Drug and Alcohol Dependence 133 (2013) 633–640

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

The Twelve Promises of Alcoholics Anonymous: Psychometric measure validation and mediational testing as a 12-step specific mechanism of behavior change

John F. Kelly*, M. Claire Greene

Center for Addiction Medicine, Department of Psychiatry, Massachusetts General Hospital, Harvard Medical School, 60 Staniford Street, Boston, MA 02114, United States

ARTICLE INFO

Article history:
Received 24 May 2013
Received in revised form 25 July 2013
Accepted 9 August 2013
Available online 22 August 2013

Keywords:
Alcoholics Anonymous
12-Step
Twelve Promises
Recovery
Addiction
Young adults

ABSTRACT

Background: Empirical support for the recovery utility of 12-step mutual-help organizations (MHOs) has led to increased investigation of how such organizations confer benefit. The Twelve Promises of Alcoholics Anonymous (AA) feature prominently in 12-step philosophy and culture and are one of the few documented explications of the cognitive, affective, and behavioral benefits that members might accrue. This study investigated the psychometric properties of a measure of AA's Twelve Promises and examined whether it mediated the effect of 12-step participation on abstinence.

Method: Young adults (N = 302, M age 20.4 [1.6], range 18–25; 27% female; 95% White) enrolled in an addiction treatment effectiveness study completed assessments at intake and 3-, 6-, and 12-months post treatment including a 26-item, Twelve Promises Scale (TPS). Factor analyses examined the TPS' psychometrics and lagged mediational analyses tested the TPS as a mechanism of behavior change.

Results: Robust principal axis factoring extraction with Varimax rotation revealed a 2-factor solution explaining 45–58% of the variance across three administrations ("Psychological Wellbeing" = 26–39%; "Freedom from Craving = 17–21%); internal consistency was high (alpha = .83–.93). Both factors were found to increase in relation to greater 12-step participation, but significant mediation was found only for the Freedom from Craving factor explaining 21–34% of the effect of 12-step participation in increasing abstinence.

Conclusions: The TPS shows potential as a conceptually relevant, and psychometrically sound measure and may be useful in helping elucidate the extent to which the Twelve Promises emerge as an independent benefit of 12-step participation and/or explain SUD remission and recovery.

© 2013 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

For individuals seeking recovery from substance use disorder (SUD) achieving stable remission can take several years and typically involves multiple interventions and strong social support (Dennis et al., 2005; Kelly and White, 2011; Moos and Moos, 2006; Stout et al., 2012; White, 2010). A major additional contributing factor for many is participation in peer-led mutual-help organizations (MHOs), such as Alcoholics Anonymous (AA), Narcotics Anonymous, SMART Recovery, and myriad others (Humphreys, 2004; Kelly and Yeterian, 2008; Moos and Moos, 2004). In the United States, there are approximately 1.3 million active members of AA alone, meeting in around 57,000 weekly meetings. Its widespread reach and popularity is supported by systematic empirical research, which has found AA participation to facilitate abstinence and long-term recovery in a highly cost-effective manner (Ferri et al., 2006; Humphreys and Moos, 2001, 2007; Kaskutas, 2009; Kelly et al., 2006; Mundt et al., 2012; Tonigan et al., 1996).

As support for its effectiveness has increased, a growing body of research has begun to investigate how exactly 12-step MHOs like AA help individuals achieve and maintain long-term recovery from SUD (Kelly et al., 2009). Research has found that MHOs aid recovery through facilitating changes in social networks (Kaskutas et al., 2003; Kelly et al., 2010), increasing coping, motivation, and self-efficacy (Humphreys et al., 1999; Kelly et al., 2012, 2000; Morgenstern et al., 1997), and enhancing spirituality (Kelly et al., 2011a; Krentzman et al., 2013; Robinson et al., 2007; Zemore, 2007). From AA's own theoretical perspective on how recovery is purported to be achieved, however, research has been compromised, in part, because of challenges in construct conceptualization and measurement of AA-specific factors, such as spirituality.

* Corresponding author at: 60 Staniford Street, Boston, MA 02114, United States. Tel.: +1 617 643 1980; fax: +1 617 643 1998.
E-mail addresses: jkelly11@partners.org, kellyjohn@verizon.net (J.F. Kelly).

0376-8716/$ – see front matter © 2013 Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.drugalcdep.2013.08.006

The central proposed mechanism of recovery from addiction according to AA is through a "psychic change" (Alcoholics Anonymous, 2001, p. xxvi), "spiritual experience," or "spiritual awakening" (Alcoholics Anonymous, 2001, Appendix II), achieved through completion of the 12-step program (as noted in Step 12: "Having had a spiritual awakening as the result of these steps we tried to carry this message to other alcoholics and to practice these principles in all our affairs"). Although AA states that this "awakening" can take the form of a sudden and sometimes dramatic shift in belief and perspective, it also characterizes this transformation as a gradual change of an "educational variety" that leads to "... a profound alteration in [his] reaction to life" (Alcoholics Anonymous, 2001, Appendix II, p. 567). This is not only associated with belief in a potentially more traditionally defined, "higher power," but also involves concrete changes in specific attitudes and behaviors that result in recovery.

In the main AA text (Alcoholics Anonymous, 2001), AA states that as a result of beginning to work on the AA program, members will start to accrue twelve outcomes, or "promises," that describe rewarding shifts in quality of life that are likely to culminate from participation (Alcoholics Anonymous, 2001, p. 84–85). These "Twelve Promises" are often read out at the beginning or end of AA and other 12-step MHO meetings (Kelly and McCrady, 2008) and describe benefits, such as decreased cognitive-affective distress (e.g. freedom from craving/addiction; elimination of past regrets; decreases in fear of people and economic insecurity), as well as increases in psychological well-being (e.g. increased feelings of usefulness/meaning and purpose; increased intuition and gratitude). Thus, these Twelve Promises may capture elements of what is commonly referred to as a "spiritual awakening" of the "educational variety." Framed in this way, the attainment of the 12 Promises may play two important roles: first, as recovery benefits and ultimate outcomes in their own right; in fact, some may argue that these are "recovery"-adding quality of life beyond mere abstinence (Betty Ford Consensus Panel, 2008); and, second, as an intermediate outcome, or mechanism, through which members are spurred on to continued sobriety. In other words, 12-step MHO participation leads to these negative reinforcing benefits (e.g. freedom from craving, decreased affective distress) and positive reinforcing benefits (e.g. gratitude, meaning/purpose) captured in the Promises that make continued sobriety worthwhile. In plain language, "you go to AA, it helps you feel better, and you don't drink."

Consequently, the Twelve Promises are significant within the AA literature and broader 12-step MHO culture. While measures exist that capture some of the same broad elements encapsulated within the 12 Promises, such as craving, distress, and psychological well-being (Sajatovic and Ramirez, 2012; Baer and Blais, 2009), the 12 Promises have never been examined empirically, despite their prominence. Given the size and influence of 12-step MHOs, the extent to which the Promises become a reality for 12-step participants and whether the manifestation of these rewards in members' lives is, to some degree, responsible for their recovery, is worthy of investigation. Consequently, to help fill these knowledge gaps, the current study had two main aims: (1) To construct and test the psychometric properties of a self-report measure derived from AA's Twelve Promises; and, (2) To test its relation to 12-step participation and whether it mediates the effects of 12-step participation on abstinence outcomes. We examined the effects of both 12-step MHO attendance as well as active 12-step MHO involvement (e.g. having a sponsor, verbally participating during meetings, reading 12-step literature outside of meetings) with the prediction that active involvement would have a stronger relationship to increases in the Twelve Promises.

2. Method

2.1. Participants

Participants were 302 young adults (18–24 years old) undergoing residential treatment and enrolled in a naturalistic study of treatment process and outcome. At admission, participants were 20.4 years old on average (SD = 1.6), primarily Caucasian (94.7%), male (73.8%) and single (100.0%). At admission, 11.9% were employed full-time and 41.1% were enrolled in school (high school or college). Most had completed high school: 43.4% had a high school diploma and 39.8% had some college education. The most commonly reported "drug of choice" was alcohol (28.1%) and marijuana (28.1%), followed by heroin or other opiates (22.2%), cocaine or crack (12.3%), and amphetamines (6.0%). Small proportions reported benzodiazepines (2.0%), hallucinogens (1.0%), or ecstasy (1.0%) as their drug of choice (a small number of participants ($n = 5$) reported more than one drug of choice, such that these proportions do not sum to 100%).

Participants in this private treatment sample were more likely to be Caucasian than young adults (18–24 years old) in public sector residential treatment (76%; Substance Abuse and Mental Health Services Administration, 2009), or adults (18+ years old) in the broader private treatment sector (71%; Roman and Johnson, 2004). They were, however, comparable in terms of gender, marital status, and employment status, suggesting that results are broadly generalizable to youth treated for substance-related disorders in the US.

2.2. Treatment

Treatment was comprehensive and multi-faceted, based in a 12-step philosophy of recovery. In addition to the 12-step orientation, motivational enhancement and cognitive–behavioral therapeutic approaches, as well as family therapy, were used to facilitate problem recognition, treatment engagement and support recovery. Programming included clinical assessment, individual and group therapy, and a host of specialty groups tailored to meet the needs of individual clients. Participants' average length of stay at the residential treatment center was 25.5 days (SD = 5.7). The majority (83.8%) were discharged with staff approval, indicating a high rate of treatment completion.

2.3. Procedure

Participants were enrolled in the study shortly after admission. A total of 607 young adults were admitted to treatment during the recruitment period (October, 2006 to March, 2008). All of those aged 21–24 years old were approached for study enrollment, as well as every second individual aged 18–20, in order to ensure sufficient representation of the older age group. A small number of potential participants left treatment before recruitment could take place ($n = 6$) or were not approached by staff for recruitment ($n = 14$). Of those approached ($n = 384$), 64 declined or withdrew participation. Reasons for non-participation included not wanting to participate in the follow-up interviews (44%), not being interested in the study (31%), wanting to focus on treatment (14%), and legal issues (2%). Following enrollment, an additional 17 participants withdrew prior to the baseline assessment and the consent for one participant was misplaced. The final sample of 302 represents 78.6% of those approached for participation.

Research staff conducted assessments at baseline, end of treatment, and 3-, 6-, and 12-months post-discharge. Each assessment included an interview portion and self-administered surveys. Participants were compensated for their participation. Assessment completion rates were 87.1% at end of treatment, 81.8% at 3-month

Download English Version:

https://daneshyari.com/en/article/10509576

Download Persian Version:

https://daneshyari.com/article/10509576

Daneshyari.com