where 104 participants who completed monitoring

were assessed after an average of 41 months. Management had included having a monitor assigned to each physician who recorded Twelve-Step and psychotherapy participation. Eighty percent of participants attended Twelve-Step meetings, and those who received outpatient psychotherapy were significantly more likely to attend Twelve-Step meetings than those who did not. Furthermore, the majority of participants who had initially resisted Twelve-Step attendance subsequently did attend.

In our current study, physicians who had been enrolled in physicians' health programs were similar in age and duration of abstinence to those who had not been enrolled. The fact that PHP enrollees were more likely to have attended 90 meetings in 90 days likely reflects the more directive role of these programs. The two groups, however, were not significantly different in the scales for AA beliefs or affiliation with other members. Our findings do suggest that physician entry into AA-based abstinence is viable both through PHP intervention and by other routes as well. Furthermore, it may well be that once people have become engaged in AA for an extended period of time, they may be similar in affiliative ties despite different sources of referral.

Spirituality

AA does not emphasize religious practice in its literature, but does regularly employ the term "spiritual experience." Spirituality has been defined in the medical literature¹⁷ as that which gives people meaning and purpose in life; it can be achieved through participation in a religion, but can be characterized as a belief in God, or commitment to family, naturalism, humanism, or the arts. An analysis of outcome in the large-scale Project MATCH federal study¹⁰ on the treatment of alcohol disorders clarifies that people participating in AA become oriented to a spiritual role. It revealed that attendance at AA meetings was associated with increases in spiritual practices, which was, in turn, mediated by increases in spirituality.¹¹ Furthermore, measures of increased spirituality have been found to be associated with a positive outcome of participation in both abstinence¹⁸ and psychosocial¹⁹ outcomes of treatment.

By drawing on several studies of national probability samples, it is possible to compare attitudes of the physician respondents to those of the general population with regard to spiritual and religious issues. Overall, the physicians appear to be relatively more spiritually, rather than religiously, oriented. For example, they were less self-designated as religious than a community probability sample (37% vs. 64%), but more self-designated as spiritual (97% vs. 79%).⁸ Less of the physicians indicated belief in a "personal God" than did members of a community sample (60% vs. 74%), but more indicated belief in a "Higher Power" (22% vs. 13%).⁹ This was compatible with fewer of the physicians attending church or worship services at least monthly (36% vs. 73%). Nonetheless, more responded affirmatively to feeling "God's presence" "most days" (71% vs. 57%),⁷ an experience often reported by long-term members.

The phrase, "we have experienced a spiritual awakening" appears in the fellowship's Twelfth Step, although the term is not actually defined in the AA text itself. Indeed, it may have

quite different meanings for different members, and reflect primarily a self-designation of having experienced the intensity of the group's spiritual orientation. Some investigators have attempted to ascertain how the experience of spiritual awakening is related to clinical outcome, and included a query, such as, "Have you ever had a spiritual awakening?" in scales for AA involvement or affiliation.^{20,21} These investigators, however, did not report on clinical correlates of this specific item. Kaskutas et al.,²² however, followed a large sample of men and women over 3 years after entering treatment. They found that those who reported having had a spiritual awakening during their third year were more than three times as likely to be abstinent at the time of that follow-up than those who did not so report. Significantly, greater antecedent religiosity was not associated with a better outcome, suggesting that this spiritual experience per se, not associated with religion as such, is an important correlate of abstinence.

The issue of spiritual awakening is a significant one for the physicians we sampled, and it is indicated as central to AA's 12th Step. The large majority of respondents did indicate that they had experienced this. Those who did had an appreciably longer period of abstinence, and were also much more likely to report experiencing God's presence most days. They were also less likely to report having craving for alcohol. Notably, long-term AA sobriety was not significantly different for respondents who had been enrolled in State programs from those who had not been on the variables reflecting spiritual experience. This is the case despite the fact that the former group had been in sobriety for a relatively shorter period of time, and were more likely to have attended 90 meetings in 90 days. This suggests that the spiritual orientation achieved by long-term sober members may be similar even if referred to AA under differing circumstances.

These findings lend texture to our understanding of the nature of a phenomenon, namely, the acquisition of a spiritual orientation, apparently quite important to long-term Twelve-Step-based recovery. They underline a belief system espoused in AA that is characteristic of this fellowship, as distinct from religious denominational orientations. Further research on developing an operational definition of spiritual awakening may be valuable in clarifying how recovery can be stabilized in some substance-dependent persons, and how clinicians can approach the issue of spirituality in their addicted patients.

Affective Status

Participants' responses to our survey place them about one standard deviation above norms for a community comparison group for both depression and anxiety. They may have been more materially distressed upon entry, given that recruits' affective status has been found to improve with induction into AA.²³ The fact that the majority of our respondents had undergone treatment for "general psychological," and not just substance abuse problems, also supports this. This lends credence to the need to characterize the breadth and diversity of state changes associated with the concept of "recovery" from addiction.

In our own studies of zealous new religious movements,²⁴ we found that the relief of anxiety and depression was experienced during induction into a cohesive group with strong commitment to its belief system, and that this relief was also sustained over the course of membership. In that case, the relief of distress acted as a reinforcer of continued affiliation and of adherence to group behavioral norms. Such findings may help explain the fact that our respondents strongly endorsed AA principles and successfully adhered to the AA norm of abstinence, as this may have been effectively reinforced by relief of anxiety and/or depression. Respondents' beliefs were therefore oriented more toward the AA spiritual ethos, as distinguished from a conventional religious one, than were those of respondents in studies on national probability samples of the US adult population, suggesting the possibility of ascription to the AA ethos as related to stabilization of improved affect.

Attitudes toward AA among professionals in the addiction field itself are variable, with treaters in the United States more positive than those in certain other international settings. One sample of American clinicians, for example, all referred at least some patients to Twelve-Step groups, and most held a highly positive view of the fellowship's utility.²⁵ In two European surveys, however, one in England²⁶ and one in Norway,²⁷ less than 10% of programs employed the Twelve-Step model. An organization like International Doctors in Alcoholics Anonymous (IDAA) can have a significant impact on referral to AA among health professionals, as many clinicians are not necessarily trained to be understanding of, or hospitable to, AA's spiritual orientation. For example, in one study on clinical training, medical students were found to experience a decline in orientation toward a spiritual approach (so essential to AA) over the course of their psychiatry clerkships.²⁸

The impact of AA-based recovery on recovering physicians was evident in one study²⁹ that examined a sample of physicians discharged an average of 33 months beforehand from an AA-oriented treatment program. They were high Twelve-Step attenders, averaging almost one meeting daily, and ascribed their recovery to AA more so than to professional treatment or family support, and 51% of them were involved in addiction-related professional activities. Similarly, the sample in our study, drawn from a medical society that strongly supports Twelve-Step-based recovery, may be instrumental in promoting better use of AA as an adjunct to professional treatment of addiction.

Inferences from the findings of this study must be viewed with caution for a number of reasons. The study was limited by the anonymity adhered to by AA members, the narrowly defined professional role of respondents, and the need to limit the length of the survey instrument to the administrative circumstances in the setting in which it was carried out. Physicians, particularly ones whose licensure could become subject to constraint due to past history, may feel a need to overstate the stability of their recovery and AA affiliation, even when responding anonymously. Additionally, our findings are cross-sectional, rather than longitudinal, and responses

were not corroborated by other informants, breathalyzer, or urine toxicology testing. Furthermore, it should be pointed out that AA's spiritual orientation is only one aspect of what is found to contribute to its help in stabilizing long-term abstinence. The social support received from other AA members,³⁰ and the opportunity to help others,³¹ have also been found to be significant in assuring a stable recovery.

Nonetheless, the conduct of this survey presented an opportunity to study certain aspects of the experience of long-term abstinence in AA outside of treatment follow-up. It thereby allowed for improving understanding of this phenomenon which is pertinent to the ongoing recovery of other highly compromised substance abusers. Such findings can provide a basis for further investigation into the mechanisms that underlie the role of AA in stabilizing long-term abstinence. They may also be of value to clinicians to facilitate more effective communication with addicted patients for referral to Twelve-Step recovery programs, since the concept of spirituality in AA is often difficult for non-members to understand.²⁵

The experience of abstinent long-term AA members is important to the character of the fellowship experience for all meeting attendees, and for the program's recruitment of new members. This experience, however, has been subject to limited empirical study. Given the nature of our findings, it is important to note that there are certain important attitudinal issues that such members typically have in common, and that these can be defined in relation to their affective status and the diminished craving for alcohol they report. Among these is a strong spiritual orientation, one that may be distinguished from a traditional denominational commitment, but which serves as a key element in the movement's effectiveness.

In its own survey, AA reported a membership of 1,264,726 in the United States and Canada, and 704,266 overseas.³² This represents numbers of considerable significance relative to the limited availability of long-term, professionally based treatment for substance dependence, particularly given the vulnerability of addicted people to relapse. The study of long-term AA members in the community may therefore allow for a better understanding of AA membership, and thereby, how appropriate referral can be made by health professionals.

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