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Marc Galanter MD [a] , Helen Dermatis PhD [a] & Courtney Santucci BA [a]
[a] Division of Alcoholism and Drug Abuse, NYU School of Medicine , New York , New York , USA
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YOUNG PEOPLE IN ALCOHOLICS ANONYMOUS: THE ROLE OF SPIRITUAL ORIENTATION AND AA MEMBER AFFILIATION

Marc Galanter, MD, Helen Dermatis, PhD, Courtney Santucci, BA

Division of Alcoholism and Drug Abuse, NYU School of Medicine, New York, New York, USA

Empirical findings characterizing long-term, committed Alcoholics Anonymous (AA) members are limited, particularly among younger members. The authors studied a sample of 266 highly committed attendees (mean age, 27 years) at an annual conference of Young People in Alcoholics Anonymous (YPAA), whose first encounter with AA was 6 years previously. Most (72%) had abused drugs and alcohol, and 36% had never received substance abuse treatment. They now reported a mean duration of abstinence of 44 months and had attended an average of 233 AA meetings in the previous year; 66% had served as AA sponsors, and 92% reported experiencing an AA "spiritual awakening," itself associated with a decreased likelihood of alcohol craving. Scores on AA beliefs, affiliation to other members, and the experience of spiritual awakening were associated with lower depression scores. These findings are discussed to clarify the nature of long-term AA membership.

KEYWORDS. Alcoholics Anonymous, spirituality, addiction recovery

Members of Alcoholics Anonymous (AA) are typically believed to be middle-aged. This is in keeping with survey data collected by AA itself, which gives the average age of members as 48 years.[1] However, recently interest has emerged regarding the suitability of referral of youthful substance abusers to this fellowship.[2,3] In this exploratory study, we have evaluated a sample of community-based longstanding youth AA members, independent of their being followed-up from prior treatment. The purpose of this study was to obtain basic information on prior substance use, treatment experience, and duration of abstinence, which has not been generally available for community-based long-term AA samples.

Studies on AA members of all ages are typically limited by the fellowship's tradition of anonymity and noncollaboration with other organizations, as stipulated in the AA literature and formalized in its Twelve Traditions. Because of this, with few exceptions, access has been effectively limited to members who have been registered and followed-up as part of treatment program outcome studies.[4–6] The current study was undertaken on the basis of an understanding reached with a free-standing organization called Young People in Alcoholics Anonymous (YPAA), consisting of youth members of AA who help other young substance abusers find appropriate ties to the AA fellowship and organize an annual conference. Because many attendees at these conferences have come to AA independent of treatment programs and may be longstanding affiliates of AA itself, access to individuals associated with this organization provides an opportunity to study a population of AA members not usually available for evaluation. It further helps explain certain aspects of AA as a spiritually oriented recovery movement.

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Address correspondence to Marc Galanter, MD, Division of Alcoholism and Drug Abuse, NYU School of Medicine, 550 First Avenue, New York, NY 10016. E-mail: marcgalanter@nyu.edu

METHOD

The Sample Studied

YPAA is a loosely knit organization that lists affiliated groups in 40 states in the United States and in 10 other countries (www.ypaa.info). An International Conference of YPAA is held each year, and the site of the conference is selected by a committee constituted of diverse members designated in collaboration with that year's host committee. This study was performed at a conference held in New York in August 2010, where there were 4,789 registrants. Of those registered at the conference, 358 attendees volunteered at registration to complete a codeable survey instrument. Responses of the 266 who were younger than 40 years are presented here.

The Survey Instrument

The instrument applied to the respondent sample consisted of 71 computer-coded items. Topics addressed included demographics, substance abuse history, general psychological and addiction treatment, and experience in and views of AA, which were adapted from previous studies of ours.[7] Depression experienced in the past week was assessed by a 6-item scale included in the Brief Symptom Inventory.[8] Craving for alcohol was assessed by responses on a 10-point visual analog scale, similar to ones applied in other studies on substance abusers in treatment.[9] Participants' spiritual and religious orientation was assessed by items employed in surveys of U.S. national probability samples.[10–12]

We adapted two scales to assess the nature of members' involvement in AA based on findings in our previous studies, one for AA member affiliation[13] and the second for ascription to AA-related beliefs.[14] Items on both scales were scored on a five-point continuum, ranging from "not at all" to "very much." For the first of these scales, based on AA member affiliation, participants scored the 10 AA members they "know best" on eight characteristics. Typical items were "They care for me" and "I like being part of their activities." The second scale included eight items reflecting a respondent's degree of belief in AA's principles, such as "I am powerless over alcohol" and "I should turn my will and life over to God as I understand Him." Participants were also asked to indicate whether they had experienced a "spiritual awakening," a phenomenon referred to in the Twelfth Step of AA.

Primary statistical analyses were conducted to assess differences between attendees younger than 25 years versus those who were between 25 and 39 years on background variables and program-related characteristics. The bivariate relationships between age group and background and program-related variables were assessed by chi-square analysis for categorical variables and independent *t* tests for continuous variables. In addition, a multiple linear regression analysis was conducted in which level of depression was regressed on program involvement related characteristics including AA member affiliation, AA beliefs, and spiritual awakening.

RESULTS

The responses of the 266 conference attendees younger than 40 years were tabulated. Almost all (91.3%) were either employed or were students, with a mean age of 26.9 years (standard deviation [SD] = 5.21 years), and 57.8% were male. The respondent group was divided among those who designated their principal problem as alcohol only (28.2%), or both drug and alcohol abuse (71.8%). All reported being currently abstinent from substances, with a mean duration of 43.9 months (SD = 46.2 months).

Scale Reliability

Inter-item reliability was calculated for each of three scales used based on scores of the respondent sample: for Brief Symptom Inventory scale for depression (0.86), AA beliefs (0.67), and AA member affiliation (0.79).

Involvement in AA Activities

Participants had attended their first AA meeting at a mean of 20.6 years (SD = 4.33 years), and reported an average of 43.9 months (SD = 46.2 months) of abstinence. At some point,

most (74.5%) had gone to 90 AA meetings in 90 days, a criterion considered by AA members as optimal for induction. Regarding current involvement in the AA program, participants were frequent meeting attenders ($\bar{x} = 233.02$, SD = 128 meetings in the past year), and the large majority indicated that they currently had a sponsor (92.4%) and had done service (98.5%) for the fellowship in the past year (e.g., greeting meeting attendees, making coffee at meetings). Moreover, 66.2% had also served as sponsors of other AA members, with 33.1% of the overall sample having sponsored more than 5 other members.

Responses to items on the scale of AA affiliation reflected strong ties to other AA members. This was evident in the portion of participants who answered 4 (a lot) or 5 (very much) on the 5-point scale regarding the 10 members they knew best: "They care for me" (91.3%), "I like being part of their activities" (86.3%), and "I care for them" (91%).

Spirituality and Belief

Members' spiritual and religious orientations were evaluated by means of several questionnaire items. Regarding their belief in a deity, most (62.1%) indicated that they believed in a personal God as opposed to a Higher Power only (17.2%) or neither God nor a Higher Power (20.6%). However, the majority (77.9%) reported that they felt God's presence at least most days. Only a small minority went to church at least monthly (14.6%) or designated themselves as religious (19.9%); however, 99.2% designated themselves as spiritual. Commitment to AA principles was high, as reflected in items on the AA Belief Scale. For example, participants scored statements reflecting their degree of agreement with the First and Third Steps of AA, respectively, on a scale of 1 (not at all) to 5 (very much). Almost all (97.4%) endorsed 4 or 5 for "I am powerless over alcohol" and 91.6% scored 4 or 5 for "I should turn my will and life over to the care of God as I understand him."

The large majority (91.6%) of participants reported having experienced a "spiritual awakening." Scores on the analog scale for craving ranged from 0 to 10, with the majority (68.1%) of participants reporting a score of 0, indicating that they had no craving for alcohol in the past week. On average, those who had experienced a spiritual awakening were less likely to report experiencing any craving for alcohol than those who reported they had not (i.e., 0 on a 10-point craving scale [29.5%] vs. greater than 0 [54.5%], $\chi^2 = 5.82$, df = 1, $P = .02$), but they did not report a significantly longer a period of recent abstinence than those who had not nor had they significantly attended fewer AA meetings in the past year. However, those who had experienced the awakening were more likely to have served as sponsors (69.2% vs. 31.8%, $\chi^2 = 12.54$, df = 1, $P = .0001$).

Affect and Craving

Mean item raw scores were calculated for responses to items on the Brief Symptom Inventory Scale for depression. They were .88 for men and .85 for women, reflecting T-scores of 67 and 61, respectively, relative to community samples. Thus, participants scored more than one standard deviation higher than the mean of the community comparison groups for depression.[7] A significant positive correlation was found between scores on the craving scale and the Brief Symptom Inventory scale for depression ($r = .38$, $P < .001$), with craving scores inversely related to duration of current abstinence ($r = -.25$, $P < .01$).

We performed a multiple linear regression to ascertain the relationship between aspects of AA commitment and members' mood status. Scores on AA member affiliation, AA beliefs, and the experience of spiritual awakening were entered as predictors of depression scores. The combination of these variables ($\beta = -.314$, $-.189$, and $-.111$, respectively) accounted for 21% of the variance in depression ($F = 20.77$. df = 3, 240, $P < .0001$). In addition, relative to commitment activity, we examined sponsorship. Those who had sponsored other members had lower scores on depression than those who did not (raw scores $\bar{x} = .75$, SD = .64, vs. $\bar{x} = 1.09$, SD = .88, $t = 3.26$, df = 133, $P < .001$).

TABLE 1. Comparison of Attendees Younger than 25 Years (n = 92) with Those Between 25 and 39 Years (n = 174)

	Younger than 25 years	25–39 years	Statistic
Male (%)	53.3	60.2	NS
Alcohol problem only (%)	18.7	33.8	$\chi^2 = 4.28$, df = 1, p = .038
Prior outpatient substance treatment (%)	68.5	50.3	$\chi^2 = 8.06$, df = 1, p = .005
Prior outpatient general psych (%)	59.8	67.1	NS
Prior inpatient substance treatment (%)	52.2	42.0	NS
Months since last substance use (mean [SD])	24.2 (21.6)	56.8 (59.9)	t = 6.39, df = 236, p = .0001
Age first attended AA meeting, years (mean [SD])	17.0 (2.7)	2.0 (4.4)	t = 9.15, df = 252, p = .0001
Did 90 meetings in 90 days (%)	82.4	70.8	$\chi^2 = 4.28$, df = 1, p = .038
Ever had sponsor (%)	100.0	99.4	NS
Now has a sponsor (%)	95.7	90.6	NS
Has sponsored others (%)	50.0	74.7	$\chi^2 = 16.04$, df = 1, p = .0001
AA meetings in 12 months (mean [SD])	252.5 (145.3)	222.5 (116.6)	NS
Cohesiveness toward AA members (mean [SD])	36.4 (3.4)	35.7 (3.7)	NS
Acceptance of AA beliefs (mean [SD])	37.7 (2.5)	36.7 (3.7)	NS
Ever attended NA (%)	82.4	67.1	$\chi^2 = 7.00$, df = 1, p = .008

NS = not significant; AA = Alcoholics Anonymous; NA = Narcotics Anonymous.

Responses Relative to Age

Although most of the participants in this sample are young adults, as indicated in Table 1, some salient differences exist between those younger than 25 years and those between 25 and 39 years. Members of the younger group were more likely to have had drug problems and not just ones with alcohol, to have received outpatient treatment for substance abuse, and to have attended Narcotics Anonymous meetings. However, no difference was found between the two groups in ever having had a sponsor (almost all did) or currently having a sponsor (the large majority did). Furthermore, members of both groups had attended an average of more than 200 AA meetings in the past year and were not significantly different in mean responses to the scale for AA member affiliations or AA beliefs or the portion that had experienced a spiritual awakening. However, an analysis of responses by the 10% of participants younger than 21 years revealed that they were more likely to have been hospitalized (76.9%) or been outpatients (76.9%) in treatment for alcohol or drug abuse than those older than 21 years. In addition, few (8.0%) reported that their problems were with alcohol only and not drugs.

Prior Treatment for Substance Abuse and General Psychological Problems

The majority (64.5%) indicated that they had received treatment for general psychological problems (i.e., not substance abuse). Most (56.7%) participants had received outpatient substance abuse treatment and 46% had received inpatient treatment for this problem, but 36% had received neither inpatient nor outpatient substance abuse treatment, although most of these (19.2% of the entire sample) had received treatment for "general psychological problems." However, those 19.2% were no different from other participants in the number of AA meetings attended in the past year, their mean scores on AA beliefs or AA member affiliation, or how long ago they had last used alcohol or abused drugs than the remainder who had not received any treatment previously.

The majority (72.4%) of participants had also attended Narcotics Anonymous meetings, and those who did were more likely to have indicated having a problem with drugs and not just alcohol (76.7% vs. 57.6%, $\chi^2 = 8.64$, df = 1, $P = .003$) and to have been treated both as inpatients (50.0% vs. 33.3%, $\chi^2 = 5.83$, df = 1, $P = .015$) and outpatients (63.0% vs. 40.3%, $\chi^2 = 10.92$, df = 1, $P = .001$) for substance abuse.

DISCUSSION

The Character of Participants' Addiction and Recovery

The majority of participants indicated that their problems were with drugs and alcohol, and that

they had attended Narcotics Anonymous and AA meetings. This reflects the emergence of polysubstance use among the young in recent years. This was particularly true for participants younger than 21 years. Overall, participants typically had been exposed to professional care (83%), either for general psychological problems or substance abuse, indicating widespread exposure to professional treaters among young committed members and the importance of assuring an effective liaison and good working relationships between professionals and local AA members.

The participants now appeared to be well established in sobriety, in that almost all reported being employed or students, and had an average of more than 3 years of abstinence. Three-quarters had attended 90 meetings in 90 days, reflecting a standard maintained within the AA fellowship for becoming successfully engaged. Responses to items on the scales for AA beliefs and AA member affiliations reflected a strong commitment to the program and its members. Notably, the majority reported experiencing no craving for alcohol in the previous week. In this regard, they clearly had a successful engagement in the AA program, reflecting an association between long-term membership and decreased vulnerability to relapse.

AA Membership Among Young Adults

At its official web site (www.aa.org), AA reports having 114,070 groups and 2,133,842 members worldwide.[15] Where does AA stand as a program for young people? Available data suggest that AA members are typically middle aged. The AA triennial survey[16] gives the average age of its members as 48 years, with 71% older than 40 years. Furthermore, a follow-up on 926 individuals seeking treatment in alcohol programs conducted in Northern California revealed that 81% of those who continued with AA attendance after treatment were older than 30 years.[17] How about young adult membership? Kaskutas et al.[17] reviewed findings of the U.S. National Alcohol Survey conducted on a probability sample of the U.S. general population. It indicated that only a small portion (12%) of those who ever attended Twelve Step meetings were 30 years or younger. In addition, younger people tend to drop out after exposure. According to the 2001 National Epidemiological Survey on Alcoholism and Related Conditions, 40% of newcomers to Twelve Step groups were between 18 and 30 years, and only 13% of those who continued in engagement fell into that age group.[18]

These findings are important given the needs of young attendees in AA. Such participants' values and outlook have bearing on their health status in general.[19,20] Regarding substance use, Mason and Luckey[21] studied an alcohol treatment sample of 1022 participants from two large metropolitan urban settings and characterized those between 18 and 25 years. They found systematic differences between the young adult group and the remainder of the sample in education, employment, mental health, alcohol, and drug use. They pointed out that the young adult age group had unique psychosocial and behavioral needs when compared with those of the adult treatment population and suggested that these needs may be linked to treatment retention and outcome. In following up a sample of adolescents who were recruited during inpatient treatment, Kelly[22] found that greater age similarity was found to positively influence attendance rates.

Assessment of Long-Term AA Membership

There is a paucity of information available on AA attendees other than those followed-up after substance abuse treatment. This represents a certain deficiency on two counts. First, a significant portion of AA members enter this fellowship either independent of treatment or return to AA attendance after extended periods of post-treatment abstinence, or post-treatment relapse. Second, even among those who have had previous treatment and continued AA attendance, the character of their experience after extended periods of membership has typically not been studied. Despite this, given the aforesaid statistics on surveys of AA membership, it is the long-term attendees who constitute the majority of AA members, and

it is the character of their experience that is characteristic of those attending AA meetings.

Although information on levels of AA attendance is available from certain studies, most of these studies involve patients followed-up after engagement in specific treatment programs.[4–6] Community-based samples are less common, but do reflect an association between long-term AA attendance and positive outcome. One source of information on such long-term members is the General Service Board of AA itself. AA's central office conducts a triennial survey of members at a selected sample of meetings, most recently in 2007. It reported that 47% of attendees had been sober for at least 5 years.[16] Another source is the National Institute on Alcohol Abuse and Alcoholism, which conducted a large-scale survey[18] weighted to be representative of the U.S. adult population. Exposure to Twelve Step programs (including Narcotics Anonymous, Cocaine Anonymous, and AA) was queried, and 3.4% of participants indicated exposure to these Twelve Step programs at some point in their lives and 24% of them had maintained continued Twelve Step engagement. Most (74%) of those who had maintained engagement had undergone specialty treatment for their substance use disorder, with 36% having been abstinent for over 5 years.[18] Given these findings, it is useful to consider a population of young adults who actually are established AA members, such as the particpants surveyed here. The experience that led them to come to AA and the nature of their involvement can shed light on an age group whose substance use disorders are of considerable public health import.

Therefore, the current study describes young adult AA members in Twelve Step based recovery, unrelated to a treatment follow-up. They were attendees at a convention for late adolescent and young adult members of AA. It is notable that this respondent group also includes the experience of attendees, 36% of whom had not previously received treatment for substance abuse. Therefore, it allows for a comparison of those who had different types of treatment to those who entered the fellowship by other means. It provides some basic information on prior use, treatment experience, and duration of abstinence not generally available for community-based, long-term AA samples. It also characterizes participants' current status in abstinence regarding issues such as affective status and views related to AA and its spiritually oriented culture.

Addiction Recovery Among Adolescents

Controlled studies have been undertaken on the outcome of motivational interviewing, cognitive behavioral therapy, and multi-system treatment for adolescents.[23,24] However, findings are sparse on the effectiveness of Twelve Step participation in this population, but uncontrolled, naturalistic studies on the relationship between Twelve Step involvement in adolescent treatment programs did show an improved outcome at follow-up.[25] Although only 10% of the participants in our study were younger than 21 years and an additional 25% between 21 and 25 years, the question may be posed as to whether the findings in our current study shed light on whether and how the treatment of adolescent substance abuse can be enhanced with involvement of YPAA.

Given the role of highly committed members studied here, engaging these recovering substance abusers as role models and potential sponsors for teenagers merits consideration. Their proximity in age to younger adolescents and their enthusiastic commitment to AA may be useful in conducting AA meetings in institutional settings where adolescents are treated because adolescents may be better able to identify with them rather than with older members. Furthermore, YPAA members can guide adolescents who are in professional treatment to select appropriate AA meetings and serve as sponsors.

Spirituality and Religion

Certain items designed to clarify participants' spiritual and religious orientation were selected from probability surveys of the adult U.S. general population.[10–12] Although the participants studied here are younger on average than the general population, a comparison of the two populations can be useful. Compared with those probability samples, our participants'

attitudes were reflective of a generically but strongly spiritual disposition rather than a more traditional religious view. They less often designated themselves as religious than did members of a community probability sample (19% vs. 64%, respectively) but more often as spiritual (99% vs. 79%, respectively). A small minority indicated that they go to church at least monthly compared with a community sample (15% vs. 73%, respectively). Fewer believed in a personal God than did members of a community sample (62% vs. 74%, respectively) with more indicating belief in a Higher Power (21% vs. 13%, respectively). Nonetheless, more YPAA participants answered affirmatively to feeling God's presence most days (78% vs. 57%, respectively). These responses suggest the YPAA participants' adoption of the non-denominational orientation in AA rather than commitment to specifics of traditional religious groups.

The phrase "we have experienced a spiritual awakening" appears in AA's Twelfth Step, although this term is not actually defined in the AA text itself. However, reporting this experience has been found to be associated with a greater level of abstinence in treatment outcome,[26] and its predominance (92%) among our participants reflects their high degree of commitment to AA's spiritual format. Notably, an affirmative response on this item was associated with a lesser degree of depression and alcohol craving, suggesting the emotional stability associated with this self-defined experience. A positive response was also more common among those participants who had served as sponsors of other AA members, having adopted a role of mentorship for other members.

Analysis of findings from Project MATCH, a study on the treatment of 1,726 participants for alcohol use disorders, shed light on the psychological mechanisms and psychosocial factors associated with a positive clinical outcome. Among them were a reduction in patients' pro-drinking social network ties, with a concomitant increase in their pro-abstinent ties[27] and increases in their spirituality over time.[28] Improved outcome was also associated with the patients' helping others, including other alcoholics; elevated depressive symptoms before initial AA helping, and declined following helping.[29]

A Spiritual Recovery Movement

These same correlates of improved outcome are reflected in the sample we studied. Our participants were highly committed to AA's spiritual orientation, and their involvement in helping other AA members was reflected in their participation in AA service, their high prevalence of sponsorship, and their expression of strong affiliative ties to other pro-abstinent members.[30] Participants' strong affiliative ties toward other members and their ascription to AA beliefs were also found to be associated with a lower level of depression.[6] This is in keeping with other findings of ours on members of a religious movement wherein establishment of cohesiveness toward other members and acceptance of the movement's belief system[13] yielded an improved sense of psychological well-being; thereby, this association served to reinforce continued compliance with that group's behavioral expectations. Similarly, in the case of AA, compliance with the behavioral norms, such as maintenance of abstinence and continuing attendance at AA meetings, was associated with a lower score on the depression scale.

These membership aspects can be understood as characteristic of other social structures as well. We have previously described the phenomenon of such Spiritual Recovery Movements in this manner: they claim to provide relief from disease, operate outside the modalities of established empirical medicine, and ascribe their effectiveness to metaphysical or spiritual powers.[31] Movements that coalesce around certain alternative medical approaches such as meditative, dietary, or lifestyle changes may also be described in this manner. Social cohesiveness among adherents may also be important in such movements. Certainly, this is evident in our participants given the high rates of sponsor/sponsee affiliation. Sponsorship has been found to be a key aspect of recovery,[30] as has spirituality.[32,33]

Adherents to Spiritual Recovery Movements may experience improvement relative

to traditional medical outcome criteria (e.g., abstinence from addictive drugs, healthful behavior patterns). Alternatively, in some such movements, adherents may not derive objectively discerned health benefits (e.g., some cultic groups practicing non-beneficial dietary patterns or non-productive, health-oriented rituals). Therefore, the merit of a given movement, relative to consideration for clinical referral, rests on studies of outcome, which are sometimes available (as shown here) and sometimes not.

Determining the Tone of AA Meetings

The intensity of commitment among the young adults we studied is also important because they serve as role models for new members, reinforcing acceptance of both AA beliefs and the maintenance of close social ties with other members. The importance of these abstinent and committed members with their strong espousal of the AA explanatory model of addiction and recovery is central to maintaining an atmosphere conducive to recruitment. These members set the tone for meetings, effectively determining the context of communication and excluding alternative perspectives (such as controlled drinking). It is because of this that people first coming to AA are more likely to attribute their need for relief from symptoms of addiction to the explanatory model espoused by AA.[34,35]

Potential recruits typically come to AA meetings in distress over their problematic behaviors and in need of an explanatory model for how these compromising behaviors can be relieved. They are potentially open to a rationale for accepting the AA model to which the opportunity for change is attributed. Therefore, the predominance of longstanding members with a strong belief in the AA model can provide an explanatory attribution for new recruits to adopt. The nature of addiction recovery is then attributed to the role of a Higher Power (i.e., "God as we understood Him"). Over time, in the context of repeated exposures to this explanatory model in a cohesive social context, acceptance of the AA perspective becomes consolidated and then serves as a basis for behavioral change. In this respect, this body of acquired AA beliefs is, in part, what is understood as an underpinning of a "spiritual fellowship."

The findings presented here have clear limitations. They were obtained cross-sectionally, and therefore do not carry the reliability of a prospective study. No corroboration exists of self-reports from collaterals or from toxicology findings, and responses may be colored by the enthusiastic mood of the conference. Furthermore, the circumstances of administration did not allow for more thorough assessment of certain of the variables such as craving and affective status, for which more extensive measures have been developed.[36] Most importantly, individuals attending this YPAA conference are self-selected along lines that do reflect the considerable variability in commitment of people exposed to AA over time. It may also not be characteristic of other long-term young adults in AA who chose not to attend such a convention.

Despite these limitations, some salient observations can be made on the basis of findings from the AA members we studied; certain young people with substance use disorders are capable of responding strongly to the social and spiritual tenets of the AA movement. In conjunction with this, they are apparently able to achieve a considerable duration of abstinence and could potentially serve as a cadre of AA leaders in terms of service to the fellowship and sponsorship of new members. This can contribute to explaining how a program like AA, absent a hierarchy of professionals or paid staff, has been maintained in a vigorous manner over time. Even young people, as well as the older adults typical of AA membership, can respond to AA's social psychological mechanisms that sustain the bonds of a movement grounded in a spiritually oriented system of recovery.

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