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Facilitating comprehensive assessment of 12-step experiences: A Multidimensional Measure of Mutual-Help Activity

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Abstract

Existing measures of 12-step mutual-help activity typically capture only a narrow range of experiences and combine fellowships with explicitly different substance-specific emphases (e.g., Alcoholics versus Narcotics Anonymous). To help expand our knowledge in this important area, we report on the development and use of a comprehensive multidimensional measure of 12-step experiences in two clinical samples of young adults and adolescents (N=430). One-week test-retest reliability was verified on a subsample. Results indicated high content validity and reliability across seven dimensions of experience (meeting attendance, meeting participation, fellowship involvement, step work, mandated attendance, affiliation, and safety), and the measure successfully discriminated between samples on anticipated activity levels. This measure provides rich data on mutual-help activities and deepens our understanding of individuals' experiences across different 12-step organizations.

Keywords

Alcoholics Anonymous; Narcotics Anonymous; measurement; psychometric; self-help groups; mutual-help groups; addiction; recovery

1. Introduction

Alongside the development and spread of evidence-based professional treatments for substance use disorder (SUD) during the past 40 years, there has been an emergence and proliferation of peer-led mutual-help groups to address substance-related concerns (Humphreys, 2004; Kelly & Yeterian, 2008). The birth of Alcoholics Anonymous (AA) in 1935 (AA, 2001) spawned a new era of mutual-help movements for people with addiction problems (White, 1998). Evidence suggests that as many as five million individuals each year affected by substance use attend a mutual-help group, such as AA, Narcotics Anonymous (NA), or Cocaine Anonymous (CA; Substance Abuse and Mental Health Services Administration [SAMHSA], 2010; Weisner, Greenfield, & Room, 1995). Also, most professional addiction treatment programs attempt to link their patients with these

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resources as a way to help sustain gains made during an active treatment phase (Humphreys, Mavis, & Stofflemayr, 1991; Knudsen, Ducharme, Roman, & Johnson, 2008).

Given their importance as allies in shouldering and lessening the enormous burden of disease attributable to alcohol and other drug related conditions (Babor, et al., 2010), the Institute of Medicine (1990) called for more research on mutual-help organizations to elucidate their effects and mechanisms. Since then, research, particularly on AA but also on other large 12-step organizations, has substantially increased in quantity and level of scientific sophistication (for reviews see Humphreys, 2004; Kelly, Magill, & Stout, 2009; Kelly & Yeterian, 2008). This line of research has given rise to a number of measures of 12-step attendance and involvement (Caldwell, 1999; Gilbert, 1991; Humphreys, Kaskutas, & Weisner, 1998; Kahler, Kelly, Strong, Stuart, & Brown, 2006; Kelly, Humphreys, & Kahler, 2006; McKay, Alterman, McLellan, & Snider, 1994; Morgenstern, Kahler, Frey, & Labouvie, 1996; Snow, Prochaska, & Rossi, 1994; Tonigan, Conners, & Miller, 1996). This proliferation in measures has facilitated important new insights into the nature and benefits of 12-step group activities in relation to recovery (Humphreys, 2004; Kelly, 2003). However, the brevity and restricted focus of these measures in capturing only certain aspects of the complex phenomenon of 12-step experience has limited our knowledge of some of the most fundamental facets of 12-step experience, such as the types of fellowships with which individuals affiliate, the different kinds of meetings attended, and the degree of connection with sponsors and other fellowship members outside of meetings. This has limited the potential of research to elucidate and answer important questions regarding what specific aspects of these groups are most strongly related to the attainment of sobriety and maintenance of long-term recovery (Kelly & Myers, 2007). Furthermore, prior measures have not sought to obtain qualitative data regarding which aspects of 12-step fellowships individuals like and find helpful or dislike and find objectionable. Such information could inform our knowledge of potential barriers that could enhance 12-step facilitation efforts. The present work seeks to bridge this gap by developing and testing a multidimensional measure of 12-step activities and experiences.

1.1 The multidimensional nature of 12-step experience

Conceptually, 12-step activity is a multidimensional phenomenon, involving not only attendance at meetings, but also active participation during meetings (e.g., talking/sharing), and social interaction with a sponsor and/or other fellowship members before, after, and outside of formal meeting contexts. Active work on the 12-steps, particularly those that require more tangible action (e.g., writing a personal inventory in step 4, and discussing it in step 5), are further 12-step specific activities presumed critical to recovery (AA, 2001). Given the entirely voluntary aspect of 12-step fellowships' emphasis which state the only membership requirement is a personal "desire to stop drinking/using", an important contextual element is the degree to which individuals have been mandated by the judicial system to attend. This important dimension may affect many other indices of activity and affiliation.

Based on previous empirical and theoretical literature, we identify seven key dimensions of 12-step participation (Table 1). The first five dimensions (meeting attendance, meeting participation, fellowship involvement, step work, and mandated attendance) involve objective behaviors and events. There is empirical support linking meeting attendance with abstinence (Chi, Kaskutas, Sterling, Campbell, & Weisner, 2009; Kelly, Brown, Abrantes, Kahler, & Myers, 2008; Kelly, Dow, Yeterian, & Kahler, 2010; McKay, et al., 1994; Tonigan, Connors, & Miller, 2003), and with improvements in psychosocial functioning (Tonigan, Toscova, & Miller, 1996). Very little is known about the specific types of meetings individuals attend (e.g., speaker meetings, literature-focused meetings, meetings for beginners, women, young persons, or gay persons), preventing more detailed

examination of the effects of meeting types on individuals' fellowship engagement, retention, and derived benefit. Some meetings tend to be larger and do not provide the opportunity for during-meeting participation (e.g., speaker meetings) whereas others (e.g., literature-focused meetings) tend to be smaller and more intimate providing much greater opportunity for active participation and social engagement (Kelly, Humphreys, & Youngson, 2004). While established members may participate in a variety of meeting formats, predominant attendance by a new member at one or another type of meeting could either accelerate or diminish social engagement and integration.

Behaviors reflecting a more active level of engagement in the program itself, such as having a sponsor, working the 12-steps, and reading 12-step literature, have been linked with positive outcomes (Chi, et al., 2009; McKellar, Stewart, & Humphreys, 2003; Montgomery, Miller, & Tonigan, 1995; Weiss, et al., 2005). Similarly, despite the common 12-step fellowship recommendation to become involved in group service work, a principle shown to have therapeutic benefit (Pagano, Friend, Tonigan, & Stout, 2004), little has been documented regarding the extent to which attendees obtain service positions (e.g., help set up meetings, or make coffee) or sponsor or help others. These aspects of "service" are captured in the "meeting participation" and "fellowship involvement" dimensions in Table 1.

Absent from existing measures of 12-step participation are considerations of the extent to which group attendance has been mandated by the courts or legal authorities. This is important as studies suggest poorer outcomes for this subgroup (Kownacki & Shadish, 1999). The criminal justice system plays a large role in influencing entry into specialized addiction treatment programs (SAMHSA, 2009), with studies demonstrating variable associations with retention and active involvement in treatment (Joe, Simpson, & Broome, 1999; Stevens, et al., 2005; Wild, Roberts, & Cooper, 2002). Given these associations, further clarification of the extent and impact of criminal justice system influence on 12-step group effectiveness is needed.

The remaining two dimensions listed in Table 1 (affiliation and safety) tap subjective aspects of the overall experience of 12-step participation. Perceptions of the value and effectiveness of participation may help to clarify past and present attendance behaviors, and may predict continued attendance or future re-engagement following a period of non-attendance. Perceptions that meetings are unsafe for particular sub-populations (e.g., women, young people) (Kelly, Dow, Yeterian, & Myers, in press) or for specific reasons, such as potential exposure to substances, may be expected to influence referral patterns by treatment professionals and individual attendance behaviors. However, empirical study of these subjective aspects of 12-step participation, and their links to behavioral aspects of involvement and downstream outcomes, is particularly lacking.

1.2 The need for comprehensive measurement

Measurement of the 12-step construct has been largely limited to meeting attendance, or to scales that capture a single or small number of the above dimensions in limited detail (e.g., McKay, et al., 1994; Snow, et al., 1994; Tonigan, Conners, et al., 1996). Those more comprehensive in content (Morgenstern, et al., 1996) have nonetheless lacked an ability to differentiate between common fellowship types, such as AA, NA, and CA. Although simple summary measures are analytically appealing, they arguably fail to yield the richness of data required to answer many key research questions pertaining to 12-step organizations and recovery.

In the absence of comprehensive coverage of 12-step experiences, questions pertaining to the inter-relationships between dimensions, and the incremental predictive utility of distinct

behaviors and perceptions for outcomes, remain unanswered. In addition, collapsing information across fellowship types (e.g., AA, NA, CA and others) prohibits the study of important nuances with potentially critical importance for determining the effectiveness of matching substance use profiles to fellowship focus (e.g., an individual with primary opiate dependence attending AA instead of NA, or a primary alcohol dependent individual attending NA instead of AA). Overall, the bulk of the literature evaluating the effectiveness of 12-step groups is focused on AA, to the exclusion of other fellowship types (Kelly, 2003). Finer distinctions of participation and engagement are needed to enhance our understanding of the effectiveness of 12-step fellowships as recovery resources and to enhance the effectiveness of clinical referrals. In the increasingly cost-constricting environment of specialized addiction treatment, clearer empirical specification of the acceptability and effectiveness of these free community resources, across different subgroups of individuals in need, is timely and highly relevant.

1.3 Study aims

The current report summarizes data obtained from a structured interview approach designed to maximize representation of individuals' experience with 12-step groups among adolescents and young adults attending specialized addiction treatment programs. Although the focus here is on young people, the measurement issues apply equally to adult populations. The summaries of data across the two samples, disparate in terms of age and treatment modality (i.e., adolescent outpatient versus young adult residential), allow for a consideration of the discriminative strengths of this kind of in-depth assessment as a platform for research on the role of 12-step groups in SUD recovery. For instance, given their older age and lengthier and more severe substance involvement, we anticipated generally higher levels of 12-step group activity in the young adult sample, relative to the adolescents.

2. Method

2.1 Participants

Participants were from one of two samples recruited for separate naturalistic studies of youth attending SUD treatment (total n=430). The first sample was comprised of 127 adolescents (14–19 years old) presenting for treatment at a private outpatient treatment facility in the Northeastern U.S. between August, 2006 and May, 2009. The sample was 75.6% male, 86.6% White, and had an average age of 16.7 years (SD=1.2). At study entry, most participants were living at home with at least one parent (93.7%), enrolled in school (75.6%), unemployed (56.8%), and involved with the justice system (50.4%). Marijuana was the most commonly reported drug of choice (70.9%), followed by alcohol (11.8%), heroin/narcotics (11.1%), and cocaine/amphetamines (3.2%).

The second sample was comprised of 303 young adults (18–24 years old) presenting for treatment at a private residential treatment center in the Midwestern U.S. between October, 2006 and March, 2008. Participants were predominantly male (73.9%), and all were single at admission. Average age was 20.4 years old (SD = 1.6) and most were Caucasian (94.7%). At admission, 24.1% were employed full- or part-time and 31.7% were students. Most had completed high school: 43.6% had a high school diploma and 39.6% had attended college. The most commonly reported primary substance of use was alcohol (28.1%) or marijuana (28.1%), followed by heroin/opiates (22.4%), cocaine/crack (12.2%), and amphetamines (5.9%).

2.2 Procedures

Recruitment and assessment procedures were similar in the two studies. For the adolescent sample, potential participants and their parents (if the adolescent was <18) were informed about the study during the clinical assessment at treatment intake. Study staff contacted interested participants and their parents to provide a brief overview of the study and schedule an appointment for an interview. Consent was obtained from participants aged 18 and older and from the parents of younger participants (who assented to participate). Study interviews were conducted by trained research staff, on average within 10.6 days (SD=12.4) of admission. Participants were reimbursed $50 for their time. Of the 160 adolescents who were invited to participate in the study, 95% (n=152) agreed to be contacted by study staff and, of these, 83.6% (n=127) were enrolled. Reasons for non-participation included being unable to schedule an interview during the first month of treatment (48%), deciding not to attend treatment (24%), parental non-consent (20%), participant non-consent (4%), and transportation difficulties (4%).

A small reliability substudy was conducted at one of the follow-up time points within the adolescent study, in which 11 participants completed two study interviews approximately 1 week apart, providing data for a preliminary consideration of test-retest reliability. The main study and the reliability substudy were approved by the Partners Health Care System Internal Review Board and all participants signed informed consent documents.

For the young adult sample, potential participants were approached by study staff in person shortly after admission. All admitted individuals aged 21–24 were approached, as well as every second individual aged 18–20, to ensure representation of the older age group given the predominance of those aged 18–20 at the treatment center. 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 the 384 clients who were invited to participate, 78.9% (n=303) were enrolled. Reasons for non-participation included not wanting to participate in 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 assessment. Trained study staff conducted the interviews, which were completed either in person or by telephone. Participants were reimbursed $30 for their time. 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.

2.3 Data collection

As part of the larger assessment battery for the study, short structured interviews were conducted to provide in-depth information on 12-step participation across the seven dimensions and types of fellowships (AA, NA, CA, and “other”). The interviews were conducted by research personnel, and took approximately 3–8 minutes to complete depending on respondent history of 12-step attendance. The questions, cross-tabulated by dimension, are summarized in Table 2; the full measure can be found in the Appendix. Items used a variety of response formats and specified either a lifetime or 3-month time frame for recall, depending on the nature of the dimension. In addition to those listed in Table 2, four open-ended items assessed likes and dislikes of 12-step groups and any reasons for non-attendance and dropout. Cutting across the identified dimensions of participation, these were designed to elicit additional information to contextualize respondent experiences and to capture barriers to participation and reasons for drop-out, furthering meaningful interpretation of the quantitative data.

Responses to the two items assessing lifetime and 3-month attendance provided an anchor for the remaining content of the measure for each respondent. Specifically, those reporting any attendance in the past 3 months were asked to provide additional details on fellowship involvement, participation in meetings, and progress in step work during this time. The items assessing step work specifically targeted the five steps that require more distinct tangible action on the part of respondents (i.e., steps 4, 5, 8, 9, and 11). Those reporting any lifetime attendance at meetings, regardless of their past 3-month pre-treatment attendance, were asked items on the total number of steps they completed at least once, their affiliation and sense of safety, and to identify, in open-ended format, the most and least helpful aspects of 12-step groups. Those who reported having attended meetings in the past, but not in the past 3 months, were also asked to indicate, in an open-ended format, why they had stopped attending meetings. Those with no lifetime attendance were similarly asked to provide reasons for non-attendance. Finally, in recognition of the fact that individuals may choose not to fulfill court mandates to attend meetings, all respondents, regardless of the lifetime or recent attendance, were asked to report on mandated attendance. With the exception of the open-ended items and those assessing mandated participation, all questions collected information separately by fellowship type.

2.4 Analysis

Frequency distributions and/or summary statistics were obtained for all items, separately for the two samples. The numbers of valid responses to the open-ended questions were counted to provide an overall sense of the degree to which these items were contributing information to the assessment. Correlation coefficients were calculated between item pairs for the subset of adolescent respondents who participated in the test-retest substudy.

3. Results

3.1 Types and amounts of 12-step meetings attended

Meeting attendance is summarized in Table 3 separately for the adolescent and young adult samples and for each of the four fellowship types. Forty percent of adolescents and 60% of young adults reported ever having attended AA, with smaller proportions reporting NA attendance (16%–40%). None of the adolescents and a minority of young adults had attended fellowships of other kinds. These included groups such as ACOA, ALAnon, Methamphetamine Anonymous, Marijuana Anonymous, Gamblers Anonymous, and Step Now. At the time of admission to the current treatment episode, just over one-quarter of adolescents and approximately one-third of young adults reported AA meeting attendance in the prior 3 months, with smaller proportions attending other types of fellowships. A small minority (13.5% or less, across types) had been attending 12-step meetings on a weekly basis or more often during this pre-treatment period. Attendance at specific types of meetings was also fairly uncommonly reported. Most notably, approximately 1 in 5 young adults reported having attended literature-focused or speakers AA meetings in the past 3 months. Approximately 1 in 10 respondents in both samples reported attending beginners meetings or young persons AA meetings during this period. Among those with recent AA attendance, 67% of adolescents (n=24) and 61% of young adults (n=59) reported that none or few of the other members were the same age as them. For NA, these percentages were lower, at 25% (n=3) and 38% (n=19) for adolescents and young adults, respectively.

3.2 Recent levels of participation, involvement and step work

Table 4 summarizes recent levels of fellowship involvement, meeting participation, and progress in step work in the subset who reported attending each fellowship type in the 3 months prior to treatment entry. Only a small number of adolescents considered themselves to be a member of a fellowship at this point in time. Higher proportions of young adults

endorsed this item, with 44%–52% identifying as members of AA or NA. Approximately one-third of young adults who were attending AA reported having a sponsor, and almost all of these individuals had contact with their sponsor outside of meetings. Fewer of the adolescents and young adults attending other fellowships reported a sponsor. Sponsoring other individuals was particularly rare in these samples. In contrast, contacts with other group members were more commonly endorsed, particularly among the young adults.

Participation in meetings, defined in terms of sharing or talking in a meeting, was endorsed by approximately three-quarters of young adults and 40% of adolescents who had attended each type of fellowship in the past 3 months. A minority reported helping to set up or run meetings during this period.

As with fellowship involvement, step work was limited in these samples. Among those with recent meeting attendance, between 59% and 71% of respondents across samples and fellowship types reported that they had not completed any of the 12 steps, and only a handful of participants in either sample reporting having completed any of the steps requiring specific actions (e.g., writing an inventory, making direct amends). That said, a majority of young adults who had attended groups during the past 3 months (57%–74%) indicated that they had completed Step 11, which involves praying or meditating outside of meetings.

3.3 Court mandated attendance

Similar proportions of respondents in the two samples had been mandated by the courts to attend 12-step groups, including 10% of adolescents (n=13) and 11% of young adults (n=33). Among the adolescents, respondents reported being mandated to attend a median total of 6 meetings (ranging from 2–90) or a total of 2 meetings per week (ranging from 1–7), for a median period of 3 months (ranging from 0.5–24). Among the young adults, respondents reported being mandated to attend a median total of 5.5 meetings (ranging from 1–25) or a total of 2 meetings per week (ranging from 1–14), for a median period of 2 months (ranging from 1–36). Respondents varied in the degree to which they attended these meetings as required: 8% of the adolescents and 15% of young adults attended no meetings, while 75% of adolescents and 47% of young adults attended fully as required, with the remainder of clients falling between these extremes.

3.4 Affiliation and safety

For the subset of respondents who had ever attended each of the fellowship types, Table 5 summarizes overall experiences of affiliation and safety. Respondents varied in terms of the degree to which they perceived 12-step groups to be important and helpful to their recovery efforts. Mean ratings among adolescents for AA/NA were 5 or lower on the 10-point scale, indicating low average perceived importance or helpfulness. Young adults reported a higher degree affiliation with AA/NA, on average, but with lower ratings for CA and “other” fellowship types. Average ratings of the level of enjoyment of meetings followed a similar pattern.

Threats to safety, including incidents of intimidation, threats, or sexual harassment, were rare. These exceeded 10% percent for NA attendance among adolescents, although the absolute number of affected individuals (3) was low. Overall, respondents in both age groups reported high levels of perceived safety at meetings, with average ratings all exceeding 7.5 out of 10.

3.5 Open-ended responses

Of those who had never attended any 12-step meetings, 98% of adolescents (72/73) and 91% of young adults (95/105) provided reasons in the open-ended question addressing non-attendance. Of those with prior 12-step experience, 96% of adolescents (52/54) and 72% of young adults (141/197) provided information on what they found most helpful, while 96% of adolescents (52/54) and 57% of young adults (112/197) provided information on what they liked least. Among those with lifetime, but not recent, attendance, 82% of adolescents (14/17) and 63% of young adults (55/87) provided information on why they had stopped attending meetings.

3.6 Test-retest reliability

Thirteen of the 32 items demonstrated variability across the 11 respondents on whom test-retest interviews were conducted, allowing for the calculation of correlation coefficients. In this subset of items, correlations ranged from .866 to 1.000, indicating excellent stability over a 1-week period.

4. Discussion

This article describes the content and results of a structured interview designed to support comprehensive multidimensional assessment of 12-step experiences across different fellowship types. The interview was shown to be easily and quickly administered and was acceptable to patients exhibiting a broad range of substance involvement and impairment in the outpatient and residential samples. Previously identified as an understudied subgroup of those who may access and potentially benefit from 12-step fellowships (Kelly, 2003), the present approach was tailored for adolescents and young adults; for instance by including questions addressing the age composition of groups and attendance at young persons' groups. However, with the exception of these items, the interview content is equally applicable to adults with addiction problems. This measure may facilitate a more detailed and nuanced understanding of individuals' 12-step attitudes and behaviors.

Strengths of the measure include its higher "bandwidth" by way of expanded content validity in representing the complex range of 12-step experience. The data generated represent a comprehensive array of behavioral indicators previously shown to be associated with abstinence, as well as subjective states and perceptions, judicially mandated attendance, and qualitative, phenomenological aspects related to both participation and non-participation. The mixture of behavioral indicators and subjective perceptions matches other conceptualizations of the treatment process, developed and tested in specialized addiction treatment programs (Simpson, 2004), as well as a broader recognition of the need to supplement indices of physical presence in treatment with measures of meaningful and active involvement (Schacht Reisinger, Bush, Colom, Agar, & Battjes, 2003; Sung, Belenko, Feng, & Tabachnick, 2004).

Additional strengths of the present approach include the collection of information on group and meeting characteristics (e.g., age composition and gender specific meetings; speaker or literature-based meetings), as well as an ability to differentiate between fellowship types (e.g., AA, NA, or CA). Preliminary evidence highlights the relevance of age composition of groups for 12-step participation among youth (Kelly, Myers, & Brown, 2005). Future work capturing 12-step experiences at the high level of detail afforded by this measurement approach is needed to examine potentially important nuances in the relationships between individuals' demographic and clinical characteristics, fellowships attended, and various aspects of participation in 12-step organizations, and recovery.

Logistically, the measure is relatively easily incorporated into a larger assessment battery in research studies, and can be administered by lay (non-clinical) research staff with minimal training. On the part of participants, the interview appeared to be acceptable to young people entering specialized treatment programs, who responded not only to the closed-format questions, but typically also readily provided free-form answers to open-ended questions when asked.

Substantively, and in accordance with previous reports, these adolescents and young adults exhibited fairly low levels of 12-step attendance, involvement, and step work at entry into SUD treatment (Chi, et al., 2009; Kelly, Myers, & Rodolico, 2008). Differences in age composition of meetings were particularly stark for AA. Average ratings suggested that the adolescent outpatients in particular were not placing a high level of importance on 12-step meeting attendance at the time they entered treatment. Conclusions from these data must be drawn with caution, however, due to the small number of respondents endorsing some items, particularly for many of the behavioral items in the adolescent sample. Future analyses will concentrate on modeling the interrelationships between these factors concurrently and prospectively, and their impacts on outcomes of treatment.

A small amount of data was available to permit tests of reliability, with very promising preliminary results. In addition, the patterns of attendance and involvement exhibited across the two samples conformed to expectations based on differences in developmental stage and clinical severity at admission to specialized SUD treatment. Thus, the measure appears to be sensitive enough to effectively discriminate between groups of potential attendees. That said, more information is needed on reliability and construct validity of the different elements of the interview. Based on our previous experiences with the interview and data analysis, we recommend ascertaining events of intimidation, threats, and sexual harassment separately rather than in a single question (Kelly, et al., in press). These incidents are likely experienced differently; for instance, a large AA meeting may make an individual feel “intimidated”, which may be a very different phenomenon than being sexually harassed or threatened). These different aspects of safety may, in turn, relate very differently to future attendance patterns and involvement. Also, the assessment of mandated attendance would benefit from expansion to include individual perceptions of coercion and other, non-judicial, sources of mandates and ultimatums to attend meetings, in line with recent recommendations (Urbanoski, 2010; Wild, 2006).

Conclusion

Mutual-help organizations such as AA and NA have proven to be highly cost-effective public health resources in addressing alcohol and other drug related problems (Humphreys, 2004; Humphreys & Moos, 2001; Kelly & Yeterian, 2008). Through an increase in quantity and quality of research in this area supported by federally funded initiatives, much has been learned about these organizations’ therapeutic effects (e.g., Humphreys, 2004) and mechanisms of action (Kelly, et al., 2009). Yet, almost nothing is known about the relative benefit of different 12-step organizations in relation to the fit between their primary focus (e.g., alcohol vs narcotics vs cocaine) and the primary substance of use of attendees. Furthermore, many aspects of 12-step experience, like safety, mandated attendance, and degrees of fellowship involvement and meeting participation within different types of meetings, have not been captured in existing research. Through the application of a more detailed, but still brief, structured interview, it is possible to capture the multidimensional construct of 12-step experience more thoroughly than has been the norm in previous work. This kind of comprehensive measurement approach is sorely needed to expand our knowledge about the range of individuals’ activities and experiences across different 12-step organizations and how these may relate to fellowship engagement, retention, and recovery from substance use disorder.

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Table 1

Seven dimensions of 12-Step mutual-help experiences

Dimension	Definition
Meeting attendance	Physical presence at meetings, indexed by the frequency and/or quantity of meetings attended during a given time period; should include types of meetings attended
Meeting participation	Active behavioral engagement in meetings, such as talking or sharing during meetings or helping to set up and run meetings (service work)
Fellowship involvement	Active behavioral engagement in the fellowship and its activities, such as obtaining a sponsor or sponsoring others (service work), having contacts with members outside of meetings
Step work	Progress in working through the 12-step program of action
Mandated attendance	Presence and duration of, and compliance with, mandates from the courts or justice system to attend 12-step meetings
Affiliation	Subjective commitment and engagement in the fellowship, such as perceptions of the degree to which the meetings are enjoyable, as well as important and helpful to recovery efforts; reading 12-step literature outside meetings
Safety	Extent to which individuals feel safe at meetings, and whether previous threats to safety have been perceived

Table 2

Structured interviews for 12-step mutual-help group experiences

	Meeting attendance	Fellowship involvement	Meeting participation	Step work	Mandated attendance	Affiliation	Safety
Number of meetings attended (lifetime)	X						
Number of meetings attended (past 3 months)	X						
Percent of group members your age	X						
Attended specific types of meetings (e.g., gender-specific, speakers or literature meetings)	X						
Consider yourself a member		X					
Had sponsor		X					
Contacts with sponsor outside of meetings		X					
Served as sponsor		X					
Contacts with those you sponsor outside of meetings		X					
Contacts with other members outside of meetings		X					
Talking or sharing in meetings			X				
Helped set up or run meetings			X				
Number of steps completed				X			
Completed a written inventory				X			
Discussed written inventory with another person				X			
Made a list of people you have harmed				X			
Made direct amends to people you have harmed				X			
Prayed or meditated outside of meetings				X			
Required or mandated by legal authorities to attend meetings					X		
Length of mandated attendance					X		
Frequency of mandated attendance					X		
Percent attended as required					X		
Perceived importance of meetings to recovery						X	
Perceived helpfulness of meetings to recovery						X	
Level of enjoyment of meetings						X	
Read 12-step literature outside of meetings						X	

	Meeting attendance	Fellowship involvement	Meeting participation	Step work	Mandated attendance	Affiliation	Safety
Felt intimidated, threatened, or sexually harassed at a meeting							X
Perceived safety at meetings							X

Table 3

Meeting attendance

Item	Fellowship Type			
	AA % (n)	NA % (n)	CA % (n)	Other % (n)
Any attendance in lifetime, % (n):				
Adolescents	40.9 (52)	15.7 (20)	0	0
Young adults	60.1 (182)	39.3 (119)	8.3 (25)	7.6 (23)
Any attendance in past 3 months, % (n):				
Adolescents	28.3 (36)	9.4 (12)	----	----
Young adults	32.0 (97)	16.5 (50)	2.3 (7)	2.3 (7)
Weekly attendance or more often in past 3 months, % (n):				
Adolescents	8.7 (11)	3.1 (4)	----	----
Young adults	13.5 (41)	5.6 (17)	0	0.3 (1)
Specific types of meetings attended in the past 3 months, % (n):				
Gender-specific				
Adolescents	5.5 (7)	0	----	----
Young adults	7.6 (23)	1.7 (5)	0.3 (1)	0.7 (2)
Literature-focused				
Adolescents	8.7 (11)	0.8 (1)	----	----
Young adults	21.8 (66)	8.6 (26)	1.0 (3)	1.0 (3)
Speakers				
Adolescents	13.4 (17)	0.8 (1)	----	----
Young adults	20.5 (62)	8.3 (25)	1.0 (3)	1.0 (3)
Beginners				
Adolescents	10.2 (13)	0.8 (1)	----	----
Young adults	8.3 (25)	4.3 (13)	0.3 (1)	0.7 (2)
Young persons				
Adolescents	11.0 (14)	0.8 (1)	----	----
Young adults	9.6 (29)	3.6 (11)	0.3 (1)	1.0 (3)
Gay persons				
Adolescents	0	0	----	----
Young adults	0.6 (2)	0	0	0

Table 4

Recent (past 3-month) involvement, meeting participation, and step work

Item	Fellowship Type			
	AA % (n)	NA % (n)	CA % (n)	Other % (n)
Fellowship involvement				
Consider yourself a member				
Adolescents	16.7 (6)	16.7 (2)	----	----
Young adults	44.3 (43)	52.0 (26)	28.6 (2)	28.6 (2)
Had a sponsor:				
Adolescents	13.9 (5)	0	----	----
Young adults	35.1 (34)	18.0 (9)	0	14.3 (1)
Had contact with sponsor outside of meetings:				
Adolescents	13.9 (5)	0	----	----
Young adults	34.0 (33)	14.0 (7)	0	14.3 (1)
Served as a sponsor:				
Adolescents	0	0	----	----
Young adults	0	4.0 (2)	0	0
Had contact with those you sponsor outside of meetings:				
Adolescents	0	0	----	----
Young adults	0	4.0 (2)	0	0
Had contact with other members outside of meetings:				
Adolescents	33.3 (12)	8.3 (1)	----	----
Young adults	50.5 (49)	48.0 (24)	28.6 (2)	42.9 (3)
Meeting participation				
Talked or shared in meetings:				
Adolescents	38.9 (14)	41.7 (5)	----	----
Young adults	73.2 (71)	74.0 (37)	71.4% (5)	71.4% (5)
Helped set up or run meetings:				
Adolescents	16.7 (6)	0	----	----
Young adults	21.6 (21)	26.0 (13)	0	0
Step work				
Total number of steps completed:				
Adolescents				
0	63.9 (23)	66.7 (8)	----	----
1 or 2	19.4 (7)	0	----	----
3+	16.7 (6)	33.3 (4)	----	----
Young adults				
0	58.8 (57)	60.0 (30)	0	71.4 (5)
1 or 2	9.3 (9)	12.0 (6)	0	14.3 (1)
3+	30.9 (30)	24.0 (12)	0	0
Completed a written inventory (step 4):				

Item	Fellowship Type			
	AA % (n)	NA % (n)	CA % (n)	Other % (n)
Adolescents	11.1 (4)	8.3 (1)	----	----
Young adults	9.3 (9)	6.0 (3)	0	0
Discussed written inventory with another person (step 5):				
Adolescents	8.3 (3)	8.3 (1)	----	----
Young adults	5.2 (5)	6.0 (3)	0	0
Made a list of people you have harmed (step 8):				
Adolescents	5.6 (2)	0	----	----
Young adults	2.1 (2)	2.0 (1)	0	0
Made direct amends to people you have harmed (step 9):				
Adolescents	0	0	----	----
Young adults	2.1 (2)	2.0 (1)	0	0
Prayed or meditated outside of meetings (step 11):				
Adolescents	22.2 (8)	16.7 (2)	----	----
Young adults	74.2 (72)	66.0 (33)	57.1 (4)	57.1 (4)

Table 5

Affiliation and safety

	Fellowship Type			
Item	**AA**	**NA**	**CA**	**Other**
Affiliation				
Perceived importance to recovery, M±SD: [a]				
Adolescents	3.7 ± 3.2	4.8 ± 3.7	----	----
Young adults	7.0 ± 3.1	6.8 ± 3.3	4.4 ± 3.2	3.4 ± 3.2
Perceived helpfulness to recovery, M±SD: [a]				
Adolescents	4.5 ± 3.3	5.0 ± 3.5	----	-----
Young adults	7.2 ± 3.0	7.0 ± 3.2	5.0 ± 3.8	3.7 ± 3.6
Level of enjoyment of meetings, M±SD: [a]				
Adolescents	3.6 ± 2.9	3.9 ± 3.1	----	----
Young adults	6.0 ± 2.8	6.6 ± 2.8	5.4 ± 3.3	5.2 ± 3.8
Safety				
Ever intimidated, threatened or sexually harassed, % (n):				
Adolescents	5.8 (3)	15.0 (3)	----	----
Young adults	8.8 (16)	5.9 (7)	0	0
Perceived safety at meetings, M±SD [a]				
Adolescents	9.0 ± 1.8	7.5 ± 3.1	----	----
Young adults	9.3 ± 1.4	9.1 ± 1.7	8.8 ± 2.5	7.6 ± 3.8

[a] Rating: 1–10