Assessing A 12 Step Approach to Mental Health

Emotions Anonymous

Introduction

Emotions Anonymous (EA) is a twelve-step program composed of people who come together in weekly meetings for the purpose of working toward recovery from emotional difficulties. The organization was founded in 1971 in St. Paul, Minnesota and has more than 300 registered support groups in each of the U.S. and Internationally. The program counts as its members both people who have and have not received a diagnosis of mental illness. The intent of this survey is to asses, based on self-reported outcomes, the effects of participation in the EA program on emotional health using clinically validated scales, as well as internally developed questionnaires.

Methods

Data was collected online in April and May, 2021, via an anonymous survey administered via Qualtrics. Invitations to participate in the survey were distributed to Emotions Anonymous members via email and advertised on the Emotions Anonymous website, social media and mobile app. Those completing the survey were provided the opportunity to request a promotional code for a nominal discount toward the purchase of Emotions Anonymous materials. A total of 264 respondents completed some portion of the survey; approximately 175 respondents provided enough data to be included in the analysis of participation in Emotions Anonymous and associated outcomes.

Table 1

	Before starting EA		Current (after EA)		Difference* (change from before to after)	
	Mean	SD	Mean	SD	Mean	SD
Positive Affect† (*n* = 180)	2.57	0.85	3.36	0.85	↑ 0.79	1.02
Negative Affect† (*n* = 181)	3.16	0.95	2.14	0.96	↓ 1.02	1.03
Emotional Reactivity‡ (*n* = 186)	95.81	18.19	67.52	21.70	↓ 28.28	21.53

† Scores range from 1 (Very Slightly/Not at All) to 5 (Extremely)

‡ Score range from 26 to 130; higher scores indicating more emotional reactivity and poorer emotion management

* Statistically significant difference between before and after EA participation ($p < .001$)

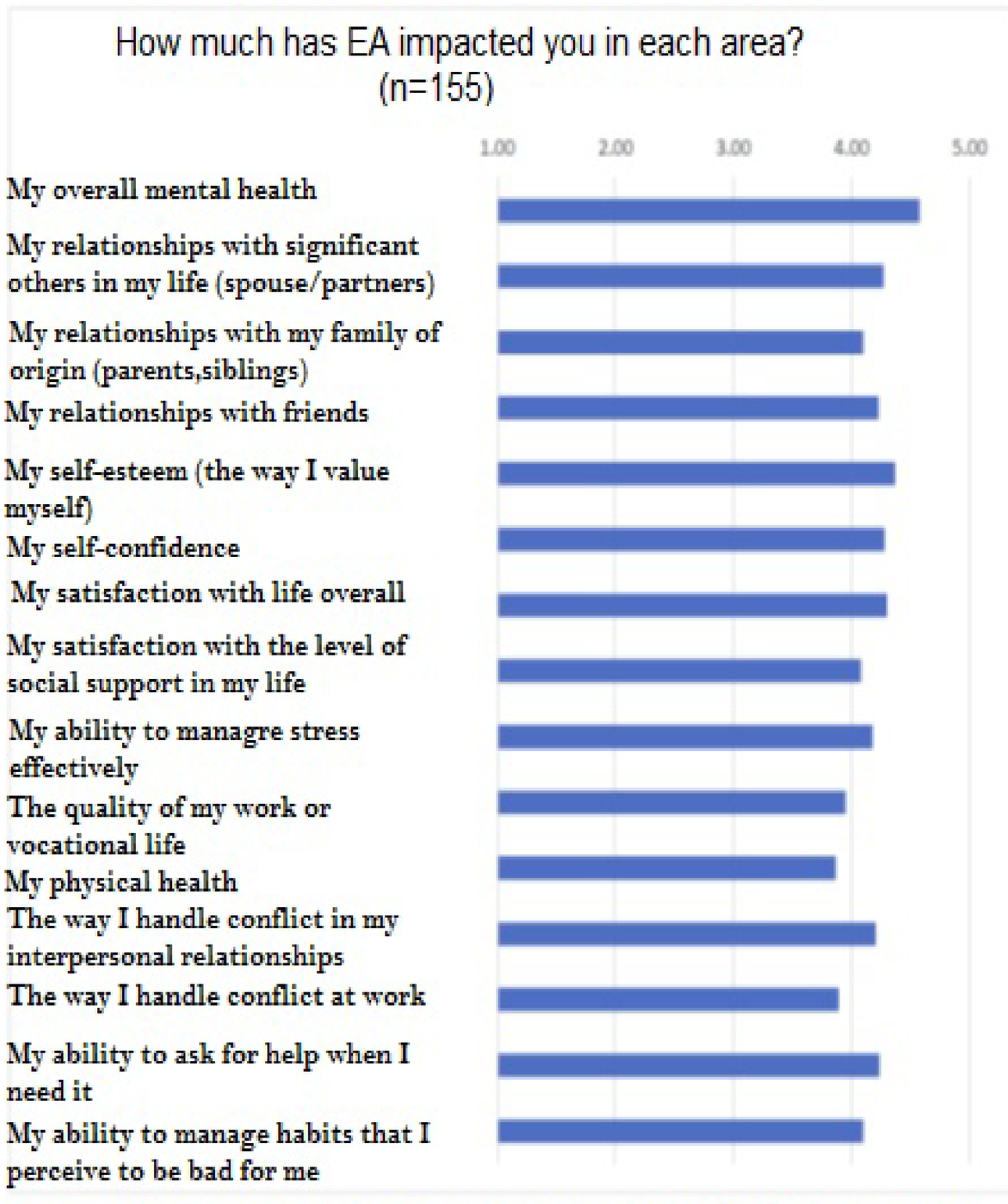
Results

The PANAS scale is a widely used measure of emotional experience that consists of two separate subscales that measure positive and negative affect. The participants were asked to rank how strongly they felt twenty different feelings on a scale from 1 (very slightly) to 5 (extremely) during two time periods: during the few weeks when they first became involved with EA and the few weeks before taking the survey. The results in table 1 show mean improvements in Positive and Negative Affect of 30.74% and 32.28%, respectively.

The emotional reactivity scale that was used (referenced in table 1) consisted of twenty-six situations when potentially strong feelings could arise. Participants were asked to rank how they reacted in each situation on a scale of 1 (not at all like me) to 5 (completely like me). The mean improvement in emotional reactivity was 30%.

Participants were also asked to fill out a fifteen-item questionnaire (figure 1) relating to how the program has impacted them in different areas of their life including family and friend relationships, work and overall mental health. The scale was from 1 (EA has had a significant negative impact) to 5 (EA has had a significant positive impact). The average level of impact across all areas was 4.16. Among those for whom it was applicable, 65% indicated that EA has a positive impact on their reliance on substances to manage emotions, 53.8% indicated that EA has a positive impact on their use of prescribed medication and 73.1% indicated that EA had a positive impact on their need to call crisis hotlines or emergency services.

Figure 1



.Mean ratings on a 1 (EA has had a signicant negative impact) to 5 (EA has had a significant positive impact) scale.

Conclusion

The survey results indicate that most (figure 2) members who took the survey experience overall improved emotional health while attending EA meetings. The proportion of participants who achieved positive affect, decreased negative affect, and decreased emotional reactivity were generally consistent across key demographic variables, including participant gender, ethnicity, education, employment, marital status, and geographic location of EA meetings. These results provide a rationale for mental health providers to consider making referrals to EA meetings. To attempt to establish causality, a more extensive study would need to take place that independently surveyed members at multiple intervals, starting with when they began the program and take into account a greater number of social and economic determinants of health.

Figure 2