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Participation in 12-Step-Based Fellowships Among Dually-Diagnosed Persons

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Abstract

Twelve-step groups (12SG), a useful recovery resource, are underutilized by dually-diagnosed persons. There has been little empirical research in this area. This study followed members of a dual-focus 12-step-based fellowship (N = 277) over one year to gain a greater understanding of participation in both specialized dual focus and traditional 12SG among dually-diagnosed persons, including reasons for attending, perceived benefits of and obstacles to affiliation, and predictors of affiliation. Findings indicate that dually-diagnosed persons do engage in both types of fellowships; patterns of engagement differed across fellowships, suggesting different comfort levels. Both types of fellowships were used to deal with addiction. Greater difficulty with substance use at baseline was associated with greater likelihood of attending 12SG at follow-up; the reverse was true for self-reported substance use at baseline. Findings are discussed in light of existing literature and clinical implications are suggested.

Keywords

12-step; self-help; dual diagnosis; comorbidity; recovery

Participation in l2-step groups (l2SG) such as Alcoholics Anonymous both during and after formal treatment has been found helpful in maintaining abstinence from alcohol and drug use (e.g., Fiorentine 1999; Fiorentine & Hillhouse; Project MATCH Research Group, 1997). The effectiveness of meeting attendance can be enhanced through other practices indicating greater affiliation such as identifying with and having between-meeting contact with other 12SG members, reading 12-step literature, working the steps and having a sponsor (e.g., Caldwell & Cutter, 1998; Chappel, 1994; Emrick, Tonigan & Montgomery, 1993; Montgomery et al., 1995; Watson et al., 1997; Weiss et al., 2000a).

A large percentage of substance abusers have a comorbid mental health disorder (e.g., Kessler, 1995). Such dually-diagnosed persons typically have poorer outcomes (e.g., Gonzalez & Rosenheck, 2000) and face more challenges than those with a “single” disorder (e.g., Laudet, Magura, Vogel & Knight, 2000); thus, dually-diagnosed persons may need more support. Yet, 12SGs are underutilized by dually-diagnosed persons (Zaslav, 1993; Minkoff & Drake,

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1991). The purpose of this paper is to gain a greater understanding of participation in both dual focus and traditional 12SGs among dually-diagnosed persons.

Correlates and Predictors of 12-Step Affiliation

Whereas 12SGs are widely used, little is known about the characteristics of participants (e.g., Fiorentine, 1999; Mankowski et al., 2001;Weiss et al., 2000b). Reviewing 100+ AA studies, Emrick and colleagues (1993) concluded that the variables predictive of affiliation were: history of use of external supports to cope with problems, loss of control over drinking, greater anxiety about drinking and greater problem severity. The latter has been consistently identified as a predictor of 12SG attendance in a number of recent studies conducted since Emrick's review (e.g., Brown et al., 2001; Humphreys et al., 1999a; Kelly et al., 2001; McKay et al., 1998; Morgenstern et al., 1997). Results for other background characteristics, including race and gender have been conflicting across studies (Emrick et al., 1993; Humphreys et al., 1994; Kessler et al., 1997; Kaskutas et al., 1999; Mankowski et al., 2001). These studies were conducted among mostly “simple addiction” samples; even less is known about predictors of 12SG participation among the dually diagnosed.

12-Step Group Affiliation Among Dually-Diagnosed Persons

Twelve-step groups are underutilized by persons with a comorbid mental health disorder (Zalav, 1993; Minkoff & Drake, 1991). This may be for several reasons, including difficulties identifying with other members (Noordsy et al., 1996) and the dynamics and ideology of the groups themselves (e.g., psychiatric medication may be viewed as “drugs” by some 12SG members who provide misguided advice about discontinuing a prescribed medication regimen-e.g., Hazelden, 1993–for review, see Laudet, 2000). Dually-diagnosed persons who are newcomers to 12-step meetings often find them alienating and unempathetic (Noordsy et al., 1996; Vogel, 1993; also see Jerrell & Ridgely, 1995; Powell et al., 1996). There is also a prevalent belief among clinicians that dually-diagnosed clients may not be able to engage in or benefit from participation in 12SGs (e.g., Humphreys, 1997; Jerrell & Ridgely, 1995; Meissen, Mason & Gleason, 1991); perhaps as a result, dually-diagnosed clients are less likely to be referred to 12SG than are “simple addiction” clients (Humphreys, 1997).

Participation in 12-step-based groups among the dually-diagnosed has received little empirical attention; the few studies available have generally used small samples (Bogenschutz & Akin, 2000) and most have used a cross-sectional design. In their review of the role of 12SGs in recovery from dual diagnosis, Noordsy and colleagues (1996) concluded that few dually-diagnosed persons use such 12SG consistently over time. However, three studies reported high levels of regular AA attendance (Bogenschutz & Akin, 2000; Kurtz, 1995; Pristach & Smith, 1999) generally comparable to those found among “single” disorder clients (e.g., Humphreys et al., 1998a). Available reports about the effectiveness of 12SG for the dually-diagnosed suggest that the demonstrated benefits of 12SG participation extended to clients with a comorbid psychiatric disorder (e.g., Gonzalez & Rosenheck, 2000; Moos et al., 1999). Two studies examined affiliation with dual-focus 12-step-based groups and have reported high rates of participation (e.g., Powell et al., 1996; Kurtz et al., 1995). Little is known about correlates and predictors of 12SG participation among dually-diagnosed clients and again, findings are inconsistent. In particular, two studies examined the role of psychiatric diagnosis in 12SG participation. In one study, absence of psychotic disorder was a significant predictor of past 90 days 12SG attendance (Bogenschutz & Akin, 2000), lending support to Noordsy and colleagues' (1996) suggestion that attendance may be more common among those diagnoses with an affective disorder than with schizophrenia; another study reported no difference in 12SG participation across diagnoses (Pristach & Smith, 1999). Further, unlike studies among “single disorder” alcoholics (e.g., Humphreys et al., 1994, 1998b) and dually-diagnosed

persons (Bogenschutz & Akin, 2000), Kurtz found no relationship between level of impairment and participation in AA.

Some clinicians and commentators have emphasized the need to prepare and assist people with severe mental illness to use AA (e.g., Powell et al., 1996). Others have suggested attendance at specialized 12SGs for people with a mental illness (e.g., American Psychiatric Association, 1995). Alcoholics Anonymous holds such specialized meetings; in addition, 12-step-based fellowships have emerged specifically to address dual-diagnosis recovery needs (e.g., Dual Recovery Anonymous-DRA, Hazelden, 1993 and Double Trouble in Recovery-DTR, see later discussion). These groups provide members with an opportunity to discuss both substance use and mental health issues, including the use of medications, in an accepting and psychologically safe forum. Findings from the only available study of the effectiveness of dual-focus 12-step-based groups indicate that participation is associated with improved substance use and mental health outcomes through processes such as perceived levels of support and member interaction (authors' citations).

Currently, dual-focus 12-step-based groups are limited in availability; most are held only once a week, often during the day, in therapeutic settings such as mental health clinics, dual diagnosis programs and group homes. Specialized AA meetings are most often held in treatment program; when held in open community settings, they are limited in availability and difficult to locate, for example, in New York City, AA lists only one specialized group in its meeting list. In sum, the restricted access, frequency and geographic availability of dual-focus 12-step-based meetings may limit their use, especially among persons who lack financial means or means of transportation. On the other hand, traditional 12SG meetings are widely available on a daily basis in most communities and cost nothing to attend; persons who lack transportation, lack financial means and who feel the need for more intensive support (and less free time on their hands) can attend such meetings every day (Jerrell & Ridgely, 1995). This is particularly relevant as there is evidence that dually-diagnosed persons report high levels of difficulties dealing with substance use issues such as the fear of “picking up” (Laudet et al., 2000). Thus, there is a need to investigate affiliation and barriers to affiliation with traditional and dual-focus 12SGs among dually-diagnosed persons.

This paper seems to gain a greater understanding of participation in both dual focus and traditional 12SG among dually-diagnosed persons. To that end, the study addresses the following questions:

- **a.** To what extent and how do dually-diagnosed persons affiliate with dual focus and with traditional 12-step fellowships?
- **b.** What are the perceived benefits of and obstacles to participating in dual-focus and traditional 12-step-based groups for dually-diagnosed persons?
- **c.** Are individual characteristics (such as gender, diagnosis, education, substance use severity) associated with participation?

METHODS AND PROCEDURES

Study participants were recruited from individuals attending Double Trouble in Recovery (DTR) meetings throughout New York City. DTR is 12 step-based mutual aid program specifically embracing those who have a dual diagnosis of substance dependency and mental disorder. DTR was started in New York State in 1989 and currently has over 120 groups meeting in the US, with the largest number in New York State and growing memberships in Georgia, Colorado, New Mexico and New Jersey. New DTR groups start at the initiative of consumers and that of professionals who believe that mutual help fellowships are a useful addition to formal treatment. DTR, Inc., a small non-profit organization, supports this growth

by training consumers to start and conduct groups, and by providing ongoing support to existing groups. DTR developed as a grassroots initiative and functions today with minimal involvement from the professional community. Groups meet in psychosocial clubs, supported residences for mental health clients, day treatment programs for mental health, substance abuse and dual-diagnosis, hospital inpatient units and community-based organizations. All DTR groups are led by recovering individuals (for more detail, see DTR, 1998: Vogel et al., 1998). At this writing, this relatively new fellowship is in the process of formalizing its own 12-step dual-diagnosis recovery program, including efforts to encourage sponsorship and step work among its members.

Participants

Potential study participants were recruited at 24 DTR meetings held in community-based organizations, supported residences and day treatment programs throughout New York City. All DTR members who had been attending for one month or more were eligible. Participation was voluntary based on informed consent; the study was approved by the NDRI Institutional Review Board. The study employed as interviewers several trusted DTR members who received training in interviewing skills and were closely supervised in their research activities. A total of 310 baseline interviews were conducted during January-December 1998 and 277 one-year follow-up interviews were completed during January-December 1999, for a follow-up rate of 90.6% (277/306) of those remaining alive (4 died). Reasons for no follow-up were: unable to locate or contact (19), refused (6), residential treatment out of state (3), incarcerated (1). These 277 subjects constitute the sample for the present study. The interviews required about 2 hours; participants received $35 for the baseline interview, $40 for the follow-up.

Study Data

The interview was a semi-structured instrument administered at study intake (“baseline”) and one year later (“follow-up”) as part of a broader prospective longitudinal study of the effectiveness of self-help for dually-diagnosed persons. In addition to sociodemographics, self-reported psychiatric diagnosis and self-reported substance use in the previous year, the following domains were assessed:

a. Difficulty with mental health and substance abuse: At baseline, participants were asked “Overall, what would you say has caused you the most difficulties?” Response categories were: Substance abuse problem, mental health problems, both equally, not sure.

b. Dual diagnosis and traditional 12-step meeting attendance (current and past year) and frequency of attendance (once a month or less, every other week, once a week, more than once a week). ['Traditional 12-step meeting attendance” was defined as “a 12-step meeting focusing on a single issue such as AA, NA, CA, and OA.”] Because the majority of DTR meetings are held in a treatment program or supported residences, it was important to determine whether DTR attendance was mandated or as clients sometimes say, “strongly suggested.” Participants were thus asked whether the DTR meeting they attended was held in a program or residence and if so, how was the attendance decision made (i.e., everyone attends, up to the individual, staff decision).

c. Sharing at meetings (DTR and 12-step): Assesses the frequency of speaking in group; at minimum, stating one's first name, clean time (optional) and speaking briefly to the topic of discussion. Response categories: never, rarely, sometimes, often and always. Frequency of sharing at meetings was asked only of those who had attended in the previous year.

d. Importance of meeting attendance to recovery: "How important to your recovery is/was coming to DTR? to traditional 12-step meetings?" Responses: very, moderately, a little, not at all important.

e. Identifying with other members: "How well do/did you relate to and identify with the experiences of other [DTR/traditional 12-step fellowship] members?" Responses: very well, moderately, a little, not at all.

f. Importance of other members to recovery: "How important are/were other [DTR/traditional 12-step fellowship] members to your recovery? Responses: very, moderately, a little, not at all important.

g. DTR networking: "Do/did you ever speak to other DTR members about your issues?" (yes/no) "How helpful is/was that to you?" Very, moderately, a little, not at all helpful.

h. 12-step recovery activities: Items were selected from the three existing standardized instruments assessing affiliation with the 12-step program of recovery (The AA Affiliation Scale, Humphreys et al., 1998a; the AA Involvement Scale, Tonigan et al., 1996; the Recovery Interview, Morgenstern, Frey et al., 1996; Morgenstern, Kahler et al., 1996) to cover a broad range of possible affiliative behaviors not all assessed by any single instrument.

Item selected in collaboration with DTR members and leaders were those most relevant to DTR members working on their recovery (e.g., of items not included: "Have you had a spiritual awakening or conversion experience as a result of your involvement with AA?"). Eight behaviors were assessed:

1. Attended a *step meeting* past month; step meeting are 12SG meetings held by AA and NA, where the discussion focuses on one of the 12-steps; step meetings are generally held weekly, discussing one step every week; (responses = Never, rarely, sometimes, often, very often). Step-meeting attendance was asked only of those who had attended 12-step meetings as DTR does not hold such meetings;
2. Do you or did you *have a sponsor* in the past year? (yes/no);
3. Are you working or did you *work the 12-step program* of recovery in the past year? (yes/no);
4. How often do you *pray or meditate?* (response categories =Never, a few times a year, once a month, once a week, several times a week, daily);
5. When making decisions, how often do you seek advice from the 12-step program (response categories =Never, rarely, sometimes, often, always). The last three items assessed behavior frequency in the previous month; Responses =Never, rarely, sometimes, often, very often;
6. *Read 12-step literature* (such as the Big Book, NA Basic text, meditation books, Hazelden books)?;
7. *Engaged in 12-step activity* other than attending meetings (such as service, setting up for meetings)?; and
8. *Taken the initiative to contact a fellowship member* outside of a meeting?

These 8 items were asked in the context of the "traditional" 12-step fellowship section of the interview. As mentioned earlier, DTR is in the process of formalizing its 12-step recovery program; at the time of data collection, the 12-step behaviors assessed here would have been performed in the context of membership in a traditional 12SG, not DTR (with the exception of prayer and meditation).

In addition to these measures, the interviews included a series of open-ended items bearing on reasons for attendance/nonattendance and perceived benefits of each type of groups (specific items are provided below in the corresponding Results section). Codes for the open-ended questions were developed on the first 30 completed interviews; based on a subsample of 25 instruments coded by two independent researchers, interrater reliability was r = .92.

RESULTS

Sample Characteristics

The sample was 73% male; 59% African-American, 25% nonHispanic white, 13% Hispanic, 3% other ethnicity; 60% single, 33% separated, divorced or widowed, 7% married/common law; 55% lived in supportive housing (community residence or apartment program), 30% in their own apartment or with relatives or friends, and 15% were living in a shelter or Single Room Occupancy Residence (SRO). Their mean age was 40 years (s.d. = 9), ranging from 20 to 63. Forty-one percent of participants did not finish high school or earn a GED, 31 % had earned a high school diploma or GED, and 28% had at least “some college.” Three-quarters (77%) were enrolled in outpatient dual-diagnosis treatment.

Substance Use and Mental Health Status

Participants had an extensive history of substance abuse starting in adolescence (median = 17 years of age); most (87%) started with alcohol use. Self-reported lifetime problem substances were;[1] alcohol (62%), cocaine/crack (59%), heroin (22%), marijuana (30%), other (3%). At baseline, 46% reported substance use in the preceding year: alcohol only (14%), drugs only (14%), both drugs and alcohol (20%). One-quarter of participants (27%) did so at follow-up: alcohol only (8%), drugs only (9%), both drugs and alcohol (10%). Self-reported primary psychiatric diagnoses were: schizophrenia (31 %), major depression (21 %), bipolar (23%), other (13%), unknown (12%). Twenty-six percent had multiple diagnoses. Most (87%) were taking prescribed psychiatric medications. Nearly two-thirds (62%) had experienced psychiatric symptoms in the past year; 8% reported being “very troubled” by mental health or emotional problems in the past month, 21% “moderately,” 31% “slightly,” 40% “not at all troubled.”

Nearly half (48%) reported that mental health and substance use had caused difficulties equally at baseline; 28% cited substance abuse as more problematic; 19% mental health; 5% were not sure.

The following analysis addresses the first research question: *To what extent and how do dually-diagnosed persons affiliate with dual-focus and traditional 12-step fellowships?*

Dual-focus meeting attendance and participation—Almost all (97%) had attended DTR in the previous year before follow-up, 71 % were still attending at follow-up (Table 1); frequency of attendance and meeting participation were high, with 85% attending at least once a week and nearly half “always” sharing at meetings. Most participants rated DTR as “very important” to their recovery. Seventy-eight percent attended a DTR meeting held in a program or residence; of those 74% reported that DTR attendance was not mandated but rather up to the individual.

Traditional 12-step meeting attendance and participation—Three-quarter had attended a 12-step fellowship meeting in the previous year, 67% were still attending, almost all (88%) at least once a week. Less than one out of five reported always sharing at meetings.

[1]Up to four "problem" substances were coded so that results add to more than 100.

The association between DTR and 12-step meeting attendance in the previous year was not significant (r = .10, p = .09).

Relationship to other members—Other group members, particularly other DTR members, were seen as important to one's recovery (Table 1), Relating to and identifying with other members was higher for DTR than for traditional 12SGs. Most DTR members (83%) spoke to other members about their issues; of those, nearly all found it very helpful (84%); 12%, "moderately helpful," 4% "slightly or not helpful at all."

12-step recovery activities—Level of engagement in 12-step activities varied across behaviors (Table 2). Most notably, while a large percentage of participants reported working the 12-step program as well as regular prayer and meditation, relatively few had read 12-step literature, engaged in 12-step activity (service) or attended a step meeting in the past month. One out of four reported having a sponsor.

The next set of analyses addresses the second research question: *"What are the perceived benefits of and obstacles to affiliation with dual focus and traditional 12-step groups?"*

Reasons for attending and obstacles to participation—Depending on attendance status at DTR and traditional 12-step fellowships, participants were asked *"In your own words, why do/did you come to [fellowship]" or "How come you are not attending [fellowship]?"* Results are summarized in Table 3. Recovery from substance abuse was cited as the chief reason to attend both DTR (36%) and traditional 12SGs (76%). Dual diagnosis mentions (to learn about both disorders, for fellowship with other dually-diagnosed persons) were also cited by one-third of DTR attenders, Among those not currently attending DTR, the most often cited reasons for not attending were: no meeting to go to (either because the member was no longer enrolled or living in the program/residence where the meeting was held, or because the meeting had been discontinued); and location constraints ("getting there"), including no transportation available to meetings or no carfare for transportation. Chief reasons for not attending 12-step meetings were: Does not meet my needs/not comfortable, and don't need it right now ("not drinking and drugging").

All DTR members currently attending meetings expressed the intention of continuing to attend (99%). Asked "*What might make it hard for you to stick with DTR?"* nearly one-half (45%) said "nothing"; 16% cited scheduling conflicts, no group available or no transportation available (13%), mental health or substance use relapse (11%), physical health (6%), lack of motivation to change (4%). Among those not currently attending, two-thirds (64%) intended to resume attendance, 15% did not, 21% were not sure. Chief reasons for not intending to resume or "not sure" (N = 24) were: DTR doesn't fit my needs/don't need it (42%), time and location constraints (32%).

Perceived benefits of dual focus and traditional 12-step groups—Open-ended items were used to learn about what participants saw as the differential benefits of both groups. The answers are summarized Table 3. *"What, if anything, do you get at DTR that you don't get at other 12-step fellowships?"* The focus on mental health ("freedom to talk about mental illness," "information about mental health," "talking about medications") was mentioned most often; 18% reported no difference (it's all the same) between DTR and traditional 12SGs. *"What, if anything, do you feel you get at 12-step fellowships such as. AA and NA that you don 't get at DTR?"* The most frequent response was that there is no difference between the two groups ("it's all the same"); 30% reported getting a different perspective ("a focus on addiction").

Participants were also asked to report on the benefits of DTR relative to formal treatment (What, if anything, do you get at DTR that you don't get at other treatment, program or group counseling sessions). *One-third (32%) cited mutual support and identification with peers ("acceptance, " "we respect each other" and "peers more available for support than counselors"); 10% appreciated the focus on mental health and how to deal with mental illness. Other mentions: information about addiction and focus on abstinence (4%), privacy from providers (confidentiality–4%). One-third (34%) found no difference between DTR meetings and other programs they had been in; 11% did not know or were unsure.*

The last set of analyses address the third research question: *What individual characteristics are associated with participation in 12-step-based groups?* Following previous studies reviewed earlier, we looked for potential differences in attendance at both dual focus and traditional l2SGs across the following variables: gender, age, race, education level, psychiatric diagnosis, substance use and psychiatric symptoms in the past year, psychiatric medication status, and most troublesome disorder (substance use or mental health) reported at baseline. Three variables yielded significant results: diagnosis, most troublesome disorder and substance use past year. Participants with a primary diagnosis of schizophrenia were significantly more likely to attend DTR (79% vs. 66%, χ^2 = 5.5, P = .02) than persons with other diagnosis such as depression, bipolar and anxiety disorders; persons who reported being more troubled by substance abuse at baseline were more likely to have attended both 12-step meetings (79% vs. 65%, χ^2 =4.7, P =.03) and DTR meetings (75% vs. 59%, χ^2 = 6.1, P = .01) in the following year than were those who reported that mental health had caused them more difficulties; further, participants more troubled by substance abuse at baseline were also more likely to attend 12-step meetings (but not DTR) weekly or more often (66% vs. 48%, χ^2 =8.5, P =.01) than those more troubled by mental health. Finally, those who had reported substance use in the previous year at baseline were less likely than those with no substance use at baseline to have attended DTR in the following 12 months (62% vs. 77%, χ^2 =7.3, P =.007).

Because the majority of DTR groups are held in outpatient treatment or supported residences where traditional 12SGs are typically not available, we examined the association of treatment enrollment and type of residence with DTR and traditional 12-step attendance. Two significant association emerged: participants who were enrolled in outpatient treatment were more likely to be attending DTR than were those not enrolled in outpatient treatment (76% vs. 54%, χ^2 = 10.8, P= .001) and individuals who lived in a shelter or SROs were more likely to attend traditional 12SG than were participants living independently or in supported housing (88% vs. 64% and 77%, respectively, χ^2 = 5.5, p = .01). There was also an association between residence status and DTR attendance at the level of a trend whereby persons living in shelters or SROs were significantly less likely to attend DTR than were other study participants (p = .06).

DISCUSSION

The first question this paper addressed was to what extent and how do dually-diagnosed persons engage in self-help recovery groups. Our findings are consistent with previous reports indicating that dually-diagnosed persons can and do engage in both dual-focus and in traditional 12SG meetings, as well as in 12-step recovery activities. Overall, levels of attendance and participation were high and did not significantly differ from previous reports, both among dually-diagnosed study participants (e.g., Bogenschutz & Akin, 2000; Kurtz et al., 1995) and among single-disorder substance users: In their study on pretreatment AA affiliation among "single disorder" participants, Humphreys and colleagues (1998a) reported meeting attendance at 83%; 59.8% had read 12-step literature (vs. 48% in the present study). Here in previous reports, meeting attendance was the most frequent 12-step recovery behavior.

The second question focused on perceived benefits of and obstacles to participation in dual-focus and traditional 12-step based groups. Our data show that participation in both types of meetings was mainly motivated by the desire to deal with recovery from substance use. This was overwhelmingly true for participation in traditional 12SGs but was also the most frequent reason cited for attending DTR. Learning about dual diagnosis and the opportunity to relate to other dually-diagnosed members were also cited by one-third of participants as a reason to participate in DTR. More participants rated DTR and other DTR members as "very important to recovery" than did so for traditional 12SGs and their members, suggesting the importance of being able to identify with and relate to dually-diagnosed peers in recovery. Alverson and colleagues (2000) reported that having a close relationship with a drug-free individual who was accepting of the one's mental health disorder was strongly associated with efforts to attain and maintain abstinence from substance use among dually-diagnosed persons. Present data showing that the majority of DTR members speak to other members about their issues and rate it as very helpful suggest that specialized dual-focus 12SGs provide the opportunity to form such relationships.

The importance of available support in affiliation with self-help groups among dually-diagnosed persons had previously been reported by Noordsy and colleagues (1996) whose participants had cited the opportunity to "just listen" as an important factor in 12SG attendance. Here, we note the different pattern of sharing at meeting between the two types of groups: while two-thirds reported often or always sharing at DTR, only 44% did so at traditional 12-step meetings; put another way, while only 9% never or rarely shared at DTR, one-quarter never or rarely shared at traditional 12-step meetings. Thus while most actively take part in DTR meetings, many attend 12-step meetings and "just listen." This may reflect a lower level of comfort at "regular meetings" where the preponderance of members are not dually diagnosed and where, generally, mental health issues are not discussed. This lower level of active meeting participation is noteworthy in the context of relatively typical levels of 12-step recovery behaviors such as frequency of attendance and working the steps. It has been suggested that persons with serious mental illness may be self-selecting a comfortable level of involvement with self-help groups that does not necessarily include all the "typical" 12-step affiliation behaviors (Noordsy et al., 1996).

Reasons provided for not currently attending DTR were largely centered around practical matters of convenience and availability: no group to go, difficulties getting to a group and scheduling conflicts. During the study period, the majority of DTR meetings were held in treatment programs and supported residences, most often during the day. Lack of transportation and scheduling conflicts were also cited as obstacles to attendance by one-third of those not currently attending traditional 12-step meetings. Other reasons cited most often for not attending 12-step meetings were feeling uncomfortable in such groups (replicating Noordsy et al., 1996) and not needing help for substance use; participants often added, "I am not using" or "I don't have cravings." This pattern of response is consistent with the finding, discussed earlier, that dually-diagnosed persons in this sample view 12SGs as an addiction recovery resource and use it when needed. When asked to compare the benefits of specialized groups with those of traditional 12-step meetings, not surprisingly, their difference in focus was mentioned frequently. Perhaps more notably, four out of ten felt that 12-step meetings and dual-focus groups were "all the same."

Much of the benefits of participation in mutual aid fellowships rests on the ability to identify with other members whose experiences offer hope, strength and coping strategies. In a traditional 12-step fellowship community group, especially early in recovery, there may not be sufficient basis for identification (Powell et al., 1996). In dual-focus groups, the combination of substance abuse and mental health disorder provides a basis for similarity. Affiliation with 12-step organizations among dually-diagnosed clients may occur over time for persons who

are still struggling with substance abuse (Noordsy et al., 1996); our findings suggest an association between difficulty with substance use and greater use of self-help groups, both specialized and traditional 12SGs. Powell and colleagues (1996) have put forth that if dually-diagnosed persons believe that participation in 12SGs can help achieve sobriety, there is likely to be an identification with members who have "good sobriety."

Some clients with severe psychiatric disorders may not be ready for 12-step fellowships (Bartels & Thomas, 1991); clinicians have emphasized the need to prepare and assist clients to use such organizations (Powell et al., 1996). It may be that in addition to their inherent benefits, specialized recovery groups such as DTR can facilitate sustained participation in 12-step fellowships. This is important because as discussed earlier, dual-focus groups are currently limited in number and in availability. Long-term studies and studies among recovering substance users indicate that recovery is a lifelong process (e.g., Anglin, Hser & Grella, 1997; Vaillant, 1983/1995) and so that the need for recovery support is ongoing (Humphreys et al., 1999b). The wide and consistent availability of 12SGs as well as the greater recovery experience of their membership (including the opportunity for sponsorship) has been cited by dually-diagnosed participants as an important aspect of traditional 12SGs (Noordsy et al., 1996; also see Jerrell & Ridgely, 1995).

Finally, this paper examined individual factors associated with 12SG participation. Three variables yielded significant results: diagnosis, most troublesome disorder and substance use past year. In this sample, diagnosis was not a predictor of affiliation, replicating Pristach and Smith's findings (1999) obtained from a sample similar to ours in terms of diagnoses. We did, however, find a diagnosis effect for attendance at dual-focus groups: persons with a diagnosis of schizophrenia were significantly more likely to attend dual-focus groups than were participants with other diagnoses. This issue had not been previously investigated. The finding is not easily explained in the context of there being no difference across diagnosis in traditional 12SG participation. We examined several possible explanations, including whether participants with a diagnosis of schizophrenia were more likely to be in treatment-where most groups are held-and whether they were more likely to be attending both types of groups (e.g., because they need greater levels of support). Neither analysis yielded significant results.

The major limitation of the present study centers on generalizability of findings: participants were members of a 12-step-based group at recruitment and thus may be more likely to engage in traditional 12SG as well. We note, however, that our findings on level of participation replicate that of prior studies (e.g., Bogenschutz & Akin, 2000). Further, qualitative data collected for this study and currently being analyzed suggest that many DTR members were attending AA prior to coming to DTR. Overall, the present study using a large sample and a prospective design adds to the scant literature on the topic and indicates that dually-diagnosed clients can and do engage in both dual-focus and traditional l2SG. Thus the belief among some clinicians, that dually-diagnosed clients may not be able to engage in or benefit from participation in 12SGs (e.g., Humphreys, 1997; Jerrell & Ridgely, 1995; Meissen, Mason & Gleason, 1991) is misguided. While participants affiliate with in both types of groups to deal with substance use, they perceive dual-focus groups as a valued and helpful opportunity to interact with other dually-diagnosed members. Overall, the differences between dual-focus and 12-step groups may not be as important as their similarity in providing support and strategies to recover. Specialized self-help groups such as DTR have the unique advantage of offering a safe and comfortable environment where often stigmatized topics–e.g., mental health symptoms and the use of medication–can be openly discussed. When dual-focus groups are available, dually-diagnosed clients should be encouraged to attend. Because most dual-focus groups are held in treatment programs, clinicians should seek information about such groups and support clients' initiative to start meetings. Traditional 12SG, while perhaps not suitable for *some* dually-diagnosed persons, are helpful for others, as our findings suggest. In view of

the restricted availability of dual-focus groups and of the strong need for support among persons in recovery from dual diagnosis, affiliation with traditional 12-step groups should also be encouraged; obstacles to participation should be identified and addressed. The need to find one's own comfort level in degree of affiliation and types of 12-step activities should be stressed.

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TABLE 1

Participation in Dual Focus and Traditional 12-step Group Meetings

	Dual Focus 12-step groups	Traditional 12-step groups
Attended past year (N = 277)	97%	74%
Currently attending	71%	67%
Frequency of attendance	N = 269	N = 205
Once a month	9%	5%
Every other week	6	7
Once a week	49	29
More than once a week	36	59
Share at meetings		
Never/rarely	9%	24%
Sometimes	24	32
Often	21	27
Always	46	17
Importance of meeting attendance to recovery		
Very important	83%	58%
Moderately	14	42
A little/not at all	3	-
Importance of other members to recovery		
Very important	76%	49%
Moderately	19	49
A little/not at all	5	2
How well relate to and ID with other members		
Very well	76%	46%
Moderately	18	51
A little/not at all	6	3

TABLE 2

Twelve-step Recovery Activities Among Past Year Traditional 12-step Attenders (N = 205)

Attended a step meeting past month	
Never	40%
Rarely	12
Sometimes	19
Fairly often	14
Very often	15
Has a sponsor	39%
Works 12-step program	68%
Seek advice from 12-step program when making decisions	
Never	28%
Rarely	11%
Sometimes	29%
Often	17%
Always	15%
Read 12-step literature past month	
Never	38%
Rarely	14
Sometimes	22
Fairly often	12
Very often	14
Engaged in 12-step activity past month	
Never	50%
Rarely	8
Sometimes	16
Fairly often	10
Very often	16
Contacted other member outside of meeting past month	
Never	39%
Rarely	13
Sometimes	16
Fairly often	14
Very often	18
Prayer and meditation (N = 277)	
Never/few times a year	8%
Once a month	2
2–3 times/ month	3
Once a week	7
Several times/wk.	11
Once a day	69

TABLE 3

Perceived Benefits of and Obstacles to Affiliation with Dual Focus and Traditional 12-step Groups[a]

Reasons for attending	**Dual focus group (N = 269)**	**Traditional 12-step group (N =205)**
Recovery from substance abuse	36%	73%
Dual diagnosis specific mentions[b]	32	-
To deal with feelings, talk, cope	12	8
To improve, get tools to recover	21	-
For motivation, hope, support	12	-
Required to attend	9	3
I like it, it works	7	-
More recovery/experienced members	-	16
Reasons for not attending	**Dual focus 12-step group (N =80)**	**Traditional 12-step group (N = 91)**
No meeting to go to	27%	-
Location/transportation constraints	16%	16%
Scheduling and time constraints	13	18
Does not meet my needs/not comfortable	10	29
Laziness or lack of motivation	10	-
Don't need to go (not Using, not in trouble)	4	27
Don't like/believe in groups	5	10
Physical health	6	-
Mental health	4	-
What, if anything, do you get	**At Dual focus groups Not at trad. 12-step (N =269)**	**At Traditional 12-step Not at dual focus groups (N = 205)**
Different focus (mental health or addiction)	44%	30%
No. difference between the 2 groups	18	39
Support, acceptance, identification with peers	17	9
Information and understanding about dual diagnosis	11	
More recovery/experienced peers	-	8
Working the steps/sponsorship	-	7
More structure/better organization	-	3
Don't know/not sure	6	-

[a] May add up to more than 100% reflecting up to 2 responses per question

[b] To learn about both disorders, their association: 16%, Fellowship/identification with other dually-diagnosed members: 16%