



Spanish Validation of the Assessment of Recovery Capital Scale in Clinical Population with Alcohol Use Disorder

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Abstract. Recovery from alcohol use disorder involves achieving certain resources for positive lifestyle changes, well-being, and long-term abstinence. The present study aims to translate and validate the Assessment Capital Recovery (ARC) in a Spanish clinical sample of individuals with alcohol use disorder, in abstinence. The participants were 184 patients who attended outpatient treatments. They were evaluated with the adapted version of the ARC (Spanish abbreviation: “Valoración del Capital de Recuperación, VCR”) and by WHOQOL-BREF (quality of life scale), in one session. Statistical analysis included the calculation of reliability, convergent validity (relationship with WHOQOL-BREF), specificity and sensitivity, as well as validity based on internal structure (confirmatory factor analysis). VCR scores show appropriate values for reliability ($\alpha = .90$), and a low convergent validity with WHOQOL-BREF ($Rho = .33-.53$). The VCR appears to distinguish between patients with early and stable sobriety ($\chi^2 = 20.55, p < .01$). The ROC curve indicates significant discrimination values ($p < .05$) for stable recovery (5 years of abstinence) and sensitivity of 85.2% and specificity of 71.2%. Further, confirmatory factor analysis suggests the presence of a single factor, with relatively acceptable values of goodness of fit and factor loadings. We used ULS parameter estimation to study VCR properties, an appropriate tool for assessing recovery in clinical populations of individuals with alcohol use disorder in abstinence.

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Recovery in alcohol use disorder (AUD) has been increasingly focusing on wellbeing aspects over time (Kaskutas et al., 2014, 2015), by comprehending the different life dimensions that are compromised for individuals who suffer from it. In this way, the process of recovery itself becomes relevant, in terms of lifestyle changes, psychological wellbeing and personal resources (Kaskutas et al., 2014; Kelly et al., 2018; Laudet, 2008; Slade et al., 2012). In this direction, biopsychosocial models aim to extend the concept of recovery in substance dependence beyond the concept of abstinence. This approach also aims to address environmental, social, personal, and cultural factors that interact in a reciprocal and dynamic manner with recovery (Kelly & Hoepfner, 2015).

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In dependence processes, recovery is defined as the voluntary process of control over the substance use, with positive influences on health, well-being, and social participation, following the UK Drug Policy Commission (2008), and it can be divided in several “recovery” stages, related to abstinence, as it follows: *Early sobriety* (first year), *sustained sobriety* (1–5 years) and *stable sobriety* (≥ 5 years). The relation between psychological dimensions related to recovery and abstinence length has been studied before, and the results indicate that quality of life, a variable strongly related to recovery (Laudet & White, 2008), significantly predicts abstinence length at 1 and even 2 years after patients’ assessments (Laudet et al., 2009).

At this juncture, the recovery capital (RC) framework is gaining momentum. Cloud and Granfield (2008), and Granfield and Cloud (1999), defines it as the amount and scope of resources that can be tapped to initiate and sustain recovery from substance use problems. The several domains to which they refer are: Physical or economic capital; human capital, related to individual’s abilities to function in society (education, physical and psychological health); social capital, related to group belonging and resources, obligations and benefits from it; cultural capital, associated with norms and the capacity to act in a correspondent manner to them, in order to satisfy needs and maximize opportunities (Hennessy, 2017). The accumulation of this capital is fundamental, since a greater quantity and availability of actives influences the resilience and coping strategies (Kelly & Hoepfner, 2015); apart from helping to mitigate stress associated to abstinence adaptation and to enhance satisfaction with life (Laudet & White, 2008). All this could contribute to the prognosis of treatment results, since individuals who show a greater capital of recovery are those who find themselves in better positions to solve substance use problems, such as alcohol dependence. In this way, these factors, distributed in an unequal manner through society, could differentiate the capacity of individuals to put an end to these issues, once they have been produced (Cloud & Granfield, 2008).

Given the evidence regarding the importance of recovery capital, the demand for its correct measurement has increased. Hennessy’s systematic review (2017) presents three scales aimed at measuring RC. Sterling et al. scale (2008) was the first to attempt to measure RC; however, it did not present adequate predictive validity of time in abstinence and severity of addiction. The Burns & Marks scale (2013), which presents four domains (physical capital; human; social; cultural and community), showed good predictive validity of the severity of addiction for physical capital, but the rest of the domains did not present such good results. Finally, the Groshkova et al. scale (2013) seems

to be a good predictor of recovery outcomes based on personal and social RC, and it was used in several studies (Best et al., 2014, 2015, 2016; Brown et al., 2019; Chen & Gueta, 2020; Honess et al., 2012; Mawson et al., 2015; Rettie et al., 2019; Best et al., 2016). This scale is named as Assessment of Recovery Capital (ARC), and it shows a single factor of recovery, that explains 57% of variance. It is developed based on 10 dimensions, related to psychological and physical health, meaningful activities, social support and participation, house safety, life coping skills and risk taking, together with substance use control and recovery experience. ARC shows good reliability values and convergent validity with quality of life (Groshkova et al., 2013), an aspect that is also strongly related to recovery efforts and remission in alcohol dependent individuals (Laudet, 2008; Laudet et al., 2009; Laudet & White, 2008). The one-dimensionality and predictive validity of this scale have also been confirmed in other studies (Arndt et al., 2017; Basu et al., 2019; Cano et al., 2017; Sánchez et al., 2020). Sánchez et al. (2020) prove that the original ARC predicts successful completion of treatment, and Basu et al. (2019) report that the Hindi version of the ARC scale predicts 1 year of abstinence.

This instrument, far from being a diagnostic tool, has the purpose to evaluate positive measures of personal and social resources, trying to approach strengths and means of the individual to satisfy his needs and aspirations in the recovery process. Thus, the use of this scale is interesting for the study of recovery and for clinical practice. It improves the understanding of how recovery capital can be leveraged to help improve people’s ability to overcome alcohol use disorder problems and it provides new guidance for interventions. In addition, among the scales for measuring recovery capital, it is the most widely used in alcohol and other substance dependence in population in recovery, therapeutic communities and/or in treatment (Hennessy, 2017), hence its use in alcohol dependent individuals in recovery can be adequate.

Considering that alcohol is the main substance of admissions to treatment for substance use in Spain (Observatorio Español de las Drogas y las Adicciones [OEDA]; 2019) the validation of the scale in this specific population is considered necessary. This work has the aim to translate and adapt to the Spanish language the ARC scale (Groshkova et al., 2013) and validate it in abstinent clinical population with alcohol use disorders, that is to say, in severe patients attending several treatment programs for this disorder. This population has been chosen since the ARC is not a diagnostic tool (these patients already have the diagnosis), but rather it is aimed at identifying strengths and points to be reinforced. Thus, the VCR could be highly beneficial for the treatment these patients are already receiving.

Method

Participants

The participants included in this study were patients diagnosed with alcohol use disorder in abstinence. These patients attended group and individual therapy programs at the Psychiatry Service of the 12 de Octubre Hospital or mutual aid group therapies, either at centres of the Federation of Former Alcoholics of the Community of Madrid (FACOMA) or at Alcoholics Anonymous groups in the hospital's area of influence.

The participants had at least one month of abstinence and no active or recent use of other substances (at least 5 years of abstinence), except for tobacco and coffee. Those with psychiatric and/or neurological comorbidities were excluded from the study. All participants gave their written consent to participate in the study. The final sample included in the analysis was 184 participants, aged 27 to 75 (mean = 54.51; *SD* = 9.42), of whom 151 were men and 33 women.

Patients had mostly primary studies (35.3%), followed by college-level (22.4%) and secondary ones (21.9%), as well as professional training (20.4%). 35% of participants had an active employment situation, while 31.7% were unemployed or under work leave and 31.2% were retired. Clinical variables associated to dependence are described in Table 1.

Materials

Recovery sources were assessed through the *Assessment Recovery Capital* (ARC), developed by Groshkova et al. (2013). This scale has 50 dichotomous items, and it is organized in 10 subscales with 5 items each: Abstinence, psychological global health, physical global health,

community involvement, social support, meaningful activities, house safety, risk taking, coping and life functioning, and experience with recovery. ARC is a one-dimensional scale, where the only factor explains 57% of variance (the weights for each variable are in the range .54–.78) (Groshkova et al., 2013). ARC scores show an intraclass correlation coefficient between .50–.73 and a convergent validity with WHOQOL-BREF scores of .80) (Groshkova et al., 2013).

The WHOQOL-BREF (*World Health Organization Quality of Life*) scale (The WHOQOL Group, 1998) is a brief version of 27 items from the original WHOQOL (World Health Organization [WHO], 1998). This instrument measures several aspects of quality of life, such as physical and psychological health and social relations, together with the environment of the individual. The range of scores for each domain is between 4 and 20 points. Its metrical data is good, with an internal consistency that varies between .68 and .8 for its subscales (Benítez-Borrego et al., 2014; Skevington et al., 2004). In the present work, the Spanish version of WHOQOL-BREF scores have a Cronbach alfa of .84.

Procedure

Firstly, a translation and adaptation to Spanish language of the recovery capital scale (in Spanish: *Valoración del Capital de la Recuperación, VCR*) (Groshkova et al., 2013) was carried out, in the most accurate and close manner to the original (See the final Spanish version of VCR in the Appendix). Since the original scale was validated in population with a predominant consumption of several substances, some items have been slightly modified, by changing the word "substances" for "alcohol". Additionally, VCR was administrated

Table 1. Clinical Variables Related to Alcohol Use Disorder

Variable	Valid frequency (%) / Mean (<i>SD</i>)	<i>Mdn</i>	<i>N</i>
Abstinence (in months)	55.52 (66.16)	31	184
Initial age of consumption	14.59 (4.53)	14	184
Age of dependence	30.87 (11.58)	30	184
N of abstinence attempts	2.45 (2.88)	2	184
Previous treatments for alcohol dependence	72.7%	-	184
Attendance to mutual-help groups (at least once)	59.2%	-	184
Usual tobacco consumption (currently)	49.5%	-	184
Usual substances consumption(past)		-	184
Cocaine	21.2%		
Cannabis	13.6%		
Opiates (heroin)	3.3 %		
Synthetic substances	1.6 %		

Note. Means, standard deviations (*SD*), medians (*Mdn*), and frequency (valid percentages) of clinical data related to alcohol and other substances consumption, as well as the past attendance to treatments and mutual-help groups.

individually to 5 additional participants to check and improve the level of comprehension of the items. Further, VCR was inversely translated to English by a bilingual expert, to ensure the similarity to the original version.

A selection phase was carried out, in which patients who attended the outpatient therapeutic program of the Psychiatric Service of the 12 de Octubre Hospital were recruited. These patients had periods of abstinence between 1 month and 2 years (the program has a duration of 2 years). We also contacted the Federation of Ex-Alcoholics of the Community of Madrid (FACOMA) and Alcoholics Anonymous (AA), with the aim of increasing the sample and recruiting patients with longer periods of abstinence.

Following the signature of the informed consent, a semi-structured interview was carried out individually, where sociodemographic and clinical data were recorded, in addition to self-informed measures administration. The questionnaires were completed in digital format with the support of the researchers. The participants of the Hospital 12 de Octubre filled out the questionnaires in the hospital; whereas, the rest of the participants were evaluated by researchers in the different installations of Community of Madrid associations. The number of subjects was determined by factor analysis criteria: Minimum sample size of 100 subjects when there are less than 2 factors and at least 10 subjects per dimension (Kline, 1986, 2013).

All procedures carried out in this study meet ethic criteria of the committee of the Biomedical Institute of Research of 12 de Octubre Hospital. The study was conducted prior to the Covid-19 pandemic.

Statistical Analysis

Before analysing the psychometric properties, an exploratory analysis was performed and the distribution of scores was checked. Descriptive and frequency data were computed for quantitative and nominal variables, respectively.

The following analyses focused on the psychometric properties of the VCR. Firstly, reliability was calculated through Cronbach's alpha for the VCR and for the WHOQOL-BREF. Secondly, the convergent validity with WHOQOL-BREF was examined, similar to previous studies (Basu et al., 2019; Groshkova et al., 2013). The rationale for this step involves the importance of quality of life in the recovery journey (Laudet et al., 2009), since WHOQOL-BREF scores are related to overall functioning, social network recovery and engaging in meaningful activities, among other aspects of recovery (Best et al., 2012). It was calculated through Spearman's correlations (since the items of the VCR were dichotomous and their distribution asymmetrical) of

VCR and the Spanish version of WHOQOL-BREF scores.

Third, we explored the differences in VCR scores between stages of recovery defined by the UK Drug Policy Commission (2008): "Early sobriety" (first year), "sustained sobriety" (1–5 years) and "stable sobriety" (more than 5 years). For this purpose, a comparison of means was performed using nonparametric tests (Kruskal-Wallis and pairwise comparisons) between the abstinence groups.

Although VCR is not a diagnostic instrument, we consider that it would be interesting to provide data on the sensitivity and specificity of the questionnaire. For this purpose, we calculated the ROC curve, considering 5 years of abstinence as stable recovery (De Soto et al., 1989; Sobell et al., 2000; UK Drug Policy Commission, 2008), as in the original validation by Groshkova et al. (2013).

For the structure validity, we carried out a confirmatory factor analysis (CFA) driven by previous results indicating the one-dimensionality of ARC (Arndt et al., 2017; Cano et al., 2017; Groshkova et al., 2013). Taking into consideration the possible spurious results obtained with non-continuous data, we comprised the dichotomous items into the 10 VCR subscales and performed the factor analyses on the scores of each of them, similar to the strategy carried out in the original scale (Groshkova et al., 2013) and as previous literature indicates (Bandalos & Finney, 2001; Nasser & Wisenbaker, 2003). This would allow obtaining more interpretable models. Further, CFA analysis was carried out through Unweighted Least Squares (ULS) parameter estimation method, which minimizes the possible residuals (differences between the observed and estimated correlations), can be robust against asymmetric data, and obtains optimal solutions for factor analysis (Ferrando & Anguiano-Carrasco, 2010; Lee et al., 2012; Sellbom & Tellegen, 2019).

Additionally, descriptive, reliability, convergent validity and predictive validity were computed through SPSS v.22, whereas CFA was calculated by AMOS v.26.

Results

VCR scores do not have a normal distribution, following Kolmogorov-Smirnov test ($p < .05$). Patients obtained a mean VCR total score of 43.62 (6.71). Descriptive data related to VCR subscales and WHOQOL-BREF can be observed in Table 2.

Psychometric Properties for VCR

With respect to reliability, Cronbach's alpha value is .902 for the 50 items scores of VCR. Whereas the convergent validity results show positive correlations between VCR scores and WHOQOL-BREF ones, with

Table 2. Descriptive Data for VCR and WHOQOL-BREF Scores

	N	M	SD	Asymmetry
VCR				
Use of substances	184	4.55	.74	-1.78
Psychological health	184	4.34	1.03	-1.75
Physical health	184	4.1	1.3	-1.45
Community involvement	184	4.35	1.06	-1.81
Social support	184	4.25	1.18	-1.65
Meaningful activities	184	4.08	1.2	-1.35
Home safety	184	4.58	0.99	-3.38
Risk taking	184	4.22	1.02	-1.28
Life functioning	184	4.32	.99	-1.40
Recovery experience	184	4.79	.49	-2.72
VCR Total	184	43.62	6.71	-1.80
WHOQOL-BREF				
Psychological health	184	14.1	2.09	-60
Physical health	184	13.69	1.84	-46
Social relations	184	13.69	3.11	-10
Environment	184	15.43	2.14	-35

Note. Mean, Standard Deviation (SD) and Asymmetry of recovery capital (VCR) and quality of life (WHOQOL-BREF) scores.

Rho Spearman values of .51 for psychological health, .27 for physical health and .54 for social relations or support ($p < .01$), among others (Table 3).

VCR Differences regarding Early, Sustained, and stable Sobriety

Kruskal-Wallis and subsequent pairwise comparisons indicate statistically significant differences (p range $< .001-.05$) between *early* (1–12 months of abstinence) and *stable sobriety* (> 5 years of abstinence), the latter obtaining higher scores for total VCR and all dimensions (except for Meaningful Activities). In addition, patients

with *sustained sobriety* also had significantly higher scores (p range $< .01-.05$) on Substance use control and Life Functioning comparing to *early sobriety*; *stable sobriety* patients had more increased (p range $< .01-.05$) scores on Total VCR and Recovery Experience compared to *sustained sobriety* (see Table 4 for descriptive data of VCR among the three groups of abstinence and Table 5 for comparative analyses).

Sensitivity and Specificity of VCR

The ROC curve presents an area under the curve of .683, 95% CI [.602, .764]. Although it does not approach

Table 3. Convergent Validity of VCR with WHOQOL-BREF

VCR	Psychological health WHOQOL-BREF	Physical health WHOQOL-BREF	Social relations WHOQOL-BREF	Environment WHOQOL-BREF
Use of substances	.253**	.090	.270**	.201*
Psychological health	.510**	.349**	.367**	.359**
Physical health	.261**	.270**	.309**	.253**
Community involvement	.296**	.234**	.339**	.145
Social support	.409**	.290**	.546**	.280**
Meaningful activities	.270**	.084	.247**	.182*
Home safety	.322**	.259**	.363**	.381**
Risk taking	.440**	.324**	.376**	.477**
Life functioning	.354**	.244**	.311**	.347**
Recovery experience	.264**	.062	.219**	.129
VCR Total	.510**	.331**	.532**	.428**

Note. Spearman correlations values between VCR and WHOQOL-BREF subscales and total scores. The asterisk indicates the significance level * $p < .05$, ** $p < .001$.

Table 4. Descriptive Data for VCR regarding Early, Sustained, and Stable Recovery

	Early sobriety (1–12 months)			Sustained sobriety (1–5 years)			Stable sobriety (≥ 5 years)		
	N	M	SD	N	M	SD	N	M	SD
Use of substances	57	4.228	.945	72	4.662	.584	58	4.741	.579
Psychological health	57	4.000	1.363	72	4.389	.881	58	4.638	.718
Physical health	57	3.632	1.566	72	4.171	1.227	58	4.500	.922
Community involvement	57	4.053	1.125	72	4.296	1.212	58	4.724	.615
Social support	57	3.860	1.420	72	4.333	1.061	58	4.534	.959
Meaningful activities	57	3.877	1.377	72	4.056	1.185	58	4.328	.998
Home safety	57	4.250	1.417	72	4.667	.769	58	4.810	.606
Risk taking	57	3.877	1.211	72	4.197	.995	58	4.603	.699
Life functioning	57	4.000	1.165	72	4.444	.886	58	4.483	.883
Recovery experience	57	4.649	.668	72	4.778	.481	58	4.966	.184
VCR Total	57	40.339	8.787	72	44.014	5.334	58	46.328	4.190

Note. Mean, Standard Deviation (SD) of recovery capital (VCR) subscales and total score, and sample size (N) for patients with early (1–12 months), sustained (1–5 years) and stable (≥ 5 years) sobriety.

values of perfect discrimination, the CI does not cover values of .50 (non-discrimination) and the *p* value is < .001, which means that the ROC curve could have discriminatory capacity between patients who are in stable recovery (considered at 5 years of abstinence) and those who are not. The Youden Index is .564, which corresponds to a score of 42.5 (Sensitivity = 85.2%, Specificity = 71.2%).

Evidence of Validity based on the Internal Structure of the VCR

Table 6 summarizes the main characteristics of CFA analysis through ULS parameter estimation method. Results indicate that measures of fit have acceptable values, such as goodness of fit (GFI) and adjusted goodness of fit (AGFI), slightly superior to the proposed criteria (.95) (Jöreskog & Sörbom, 1989; Tanaka & Huba, 1989). Further, incremental (Normative fit index, NFI; Relative fit index, RFI) (Bentler & Bonett, 1980; Bollen, 1987) and parsimony tests (Parsimony ratio, PRATIO; Parsimony normative fit index, PNFI) show good values (Mulaik et al., 1989). In this way, it seems like ULS estimation method shows a good fit for the CFA single factor model.

Considering the previous results, standardized regression weights and multiple squared correlations of variables that load on the Recovery factor by using ULS parameter estimation method, are shown in Figure 1. Variables have acceptable factor weights (between .40 and .77) and communalities (.21–.59), achieving the minimum acceptable (Child, 2006). Nonetheless, the variable use of substances had a lower communality (0.16).

Discussion

The aim of this work was to translate and validate the ARC scale in the clinical population with alcohol use disorder. The clinical context and outpatient programs allow us to evaluate patients through different phases of the recovery journey, with various periods of abstinence, that gain progressively in recovery. To have an instrument capable of measuring recovery capital in Spanish population is beneficial, given the importance of recovery capital accumulation for the prognosis and resolution of alcohol use disorders.

The main results of this study point that VCR could be an adequate instrument for measuring recovery in abstinent alcohol dependent individuals, showing certain proper psychometric properties, in line with previous findings (Arndt et al., 2017; Cano et al., 2017; Groshkova et al., 2013; Sánchez et al., 2020).

In the present study, VCR scores present good values of reliability, in the same way as previous studies (Arndt et al., 2017; Cano et al., 2017; Groshkova et al., 2013). It shows a somewhat low convergent validity with quality of life measured by WHOQOL-BREF (World Health Organization, 1996), inferior to the one found by Groshkova et al (2013), yet similar to other findings (Basu et al., 2019). Despite this result, previous literature supports a strong relationship between quality of life and recovery in terms of remission and clinical improvement (Best et al., 2012; Laudet et al., 2009; UK Drug Policy Commission, 2008) and our findings also show a moderate relationship between VCR and WHOQOL-BREF psychological health domains, social and environmental support ones.

VCR distribution is asymmetrical, and a ceiling effect is observed. This outcome is similar to other studies

Table 5. VCR Differences regarding Early, Sustained, and Stable Recovery

	Kruskal-Wallis			Pair comparisons		
	χ^2	<i>gl</i>	<i>p</i>	Groups	Mann-Whitney <i>U</i>	<i>p</i>
VCR Total	20.546	2	< .0001***	1 vs 2	-29.07	.105
				1 vs 3	-44.92	< .0001***
				2 vs 3	-24.85	.025*
Use of substances	15.162	2	.001**	1 vs 2	-30.68	.009**
				1 vs 3	-23.56	.001**
				2 vs 3	-7.33	1.000
Psychological health	7.451	2	.024*	1 vs 2	-9.73	.721
				1 vs 3	-23.64	.020*
				2 vs 3	-13.91	.275
Physical health	11.366	2	.003**	1 vs 2	-17.46	.123
				1 vs 3	-29.97	.002**
				2 vs 3	-12.51	.424
Community involvement	14.715	2	.001**	1 vs 2	-17.62	.094
				1 vs 3	-32-89	.021*
				2 vs 3	-15.26	.182
Social support	10.357	2	.006*	1 vs 2	-16.79	.132
				1 vs 3	-28.02	.004**
				2 vs 3	-11.24	.526
Meaningful activities	2.668	2	.263	1 vs 2	-	-
				1 vs 3	-	-
				2 vs 3	-	-
Home safety	7.388	2	.025*	1 vs 2	-11.13	.354
				1 vs 3	-20.32	.020*
				2 vs 3	-9.19	.577
Risk taking	13.857	2	.001**	1 vs 2	-13.09	.393
				1 vs 3	-33.52	.001**
				2 vs 3	-20.43	.054
Life functioning	8.258	2	.016*	1 vs 2	-20.28	.048*
				1 vs 3	-23.08	.027*
				2 vs 3	-2.80	1.000
Recovery experience	11.788	2	.003**	1 vs 2	-6.91	.795
				1 vs 3	-21.80	.002**
				2 vs 3	-14.83	.047*

Note. Table 3 represents VCR differences between early, sustained, and stable recovery, through non-parametric Kruskal-Wallis and pair comparison tests (Mann Whitney *U*; pair comparison tests were corrected through Dunn-Bonferonni). 1, 2 and 3 represent groups of patients with early (1–12 months), sustained (1–5 years) and stable (more than 5 years) recovery.

The asterisk indicates the significance level * *p* < .05. ** *p* < .01. *** *p* < .001.

Table 6. CFA Properties for VCR for ULS Parameter Estimation Method

Parameter estimation method	Absolute measures of fit		Incremental measures of fit		Parsimony measures of fit	
	GFI	AGFI	NFI	RFI	PRATIO	PNFI
ULS	.985	.976	.972	.964	.778	.756

Note. Absolute measures of fit: goodness of fit (GFI) and adjusted goodness of fit (AGFI). Incremental measures of fit: Normative fit index (NFI) and relative fit index (RFI). Parsimony fit measures (PRATIO, PNFI) for and Unweighted Least Squares (ULS) parameter estimation method.

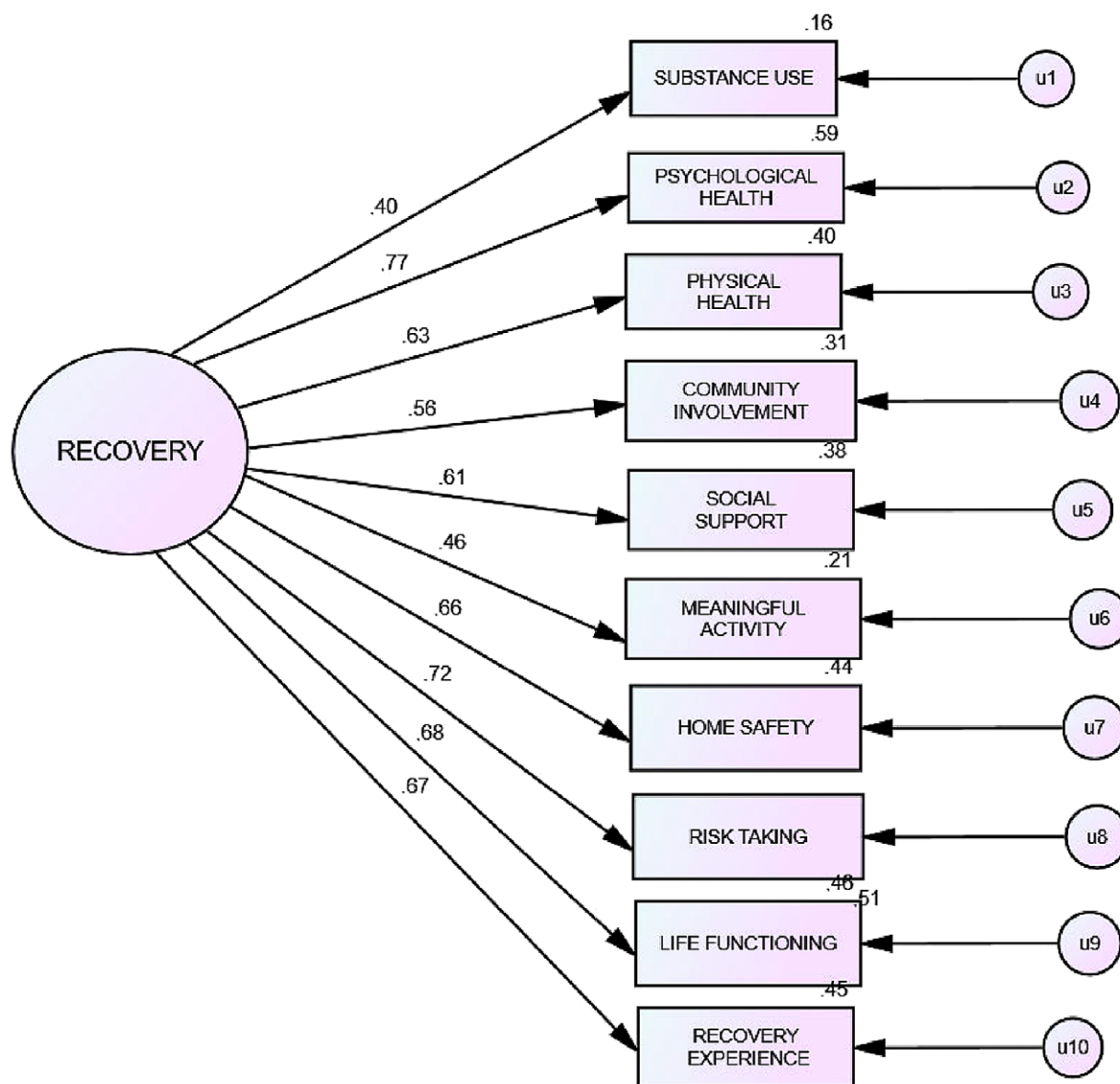


Figure 1. CFA model using ULS

Note. AMOS graphical representation of CFA using ULS parameter estimation method, where the observed variables appear (10 VCR subscales, in squares) and their relation (standardized regression weights) with the latent variable (Recovery, in the circle). Communalities are also represented for each observed variable (values next to the squares) and their uniqueness (circles with arrows).

(Bowen et al., 2020; Cano et al., 2017) and it could be due to the dichotomous features of the items, in addition to clinical, treatment and abstinence characteristics of patients, that could be affecting the variability of scores (Bowen et al., 2020).

With respect to the differences in recovery capital between different periods of sobriety, non-parametrical tests revealed significant differences between patients with early, sustained, and stable recovery in VCR dimensions, as defined by The UK Drug Policy Commission (2008). Specifically, our data reveals that recovery (understood as psychological, physical health,

community involvement, home safety, life functioning, etc) is increased in patients who are in a more advanced stage of sobriety (≥ 5 years of abstinence), compared to those in early stages, understood as the first year of abstinence. Moreover, patients with stable sobriety seem to gain in psychological recovery in comparison to those in sustained sobriety periods (1–5 years of abstinence). And the patients with sustained sobriety also seem to have a gain in life functioning and substance use control comparing to those in early stages. Hence, it may seem like VCR could be beneficial in studying changes that might occur in the recovery

process related do sobriety periods. And this might be in line with previous findings regarding VCR's predictive ability with respect to long-term recovery and abstinence (Basu et al., 2019; Groshkova et al., 2013). Moreover, our results regarding specificity and sensitivity features of VCR seem to indicate that statistically the VCR has the capacity to predict stable recovery, although the area under the curve (AUC) is somewhat low (.68). These values are similar to those found by Sánchez et al. (2020), AUC of .67, for predicting successful completion of treatment. Other studies, such as those by Basu et al. (2019) and by Groshkova et al. (2013), have found more appropriate values (.82 for 1 year of abstinence and .89 for 5 years of abstinence, respectively), although both studies used participants with active alcohol consumption, which may contribute to the differences between those who are recovered and those who are not.

With respect to VCR structure, the CFA shows that the 10 VCR subscales load acceptably on the recovery dimension, indicating acceptable regression weights values (0.40–.77), similar to previous research (Arndt et al., 2017; Cano et al., 2017; Groshkova et al., 2013). Notwithstanding, the variable use of substances and sobriety had a lower factor weight, likely indicating a lesser contribution to the recovery dimension. Possibly, maintaining sobriety or the perception of controlling the substance use has less impact than other resources that are gained through the recovery process, which is also indicated by Bowen et al. (2020) and the results of Arndt et al. (2017). Or, perhaps, it is because the entire sample in this study was abstinent, giving place to more homogenous results in this dimension.

Regarding the parameter estimation method, ULS showed proper goodness of fit indexes and simplicity values and it showed an adequate proportion of covariance between VCR subscales. Therefore, it seems that the ULS parameter estimation method would be a right choice for VCR factorial solution, in line with previous literature on its suitability with non-continuous and non-normal distributions (Ferrando & Anguiano-Carrasco, 2010; Sellbom & Tellegen, 2019).

Thus, the results suggest the existence of a single factor, since the VCR subscales could be adjusted to a one-dimensional structure of recovery capital in alcohol dependence. However factor weights and communalities values could be interpreted as somewhat low and VCR could benefit from further exploration for its psychometric properties, as noted in Bowen's study (2020), in which CFA failed. This could indicate, in line with other studies, the need to consider the multiple dimensions of recovery (Cloud & Granfield, 2008), revealing the need to improve the structure and items characteristics of the VCR scale (Arndt et al., 2017; Bowen et al.,

2020). That is, although the VCR can fit into a one-dimensional model, it would be necessary to assess whether the unique information provided by each dimension is also relevant to clinical practice.

As to the limitations of this study, we would have to mention the sample size. Despite its properness for factor analysis ($N > 100$), the literature indicates that some of the aspects of factor models could be influenced by the sample size (e.g., goodness of fit measures, communalities, etc.), (Mundfrom et al., 2005). Moreover, it would be of interest to analyse the characteristics and structure of VCR by using tetrachoric correlation matrices, given the dichotomous features of the items (Arndt et al., 2017; Bowen et al., 2020). This type of analysis has better results with greater sample sizes ($> 250, 500$ or $1,000$) (Lee et al., 2012; Lorenzo-Seva & Ferrando, 2012), hence, future studies should take this into account.

Another limitation may be given by the clinical characteristics of the sample, since all patients attended therapeutic resources and remained under total abstinence, which implies a lower heterogeneity of the data, which may have an impact on the robustness of the statistical analyses used. In addition, people in treatment seem to gain in values and resources and have more opportunities than other types of population, which may have led to the ceiling effect. Therefore, in the future it could be interesting to compare this sample in treatment with others without these opportunities, in which some measures collected by the VCR can be better captured. For example, it would be of interest to study VCR behaviour in alcohol dependence in the general Spanish population or in individuals in different type of treatments or facilities.

Considering the importance of measuring recovery and personal resources, as well as social and environmental ones along the dependence and its impact on the therapeutic success, it becomes necessary to dispose from an instrument able to measure properly all these aspects. In this way, the VCR scale could show its usefulness in the assessment of capital recovery in alcohol use disorder, although it would require more detailed and precise exploration in further research.

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Appendix

*Recovery Capital Assessment (ARC) Spanish Version**Versión española de la escala de Valoración del Capital de Recuperación (VCR)*

Este es un cuestionario que pretende valorar los recursos personales que usas para tu recuperación. Solo tienes que responder si te identificas o no con cada una de las frases que aparecen a continuación:

En relación al uso de sustancias y a la sobriedad: Cierto Falso

En este momento no consumo nada de alcohol.

Siento que controlo mi consumo de alcohol

No he estado a punto de recaer.

No he tenido episodios recientes de intoxicación.

Existen cosas más importantes en mi vida que el consumo.

En relación a mi salud psicológica global:

Soy capaz de concentrarme cuando lo necesito.

Afronto las situaciones difíciles de mi vida.

Estoy contento con mi apariencia.

En general, estoy contento con mi vida.

Lo que me ocurra en el futuro depende sobre todo de mí.

En relación a mi salud física global:

Me enfrento bien a mis tareas diarias.

Físicamente, me siento lo suficientemente bien para trabajar.

Tengo suficiente energía para completar las tareas que me propongo.

No tengo problemas físicos para desplazarme.

Duermo bien la mayoría de las noches.

En relación con mi implicación en la sociedad:

Estoy orgulloso de la comunidad en la que vivo y siento que formo parte de ella (sentido de pertenencia).

Es importante para mí contribuir a la sociedad y estar implicado en actividades que contribuyan a mi comunidad

(Ej: voluntariados, asociaciones, actividades de mi barrio, ONG, etc...).

Es importante para mí hacer lo que pueda para ayudar a otras personas.

Es importante para mí hacer una contribución a la sociedad.

Mi identidad personal no gira en torno al consumo.

En relación al apoyo social:

Estoy contento con mi vida personal.

Estoy satisfecho con mi implicación familiar.

Recibo mucho apoyo de amigos.

Recibo la ayuda emocional y el apoyo que necesito de mi familia.

Tengo una persona especial con la que comparto mis penas y alegrías.

En relación a las actividades importantes:

Estoy activamente implicado en actividades deportivas o de ocio.

Estoy haciendo grandes esfuerzos para mejorar (ejm. formación, educación, conocimiento de mí mismo).

Me implicó en actividades que encuentro agradables y satisfactorias.

Tengo acceso a oportunidades para el desarrollo personal (oportunidades de trabajo, voluntariado, algún tipo de formación).

Veó mi vida como estimulante y gratificante sin la necesidad de utilizar alcohol u otras sustancias.

En relación con mi casa y seguridad:

Estoy orgulloso de mi hogar.

Me siento libre de amenazas o peligros cuando estoy en casa.

Me siento seguro y protegido donde vivo.

Me siento libre para elegir mi propio destino.

El lugar en el que vivo ayuda a mi recuperación.

En relación a los riesgos que puedo asumir:

No tengo preocupaciones por el dinero.

Tengo los recursos necesarios para tomar decisiones con respecto a mi futuro.

Tengo la privacidad que necesito.

Appendix (Continued)

Este es un cuestionario que pretende valorar los recursos personales que usas para tu recuperación. Solo tienes que responder si te identificas o no con cada una de las frases que aparecen a continuación:

En relación al uso de sustancias y a la sobriedad:	Cierto	Falso
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Me aseguro de que no hago nada que lastime o dañe a otras personas.

Asumo la total responsabilidad de mis actos.

En relación con el afrontamiento y funcionamiento vital:

Estoy cómodo tratando con diferentes profesionales.

No defraudo a otras personas.

Como regularmente y tengo una dieta equilibrada.

Cuido mi salud y bienestar.

Cumplo con mis obligaciones sin demora.

En relación a la experiencia con la recuperación:

Tener un propósito en la vida es importante para mi recuperación.

Estoy haciendo progresos adecuados en mi recuperación.

Me comprometo en actividades y eventos que ayudan a mi recuperación.

Tengo personas en las que me puedo apoyar para mantener mi recuperación.

Cuando pienso en el futuro me siento optimista.
