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# Recovery benefits of the “therapeutic alliance” among 12-step mutual-help organization attendees and their sponsors

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### ABSTRACT

**Background:** The “therapeutic alliance” between clinicians and patients has been associated with treatment response and outcomes in professionally-delivered psychotherapies. Although 12-step mutual help organizations (MHOs), such as Alcoholics Anonymous, are the most commonly sought source of support for individuals with substance use disorder (SUD), little is known about whether a stronger alliance in comparable MHO relationships between 12-step sponsors and those they help (“sponsees”) confers benefits similar to those observed in professional contexts. Greater knowledge could inform clinical recommendations and enhance models that explain how individuals benefit from 12-step MHOs.

**Method:** Young adults ( $N = 302$ ) enrolled in a prospective, clinical effectiveness study of residential SUD treatment were assessed at treatment entry, and 3, 6, and 12 months after discharge on whether they had a sponsor, contact with a sponsor, and degree of sponsor alliance. Hierarchical linear models (HLM) tested their effects on 12-step MHO attendance, involvement, and percent days abstinent (PDA).

**Results:** Approximately two-thirds of the sample ( $n = 208$ , 68.87%) reported having a sponsor at one or more follow-up time points. Both having sponsor contact and stronger sponsor alliance were significantly associated with greater 12-step participation and abstinence, on average, during follow-up. Interaction results revealed that more sponsor contact was associated with increasingly higher 12-step participation whereas stronger sponsor alliance was associated with increasingly greater abstinence.

**Conclusions:** Similar to the professional-clinical realm, the “therapeutic alliance” among sponsees and their sponsors predicts better substance use outcomes and may help augment explanatory models estimating effects of MHOs in SUD recovery.

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## 1. Introduction

In both the general psychotherapy (Horvath and Luborsky, 1993; Wampold, 2001) and addiction-specific treatment literature (Beutler et al., 1994; Kiluk et al., 2014; Moos, 2007; Urbanoski et al., 2012), the “therapeutic alliance” is viewed as an essential factor in treatment. This working relationship between therapist and patient is purported to create the necessary climate and conditions in which other intervention contents, from whichever specific theoretical orientation, can be successfully delivered by the therapist and absorbed by the patient (Kelly et al., 2016; Luborsky et al., 1988; Miller and Moyers, 2015; Wampold, 2001). Various referred to as the “working”, “helping”, or “therapeutic” alliance,

it is defined as the degree to which clinicians and patients agree on the goals, tasks, activities, and pacing of treatment and also possesses relational elements of perceived trust, empathy, and caring (Barrett-Lennard, 1962; Horvath and Luborsky, 1993; Luborsky et al., 1988; Wampold, 2001). Research supports the value of establishing a strong therapeutic patient-clinician bond since it has been consistently associated with improved treatment engagement and substance use outcomes independent of the presumed “active” ingredients of treatment, such as teaching of cognitive and behavioral relapse prevention skills (Orlinsky et al., 2004).

In the addiction treatment arena, most treatment programs refer patients to free community-based recovery mutual-help organizations (MHOs), such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) to help prevent relapse and support long-term recovery (Greenfield et al., 1998; Hacker and Walker, 2013; Humphreys and Moos, 2001; Kelly and Yeterian, 2013, 2012; Maust et al., 2013; Public Health England, 2013; Weisner et al., 1995). In addition to recommending regular AA/NA meeting attendance, most treatment programs recommend also obtaining an AA

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or NA “sponsor”. A sponsor is a fellow 12-step MHO attendee who is typically in long-term stable recovery from substance use disorder (SUD) and who agrees to serve as a recovery role model and supportive guide. These individuals often make themselves available 24 h a day in order to help new members get through the challenges of early recovery and beyond (Narcotics Anonymous World Services 2004; Alcoholics Anonymous World Services, 2010).

The relationship between a sponsor and those they help (“sponsees”) has some similarities and some differences to the professional relationship between a therapist and their patient. Both a clinician and a sponsor possess and impart knowledge and recovery skills, they provide accountability, empathy, and support, and may guide and instruct those they help using a specified behavior change program (e.g., a sponsor may guide a sponsee through the 12 steps in AA/NA and a therapist through a treatment protocol, such as in cognitive-behavioral therapy). In addition, however, a sponsor necessarily possesses the lived experience of addiction and recovery and offers greater accessibility and flexibility (via phone/text/in-person “check-ins”). He/she also serves as a role model for success through purposeful self-disclosure and providing visible demonstration of how to live a sober and satisfying life in recovery (Kelly and Yeterian, 2012; Tonigan and Rice, 2010). AA’s own surveys estimate that 80% of AA members have a current sponsor, and 72% obtained one within the first 90 days of starting AA (Alcoholics Anonymous World Services, 2014). Research, too, supports this 12-step specific recommendation of obtaining and using an AA/NA sponsor as it is associated with better substance use outcomes, especially during early AA engagement (Bond et al., 2003; Emrick et al., 1993; Kelly and Urbanoski, 2012; Tonigan and Rice, 2010; Witbrodt et al., 2012).

Despite the significance of the therapeutic alliance in the formal psychotherapy literature, and the central therapeutic role of sponsors within MHOs like AA, little is known regarding the sponsee–sponsor “therapeutic alliance” within the peer-based 12-step recovery community. Also not known is whether this relationship is of similar value in widely accessed MHOs as it is in formal psychotherapies, and whether a stronger sponsor–sponsee alliance confers additional benefit even when accounting for frequency of contact with a sponsor. In prior work, we developed a measure of the sponsor–sponsee alliance using the Sponsor Alliance Inventory, with strong internal reliability and criterion validity (Kelly et al., 2016). We conceptualize the alliance between a sponsor and those they help as the extent to which the sponsee perceives the sponsor to be trustworthy and empathic, as well as sensitive to, and supportive of, their recovery goals. In this study, we use this measure to test associations among the sponsor–sponsee alliance construct, and 12-step attendance, involvement, and abstinence. Given it was expected that sponsorship would help facilitate continued AA/NA engagement, it was hypothesized that indices related to sponsorship (having a sponsor, contact with one’s sponsor outside meetings, and sponsor alliance) each would be associated with more 12-step meeting attendance, greater 12-step involvement, and more abstinence over the follow-up period. It was hypothesized also that a stronger sponsor alliance, in particular, would be associated with more attendance, involvement, and abstinence, even when accounting for contact with one’s sponsor.

## 2. Methods

### 2.1. Participants

Participants were 302 young adults (18–24 years old) from a single residential treatment facility enrolled in a naturalistic study of treatment process and outcome. At admission, participants were 20.4 years old on average ( $SD = 1.6$ ). Most were Caucasian (95.0%),

male (73.8%), and single (100.0%). Many were employed part-time, full-time, or were students (56%), and a majority had at least a high school diploma (83%). The most commonly reported “drug of choice” was alcohol (28.1%) and marijuana (28.1%), followed by heroin or other opiates (22.2%). 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%), 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.

### 2.2. Index treatment episode

Participants attended a comprehensive and multi-faceted residential treatment program, 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 and treatment engagement, and to support recovery. Integrated mental health care was available, including clinical assessment, therapy, and medication management. Participants’ average length of stay at the residential treatment center was 25.5 days ( $SD = 5.7$ , ranging from 4 to 35 days). 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. Among young adults approached to be in the study (384 between October, 2006 to March, 2008), 64 declined or withdrew participation. 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 and 3, 6, and 12 months post-discharge for which participants were reimbursed \$30, \$30, \$40, and \$50, respectively. Each assessment included an interview portion, completed either in person or by telephone, and self-administered surveys, which were returned by mail. Study retention rates were 81.8% ( $n = 248$ ) at 3-month follow-up, 74.3% ( $n = 225$ ) at 6-month follow-up, and 71.3% ( $n = 216$ ) at 12-month follow-up.

At each time point, those who did not complete the assessment were compared to those who were retained in terms of gender, age, race, education, employment status, and baseline psychological symptoms, dependence severity, and percent days of abstinence (from all substances except nicotine) in the 90 days prior to treatment ( $\alpha = 0.05$ ). Relative to those with post-secondary education, those with a high school education or less were more likely to be missed at all time points. Thus, education was retained as a control variable in inferential longitudinal analyses.

The study was conducted in accordance with the Institutional Review Board at Schulmann Associates IRB, an independent review board, and all participants signed informed consent documents.

### 2.4. Measures

Background sociodemographic information, including age, gender, marital status, race and ethnicity, employment status, educational attainment, and student status, was obtained, with full permission, from the medical record.

**2.4.1. Diagnoses.** Structured Clinical Interview for DSM-IV-TR (SCID; First et al., 2002) was conducted by trained personnel

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