12-12-2011

The development and initial validation of the Glassboro Inventory for Twelve-Step (GIFTS)

Andrew Assini

THE DEVELOPMENT AND INITIAL VALIDATION OF THE GLASSBORO INVENTORY FOR TWELVE-STEP (GIFTS)

by

Andrew J. Assini

A Thesis

Submitted to the

Department of Psychology

College of Liberal Arts

In partial fulfillment of the requirement

For the degree of

Master of Arts in Clinical Mental Health Counseling

at

Rowan University

November 2011

Thesis Chair: D.J. Angelone, Ph.D.

Dedication

I would like to dedicate this manuscript to all those who have suffered as a result of addiction. May you find the peace you seek.

Acknowledgments

I would like to express my extreme appreciation to Dr. D.J. Angelone, for more than I could ever possibly hope to fit in this one sentence.

Abstract

Andrew J. Assini
THE DEVELOPMENT AND INITIAL VALIDATION OF THE GLASSBORO INVENTORY FOR TWELVE-STEP (GIFTS)
November 2011
D.J. Angelone, Ph.D.
Master of Arts in Clinical Mental Health Counseling

The purpose of the present research was to collect qualitative data regarding twelve-step programs which was then used to inform the creation of a new measure of twelve-step engagement. Focus groups were conducted, consisting of twelve-step members, to ascertain an *insider* perspective on the twelve-step experience. Results showed that "successful recovery" was considered more than just time abstinent by these *insiders*. These findings were then used to guide the creation of the Glassboro Inventory For Twelve-Step (GIFTS), a new measure of twelve-step engagement which improves upon previous twelve-step measures. The GIFTS was validated against the Alcoholics Anonymous Involvement (AAI; Tonigan, Connors, & Miller, 1996) as well as several positive psychology measures. Results indicated that the GIFTS was positively correlated with the AAI and all four positive psychology measures. The GIFTS also appears to be particularly attuned to quality of life rather than time abstinent, as indicated by its predictive relationship with positive psychology constructs.

Table of Contents

List of Tables

Chapter 1

Introduction

Addiction is a highly prevalent and costly phenomenon. In 2008, over 17 million Americans qualified as "heavy drinkers" and over 20 million reported current illicit drug use (SAMHSA, 2009). Americans meeting DSM-IV criteria for alcohol abuse or dependence at some point in their lifetime exceeds 30% of the population (Hasin, Stinson, Ogburn, & Grant, 2007), while Americans meeting DSM-IV criteria for illicit substance abuse or dependence at some point in their life exceeds 10% of the population (Compton, Thomas, Stinson, & Grant, 2007). Some estimates approximate that addiction prevention and treatment efforts, coupled with societal problems stemming from addiction-related disorders, cost the US $350 billion annually (Miller & Hendrie, 2009). With such a large portion of the population affected and such a considerable cost, research is needed to assist in maximizing the efficiency of treatment options available for individuals suffering from addiction.

Chapter 2

Twelve-Step Programs

Possibly the most accessible and cost-effective method of providing widespread relief for addiction-related issues are Twelve-Step programs. Meetings are held daily in many parts of the world, and in more densely populated areas, several times a day in several different locations. Individuals can attend as many twelve-step meetings as they like, without concern for cost or health insurance provider limitations. Twelve-Step program literature states that there are "no initiation fees or dues" and "there is only one requirement for membership, the desire to stop using" (NAWS, 2008).

Twelve-Step membership is a prodigious phenomenon (Finlay, 2000). Alcoholics Anonymous, the most popular 12-step program, has approximately 117,000 groups meeting in over 180 countries and an estimated worldwide membership of two million members (www.aa.org, 2009). Narcotics Anonymous (NA) has more than 25,000 groups holding over 40,000 weekly meetings in 127 countries (www.na.org, 2009). Overeaters Anonymous (OA) has a worldwide membership of over 50,000 in 75 countries (www.oa.org, 2009). In addition, there are countless other twelve-step groups (e.g., Cocaine Anonymous, Marijuana Anonymous, Crystal Meth Anonymous, Sex and Love Addicts Anonymous, Gamblers Anonymous, Debtors Anonymous) for which individuals can turn for a variety of issues.

The primary vehicle of Twelve-Step programs are meetings, where individuals assist each other in handling their common affliction (e.g., alcoholism, overeating, spending) by sharing their "strength, experience, and hope." Individuals are also encouraged to participate in associated social and service activities (e.g., picnics, dances, committees, sponsorship) as well.

Twelve-Step literature emphasizes the importance of individuals helping each other, stating that the "ultimate weapon for recovery is the recovering addict" and that "the therapeutic value of one addict helping another is without parallel" (NAWS, 2008).

Chapter 3

Criticisms of Twelve-Step Programs

Despite their logistic and financial accessibility, many arguments have been made against twelve-step programs and their efficacy. Critics may philosophically dismiss twelve-step programs for a number of reasons. Two common protests address the wording of the twelve steps and complete abstinence. Detractors may object to the phraseology of the twelve steps (e.g., *Him, His, God*), arguing that twelve-step programs are a Judeo-Christian controlled entity. Despite the wording used, this belief is incorrect. The language of the twelve steps is more appropriately attributed to the influence of the Oxford Group, a Christian movement of the 1920's and 1930's, upon Alcoholics Anonymous' cofounder Bill Wilson. Twelve-Step literature actually encourages a *personal understanding* of a higher power, with the only suggestion being that this higher power is "loving and caring." Critics may also object to the idea of complete abstinence. These individuals may be somewhat correct in that complete abstinence may not be the most accurate measure of *successful* recovery from addiction. Regardless, while sustained abstinence is considered the keystone of twelve-step recovery, with members celebrating at different milestones (e.g., 30 days, 60 days, 90 days), it is never enforced as an exclusion criterion. Attendees are encouraged to discover for themselves whether abstinence is desirable

Additionally, research literature has called the efficacy of twelve-step programs into question. Critics argue that there no relationship between twelve-step participation and positive addiction-related outcomes (Brandsma et al, 1980; Ditman et al, 1967). However, there is a large amount of more recent data supporting the efficacy of twelve-step programs for a wide range of individuals, especially with regard to Alcoholics Anonymous (Kelly, Magill, & Stout,

2009; McKellar, Stewart & Humphreys, 2003; Straussner & Byrne, 2009). For example, increased abstinence rates and improvements in psychological and emotional well-being (e.g., presence of depressive symptoms, issues related to emotional regulation) have been found to be associated with twelve-step program attendance (Kelly, Stout, Magill, Tonigan & Pagano, 2010; Thurstin, Alfano & Nerviano, 1987). Specifically, in one study twelve step attendance was found to be significantly associated with a decrease in depressive symptomology in outpatient and aftercare samples (Kelly, et al., 2010). Twelve-step programs have also been associated with desirable treatment outcomes, comparable or superior to psychotherapeutic interventions (Knack, 2009). For example, patients treated using a 12-step treatment program demonstrated significantly better abstinence rates (49.5% vs 37.5%) than patients receiving a cognitive-behavioral treatment program at a two-year follow-up (Humphreys & Moos, 2007). Even twelve-step treatment approaches, such as Twelve-Step Facilitation (TSF), have been associated with positive addiction-related outcomes (Nowinski, 1996). Project MATCH, a comprehensive treatment study supported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), found the TSF treatment condition to be as effective as mainstream treatments (Cognitive Behavioral Therapy and Motivational Enhancement Therapy) in relation to positive addiction outcomes (e.g., abstinence, frequency/presence of relapse) and superior in predicting continued abstinence (Kelly, Magill, & Stout, 2009). In accordance with these findings, twelve-step programs are viewed as a reliable option for addressing addiction-related issues have begun to be generally accepted by the field of addiction treatment (Vaillant, 2005).

Chapter 4

Inadequacy of Existing Twelve-Step Measures

Following suit, the focus of a considerable amount of recent research has been investigating and identifying the mechanisms of change involved in twelve-step programs. Instruments have been created to assist in this endeavor, including the Alcoholics Anonymous Involvement Scale (AAI; Tonigan, Connors, & Miller, 1996) and the Alcoholics Anonymous Affiliation Scale (AAAS; Humphreys, Kaskutas & Weisner, 1998). In general, these measures are concise, primarily target observable behaviors (e.g., attendance, steps worked) and are specifically worded (e.g., "Alcoholics Anonymous," "drinking"). Twelve-step *affiliation* has been reduced to a few core behaviors which account for the majority of the variance of positive addiction outcomes, such that the AAI containing thirteen items and the AAAS containing nine (Humphreys et al., 1998). Unfortunately, other behaviors and activities that compose the entirety of the twelve-step experience are not accounted for, with comprehensiveness being sacrificed for brevity (Tonigan et al., 1996). These instruments focus primarily upon observable behaviors, limiting their clinical utility in that they do not address elements such as cognitions and attitudes. In a clinical setting, having information from both behavioral and cognitive perspectives provides for a greater understanding of the individual in question. Finally, these measures have been developed by "outsiders" to the twelve-step experience (clinicians and researchers) and thus their wording may not be consistent with the language used by the twelve-step community. The language of these measures also restricts them to a specific twelve-step organization (AA), inhibiting comparison and generalization amongst twelve-step groups (e.g. AA vs. OA).

With Twelve Step programs providing potential relief for a large segment of the population affected by addiction related issues, further research is needed to identify factors that may maximize twelve step participation. Unfortunately, current measures of twelve step affiliation/involvement demonstrate (present with) an "outsider" bias and potential myopic perspective.

Chapter 5

Study 1

The focus of the first study was to generate informative data to assist in the development of a comprehensive assessment of twelve-step behaviors and beliefs deemed *essential to successful recovery* using "twelve-step friendly" language. This data was provided by "insiders" (twelve-step members) through the use of focus groups.

Method

Participants

Two focus groups were conducted, each consisting of 4 participants for a total of eight individuals. The sample was predominantly male (75%) and exclusively Caucasian (100%). The average age was approximately 34 years old (M = 33.8, SD = 12.9). The average length of time clean and/or sober reported was approximately 6 years (M = 6.1, SD = 6.8). Four participants identified as members of Alcoholics Anonymous, two identified as members of Narcotics Anonymous, and two participants identified as members of both Alcoholics Anonymous and Narcotics Anonymous.

Procedure

Each focus group lasted approximately one hour and utilized a focus group guide (Appendix A) to facilitate a group discussion regarding twelve-step behaviors and attitudes

deemed “essential to successful recovery.” The focus groups were audio-recorded and then transcribed. The material from these focus groups, along with previous research findings, was then used to inform the construction of a new measure of twelve-step involvement.

Chapter 6

Results 1

To begin the focus groups, individuals were asked what they believed was *essential to successful recovery*. Two primary themes emerged from the discussions that followed.

1. ***Following basic suggestions***

Individuals from both groups identified basic behaviors such as meeting attendance, sponsorship, working the 12 steps with a sponsor, and being in service as essential for successful recovery. Belief in a higher power and helping other recovering addicts/alcoholics were also identified. One individual stated:

"There's a few simple suggestions we give to all newcomers… Make meetings, get a homegroup, get a sponsor, get in service…"

Another individual stated:

"You've got to be willing to care about something besides yourself… you've got to be willing to take suggestions and listen… You've got to be honest, with yourself and others, open-minded to the suggestions that are offered, and willing to try something new… it's the HOW of the program…"

Another individual shared:

"A huge part of it for me is that you have to put your faith in something… you have to have that spirituality piece… for when shit hits the fan… developing a relationship with a power greater than yourself is so key…"

2. ***Successful recovery is more than just length of time clean/sober***

Once these basic suggestions were identified, members of the focus group began to expound upon what *successful recovery* was. In both groups, members began to speak of quality of life and an inner sense of contentment/peace as indicators of successful recovery. One individual stated:

"For me, it's about a comfortable life… getting up for work in the morning, spending time with my wife… just doing normal, healthy things."

Length of time sober/clean/abstinent was not specifically mentioned at first. When prompted about clean/sobriety time, one individual stated:

"Look, sobriety time is a big deal… a really big deal… not drinking for one day is a really big deal… but not drinking isn't the goal… living a normal life, for me, is the goal…"

Both groups appeared to echo these sentiments. Each group spent a significant amount of time discussing personal experiences that relayed a sense of successful recovery. One individual spoke about how his children looked forward to his coming home from work now, where as in the past they would fear his drunken mood swings and temper. Another individual spoke about an increased sense of gratitude for the things in his life that he once took for granted.

Chapter 7

Conclusion 1

Overall, the two aforementioned themes dominated the discussion in both focus groups. Regarding the first theme, *following basic suggestions*, specific behaviors were identified as essential to successful recovery. Previous research supports of importance of these behaviors, specifically regarding member identification, meeting attendance, serving as and having a sponsor, and working the steps (Cloud, Ziegler, & Blondell, 2004; Tonigan, Connors, & Miller, 1996). Additional items discussed in the focus group included believing in a higher power, being in service, having a homegroup, and no longer frequenting "people, places, and things" associated with active addiction. The second theme, *successful recovery is more than just length of time clean/sober*, demonstrated that traditional outcome measures for determining successful recovery (e.g., time clean/sober) may not fully account for such a multifaceted construct. In accordance with the data generated from these focus group discussions, and the areas for improvement identified in prior instruments, the need for a measure using twelve-step friendly terminology that addresses both behaviors and beliefs across all twelve-step groups became clear, and thus guided the development of such a measure.

Chapter 8

Study 2

The purpose of the second study was to synthesize and provide an initial validation of a new measure of twelve-step engagement, henceforth called the Glassboro Inventory For Twelve Step (GIFTS; Appendix B). Twenty-two items generated from the focus group discussions and supported by previous research, serve as the majority of the GIFTS. The GIFTS includes questions which address both the individual's behaviors *and* beliefs, facilitating a greater depth of understanding regarding *successful recovery*. As previously mentioned, current instruments have only assessed observable behavior, potentially limiting their clinical utility. The GIFTS was specifically designed with increased clinical applicability in mind. Established abstinence-related outcome variables (e.g., current time abstinent, presence of a relapse in the past six months, number of relapses in the past six months) are included as the last three items. In accordance with the focus group discussion results, several positive psychology measures were also included in the battery administered to assess for positive outcomes not necessarily limited to substance or behavior abstinence. Unlike previous research in this area, the intention in creating the GIFTS was not to understand the change mechanisms involved in twelve-step programs, but rather to provide a comprehensive look at the twelve-step experience of an individual, which can then be utilized in future research and clinical settings. Present measures aim for parsimony yet may result in an incomplete understanding of the twelve-step experience. It is also important to note that the GIFTS was designed with intention of being utilizable with all twelve-step programs (e.g., OA, AA, NA) however for the purposes of this study, only members of AA were used. A population of only AA members was specifically chosen because

the Alcoholics Anonymous Involvement (AAI) used an AA population for its initial validation as well. Ultimately, it is hypothesized that high scores on the GIFTS would indicate an optimal level of engagement in a twelve-step program, demonstrated by a significant relationship with positive addiction-related outcomes as identified by established abstinence-related outcome variables as well as the positive psychology measures utilized.

Method

Participants

A sample of 347 individuals currently or previously identifying as a member of Alcoholics Anonymous was used. The sample was predominantly Caucasian (86.4%) and evenly split between genders (50.9% Female). The average age was approximately 44 years old (M = 44.19, SD = 11.10) with an average time abstinent of approximately eight years (M = 7.9, SD = 9.1) and an average of approximately 9 steps worked (M = 9.6, SD = 3.7).

Procedure

The procedures described below were approved by the Rowan University Institutional Review Board prior to data collection. Eligible individuals were invited to participate in an online study examining 12-step outcomes through SurveyMonkey. Links to this survey were posted on multiple online twelve-step websites and forums as well as social networking websites (i.e., Facebook, MySpace). First, participants read the informed consent and agreed to participate prior to completing the survey. Participants were fully debriefed upon completion of

a series of questionnaires administered in the following order: Alcoholics Anonymous Involvement Scale (Tonigan, et al., 1996), Glassboro Inventory for Twelve-Step (GIFTS), Humility Scale (Caperton, 2009), Inspiration Scale (Thrash & Elliot, 2003), Gratitude Questionnaire (McCullough, Emmons, & Tsang, 2002), and Adult Hope Scale (Snyder, Harris, Anderson, Holleran, Irving, Sigmon, et al., 1991). Participants did not receive any compensation for their participation.

Measures.

Alcoholics Anonymous Involvement Scale (AAI).

The Alcoholics Anonymous Involvement Scale (AAI; Tonigan et al., 1996) was used as the current standard by which the Glassboro Inventory for Twelve-Step (GIFTS) was validated. The AAI measures involvement in the program of Alcoholics Anonymous as well as meeting attendance, yielding two subscales (involvement and attendance) which have a moderate correlation ($r = .52$). The AAI was developed within Project MATCH, a comprehensive treatment study and evaluation supported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and consists of 9 dichotomous (yes/no) items (e.g., "Have you ever considered yourself to be a member of AA?") and 4 additional items (e.g., "Regardless of whether you have or have not been to alcohol treatment, which of the 12 steps of AA have you 'worked'?", "How many AA meetings have you attended in the last year?") for a total of 13 items. The AAI demonstrates excellent test-retest reliability ($r = .76$) and high internal consistency ($\alpha = .85$). For this study, the AAI presented with good internal consistency ($\alpha = .65$).

Humility Scale

The Humility Scale (HS; Caperton, 2009) consists of 3 items (e.g., "I remind myself that I am still growing as a person.") on a 5-point scale (1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Frequently) and emerged as an independent subscale of a previous study on forgiveness. For this study, the HS presented with strong internal consistency ($\alpha = .79$).

Inspiration Scale

The Inspiration Scale (IS; Thrash & Elliot, 2003) consists of 8 items (e.g., "I experience inspiration.") that utilize a 7-point response scale (1 = never/not at all, 7 = very often/very deeply or strongly) and provides two subscales (inspiration frequency, inspiration intensity) as well as an overall inspiration scale derived from summing the two subscales. For this study, the IS presented with strong internal consistency ($\alpha = .95$).

Gratitude Questionnaire

The Gratitude Questionnaire (GC-6; McCullough et al., 2002) contains 6 items (e.g., "I have so much in life to be thankful for.") on a 7-point scale (1 = Strongly Disagree, 2 = Disagree, 3 = Slightly Disagree, 4 = Neutral, 5 = Slightly Agree, 6 = Agree, 7 = Strongly Agree) and demonstrates good internal reliability ($\alpha = .82$-$.87$). The GC-6 has also been demonstrated to positively correlate with other positive psychology measures (i.e., optimism, life satisfaction, forgiveness). For this study, the GC-6 presented with strong internal consistency ($\alpha = .77$).

Adult Hope Scale

The Adult Hope Scale (AHS; Snyder et al., 1991) consists of 12 items (e.g., "There are lots of ways around any problem.") that use an 8-point response scale (1 = Definitely False, 2 = Mostly False, 3 = Somewhat False, 4 = Slightly False, 5 = Slightly True, 6 = Somewhat True, 7 = Mostly True, 8 = Definitely True) and provides two subscales (pathways thinking, agency thinking). The two subscales can also be summed to provide a total Hope score. For this study, the AHS presented with strong internal consistency ($\alpha = .76$).

Glassboro Inventory for Twelve-Step (GIFTS)

The Glassboro Inventory For Twelve Step (GIFTS) is a 25 item measure of twelve-step engagement. The GIFTS consists of 19 items that utilize a 4-point response scale (1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree) as well as six additional items. The 19 likert-style items address behaviors (e.g., "I am currently maintaining a regular meeting attendance.") as well as beliefs (e.g., "I believe that maintaining a regular meeting attendance can help me recover.") related to twelve-step recovery. In addition, there are three open-ended questions addressing twelve-step organization affiliation ("Which organization do you identify yourself as a member of?"), meeting attendance ("How many meetings have you made in the last 90 days?"), and step-work ("What is the furthest step you have formally worked with a sponsor?"), as well as three items addressing time abstinent ("How much time do you currently have abstinent from your behavior/substance of choice?") and relapse ("Have you relapsed in the

past 6 months? If so, how many times?"). For this study, the GIFTS demonstrated strong internal consistency ($\alpha = .91$).

Chapter 9
Results 2

Descriptive Information

Individuals reported attending an average of approximately 51 meetings in the last 90 days and 192 in the last year. Approximately two thirds (65.6%) of the sample reported having a twelve-step sponsor and almost half (48.8%) reported serving as a sponsor. Over three-quarters (77.5%) of the sample reported believing in a higher power and the overwhelming majority (91.4%) reported having a spiritual awakening since the beginning of their twelve step involvement.

The GIFTS was found to be significantly positively correlated with the AAI (r (243) = .32, $p < .05$). The correlation between the GIFTS and the AAI also indicates that while the two are related, they appear to measure two separate constructs. In addition, it was hypothesized that higher scores on the GIFTS would significantly positively correlate with established abstinence-related outcome variables. This hypothesis was partially supported. The GIFTS was found to be significantly positively correlated with meeting attendance, both in the past 90 days (r (277) = .30, $p < .05$) and the past year (r (234) = .25, $p < .05$), but not time abstinent, while the AAI was found to be significantly positively correlated with meeting attendance in the last year (r (234) = .28, $p < .05$) and time abstinent (r (273) = .31, $p < .05$) but not with meeting attendance in the past 90 days (Table 1). Higher scores on the GIFTS were also hypothesized to positively correlate with higher scores on the measures of positive psychology. As expected, the scores on the GIFTS were found to be significantly positively correlated with scores on all four measures of positive psychology (Table 2). The AAI was found to be significantly positively correlated with three of the four positive psychology measures, with humility being the exception.

Table 1

Descriptive Statistics & Correlations (Established Abstinence-Related)

	1	2	3	4	5
GIFTS	___	**.32***	**.30***	**.25***	-.02
AAI	___	___	.07	**.28***	**.31***
Meeting Attendance (Last 90 Days)	___	___	___	**.61***	**-.25***
Meeting Attendance (Last Year)	___	___	___	___	-.09
Time Abstinent	___	___	___	___	___
n	284	245	279	236	275
M	71.73	7.16	51.6	191.9	7.91yrs
SD	7.8003	1.2463	45.2	158.2	9.11yrs

Note = * $p < .05$

Regression Analyses for GIFTS and Positive Psychology

A series of hierarchical regressions were then performed to determine the extent to which scores on the GIFTS, while controlling for the AAI, could predict positive psychology scores. Four separate hierarchical regressions were conducted with the positive psychology measure scores (humility, inspiration, gratitude, & hope) entered as the dependent variable. In each equation the AAI was entered in the first step, to control for its effect, and the GIFTS entered in the second step. All four models were found to be significant (Table 3). In addition, four stepwise regressions were conducted to evaluate whether the AAI added any additional

significant variance to the GIFTS in predicting positive psychology scores. Interpretation of the stepwise regression results suggested a single item solution for all of the four analyses, consisting of only the GIFTS (Table 4). Specifically, scores on the GIFTS, and not the AAI, were positively associated with humility (t = 2.386, p < .05), inspiration, (t = 3.049, p < .05), gratitude (t = 4.803, p < .05), and hope (t = 2.974, p < .05).

Table 2

Descriptive Statistics & Correlations (Positive Psychology Measures)

	1	2	3	4	5	6
GIFTS	___	**.32***	**.16***	**.20***	**.30***	**.19***
AAI	___	___	.03	**.18***	**.19***	**.18***
HS (*Humility)*	___	___	___	**.41***	.12	.07
IS (*Inspiration)*	___	___	___	___	**.32***	**.38***
GQ-6 (*Gratitude)*	___	___	___	___	___	**.37***
AHS (*Hope)*	___	___	___	___	___	___
n	284	245	259	282	252	232
M	71.73	7.16	12.10	42.37	38.39	50.22
SD	7.80029	1.24627	2.46006	9.42572	4.91444	8.24862

Note = * p < .05

Table 3

Hierarchical Regression Analyses (GIFTS & Positive Psychology Measures)

	B	**SE B**	**β**	***t***
HS (*Humility)*	.05	.02	.16	2.359*
IS (*Inspiration)*	.19	.08	.16	2.309*
GQ-6 (*Gratitude)*	.17	.04	.265	4.075*
AHS (*Hope)*	.16	.07	.15	2.229*

Note = *p < .05

Table 4

Stepwise Regression Analyses (GIFTS & Positive Psychology Measures)

	B	**SE B**	**β**	***t***
HS (*Humility)*	.05	.02	.16	2.386*
IS (*Inspiration)*	.24	.08	.20	3.049*
GQ-6 (*Gratitude)*	.19	.04	.30	4.803*
AHS (*Hope)*	.21	.07	.19	2.974*

Note = *p < .05

Chapter 10

Conclusion 2

GIFTS scores were found to be positively associated with scores on the AAI while also suggesting that the measures assess for two related but distinct constructs. GIFTS scores were positively related to meeting attendance in the past 90 days and the past year while AAI scores were found to be positively related to meeting attendance in the past year and time abstinent. GIFTS scores were also found to be positively related to scores on four positive psychology instruments assessing for humility, inspiration, gratitude, and hope. AAI scores were found to be positively correlated with scores on three of the four positive psychology measures excluding humility. In addition, hierarchical regression analyses revealed that scores on the GIFTS, while controlling for AAI scores, predicted scores on the four positive psychology instruments. Finally, stepwise regression analyses revealed that scores on the AAI added no additional significant variance to the predictive ability of the GIFTS.

Chapter 11

General Discussion

Focus group discussions from study 1 provided qualitative data which supported and added to current literature, primarily in reaffirming the importance of particular twelve-step related behaviors and addressing quality of life as a possible indicator of successful recovery. Previous literature has indentified core twelve-step behaviors and focused on time abstinent and the presence of relapse as the primary indicators of successful recovery (Tonigan, Connors, & Miller, 1996; Cloud, Ziegler, & Blondell, 2004). In addition to specific behaviors and time abstinent, participants in the focus group discussions spoke of a general desire to "live a normal life" and the ability to "appreciate the little things" that they once took for granted. These discussions, in conjunction with previous literature, were used to inform the construction of a new twelve-step measure entitled the Glassboro Inventory For Twelve Step (GIFTS). The GIFTS also presents with several new aspects. The GIFTS was designed specifically to be utilizable with all twelve-step organizations (e.g., AA, NA, OA) without need for modification. This was done by using language which does not specify a particular addiction or disorder, but rather uses broad terminology to avoid exclusion (e.g., "time abstinent" rather than "length of sobriety" or "clean time"). The GIFTS was also designed using the language of twelve-step organization members rather than clinical or research jargon. In previous research, measures have been predominantly designed by researchers and clinicians attempting to gain an understanding of the twelve-step experience. The GIFTS has been designed to more closely align with the language of twelve-step organizations and reduce any clinical or empirical bias experienced by the individual completing it. Finally, the construction of the GIFTS was

significantly influenced by its potential clinical utility. While other measures may provide a more parsimonious depiction of the twelve-step experience, which has its obvious empirical advantages, the GIFTS was designed to assess for the totality of the twelve-step experience, ultimately providing a more comprehensive perspective on the twelve-step experience of an individual, and thus lending itself to be a more clinically useful instrument. This clinical emphasis is evident in the GIFTS item selection. Items assess for both the individual's actual behavior as well as their belief that said behavior can be helpful in their recovery. Discrepancies in these beliefs and behaviors can then provide entry points for clinical and counseling interventions which may serve to assist an individual's participation in a twelve-step organization.

In study 2, GIFTS scores were found to be significantly positively correlated to the AAI. Even though the two are positively correlated, they appear to assess for two separate constructs. This possibility is further supported when the correlations to meeting attendance and time abstinent are considered. GIFTS scores were found to be significantly positively related to meeting attendance, in both the past 90 days and the past year, but were not found to be significantly correlated to time abstinent. The AAI was found to be significantly correlated with meeting attendance in the past year and time abstinent but not with meeting attendance in the past 90 days. These findings may indicate that the GIFTS is actually more finely tuned to the dynamics of early recovery than overall recovery, when individuals generally have less time abstinent and greater meeting attendance. Were the GIFTS designed with the intention of predicting successful recovery as determined by abstinence related variables, the lack of signficant findings regarding time abstinent might have proved dissuading.

As previously mentioned, the GIFTS was designed with the idea of quality of life being a more accurate assessment of successful recovery. As such, correlational analyses and regression analyses were performed to assess for the GIFTS predictive ability regarding positive psychology constructs such as humility, inspiration, gratitude, and hope. The GIFTS ability to predict for these positive psychology constructs while accounting for the AAI, as well as the results of stepwise regressions which demonstrated that the AAI offered no additional significant variance, may indicate that the GIFTS taps this alternative barometer of twelve-step and addiction-related recovery success. The AAI was found to be specifically indicative of time abstinent while the GIFTS appears to indicate an overall higher quality of life, which as identified by the focus group participants, is the ultimate goal of recovery for actually living the experience.

Possible limitations of the current project include the fact that the focus groups primarily consisted of only two twelve step groups (i.e., AA and NA) and that the normative sample in Study 2, although purposely done, consisted only of members of AA. Future focus groups could be conducted with members drawn from additional twelve-step organizations (e.g., OA, GA), providing further validation for the GIFTS. This may also work to help modify the measure to be sensitive to the particulars related to each twelve-step organization. Future quantitative studies may wish to use a population other than AA (e.g., NA, OA, GA) as well. There has been limited literature to date dealing with twelve-step groups other than Alcoholics Anonymous, inhibiting the ability to generalize previous findings to all twelve-step program experiences. IN addition, using additional twelve-step populations may provide insight into underlying mechanisms of change which facilitate the twelve-step experience. An exploratory factor analysis of the GIFTS may also prove beneficial in that identifying underlying sub-categories

and their impact upon established abstinence-related variables and positive psychology constructs may reveal connections that could guide future treatment foci and intervention selection.

References

Allen, J. P. (2000). Measuring treatment process variables in Alcoholics Anonymous. *Journal of Substance Abuse Treatment, 18*(3), 227-230.

Caperton, D. (2009). An investigation of the reliability and validity of the Caperton Forgiveness Styles Inventory. *Dissertation Abstracts International: Section B: The Sciences and Engineering, Vol 70(5-B)*, 3215.

Compton, W. M., Thomas, Y. F., Stinson, F. S., & Grant, B. F. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 64*(5), 566-576.

Diener, E., Emmons, R.A., Larson, R.J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49*, 71-75.

Hasin, D. S., Stinson, F. S., Ogburn, E., & Grant, B. F. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 64*(7), 830-842.

Humphreys, K., Kaskutas, L. A., & Weisner, C. (1998). The Alcoholics Anonymous Affiliation Scale: Development, Reliability, and Norms for Diverse Treated and Untreated Populations. *Alcoholism: Clinical and Experimental Research, 22*(5), 974-978.

Kingree, J. B., Simpson, A., Thompson, M., McCrady, B., Tonigan, J. S., & Lautenschlager, G. (2006). The development and initial evaluation of the Survey of Readiness for Alcoholics Anonymous Participation. *Psychology of Addictive Behaviors, 20*(4), 453-462.

Knack, W. A. (2009). Psychotherapy and Alcoholics Anonymous: An integrated approach. *Journal of Psychotherapy Integration, 19*(1), 86-109.

Kelly, J., Magill, M., & Stout, R. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. Addiction Research and Theory 17(3), 236-259.

Kelly, J., Stout, R., Magill, M., Tonigan, S., & Pagano, M. (2010). Mechanisms of behavior change in alcoholics anonymous: Does Alcoholics Anonymous lead to better alcohol use outcomes by reducing depression symptoms? Addiction, 105(4), 626-636.

McCullough, M. E., Emmons, R. A., & Tsang, J. (2002). The Grateful Disposition: A conceptual and Empirical Topography. *Journal of Personality and Social Psychology, 82*, 112-127.

McKellar, J., Stewart, E., & Humphreys, K. (2003). Alcoholics Anonymous involvement and positive alcohol-related outcomes: Cause, consequence, or just a correlate? A prospective 2-year study of 2,319 alcohol-dependent men. *Journal of Consulting and Clinical Psychology, 71*(2), 302-308.

Miller, T. and Hendrie, D. *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis*, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.

Narcotics Anonymous. (2008). *Narcotics Anonymous, 6th Edition*. Van Nuys, CA: N.A. World Services, Inc.

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., et al.(1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60*, 570-585.

Straussner, S. & Byrne, H. (2009). Alcoholics Anonymous: Key research findings from 2002-2007. Alcoholism Treatment Quarterly, 27(4), 349-367.

Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.

Thrash, T. M., & Elliot, A. J. (2003). Inspiration as a psychological construct. *Journal of Personality and Social Psychology, 84*, 871-889.

Tonigan, J. S., Connors, G. J., & Miller, W. R. (1996). Alcoholics Anonymous Involvement (AAI) scale: Reliability and norms. *Psychology of Addictive Behaviors, 10*(2), 75-80.

Thurstin, A., Alfano, A., & Nerviano, V. (1987). The efficacy of AA attendance for aftercare of inpatient alcoholics: Some follow-up data. International Journal of the Addictions, 22(11), 1083-1090.

Vaillant, G. (2005). Alcoholics Anonymous: Cult or cure? Australian and New Zealand Journal of Psychiatry, 39(6), 431-436.

Zemore, S. E., & Kaskutas, L. A. (2009). Development and validation of the Alcoholics Anonymous Intention Measure (AAIM). *Drug and Alcohol Dependence, 104*(3), 204-211.

Appendix A: Focus Group Guide

Focus Group Guide

1) A) What is "successful" recovery?
   B) How do you determine if recovery is/has been successful?

2) What are the essential behaviors and attitudes required for "successful" recovery?

3) What are common attitudes and behaviors associated with relapse?

4) What recovery/relapse attitudes or behaviors do you feel are under-rated/under-appreciated?

5) Are there any common myths/falsehoods you've come across with regard to the 12 Steps?

Appendix B: Glassboro Inventory For Twelve-Step (GIFTS)

Please indicate how much you agree or disagree with the following statements by circling the most appropriate response. For items 2, 4, 8, 23, 24, & 25 please answer accordingly.	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1. I currently identify myself as a member of a 12-Step program or organization.	1	2	3	4
2. If applicable, which 12-step program or organization do you identify with?	_____			
3. I am currently maintaining a regular meeting attendance.	1	2	3	4
4. How many meetings have you made in the last 90 days?	_____			
5. I believe that maintaining a regular meeting attendance can help me recover.	1	2	3	4
6. I currently have a 12-Step sponsor.	1	2	3	4
7. I believe that having a 12-Step sponsor can help me recover.	1	2	3	4
8. What is the furthest step you have formally worked with a sponsor?	1 2 3 4 5 6 7 8 9 10 11 12			
9. I am currently working the 12 Steps with a sponsor.	1	2	3	4
10. I believe that remaining active in the step-working process can help me recover.	1	2	3	4
11. I am currently an active member of a homegroup.	1	2	3	4
12. I believe that being an active member of a homegroup can help me recover.	1	2	3	4
13. I currently have a support network of recovering individuals.	1	2	3	4
14. I believe that having a support network of recovering individuals can help me recover.	1	2	3	4

15. I am currently in service (i.e., holding a service position, serving as a sponsor).	1	2	3	4
16. I believe that being in service can help me recover.	1	2	3	4
17. I currently believe in a higher power.	1	2	3	4
18. I believe that believing in a higher power can help me recover.	1	2	3	4
19. I currently make use of the resources available in a 12-Step program (i.e., reading literature, using phone call lists).	1	2	3	4
20. I believe that making use of the resources available in a 12-Step program can help me recover.	1	2	3	4
21. I have currently stopped associating with individuals and frequenting places prominent during my addiction.	1	2	3	4
22. I believe that stopping my associations with individuals and locations frequented in my active addiction can help me recover.	1	2	3	4
23. How much time do you currently have abstinent from your behavior/substance of choice?	_____			
24. Have you relapsed in the past 6 months?	No		Yes	
25. If so, how many times?	_____			