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ATTITUDES AND BELIEFS ABOUT 12-STEP GROUPS AMONG ADDICTION TREATMENT CLIENTS AND CLINICIANS: TOWARD IDENTIFYING OBSTACLES TO PARTICIPATION

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Abstract

Participation in 12-step groups (12SG) during and after formal treatment has been associated with positive outcome among substance users. However, the effectiveness of 12SG may be limited by high attrition rates and by low participation, areas on which there has been little research. Clinicians play an important role in fostering 12-step participation, and the insights which they develop in their practice can greatly contribute to informing the research process. Yet, little is known about clinicians' attitudes about 12-step groups or about their experiences in referring clients. This study surveyed clients (N = 101) and clinicians (N = 102) in outpatient treatment programs to examine 12-step related attitudes and to identify potential obstacles to participation. Data collection was conducted between May 2001 and January 2002 in New York City. Both client and clinician samples were primarily African-American and Hispanic; 32% of clients reported substance use in the previous month, with crack and marijuana cited most frequently as primary drug problem. On average, clinicians had worked in the treatment field for 8 years. Both staff and clients viewed 12SG as a helpful recovery resource. Major obstacles to participation centered on motivation and readiness for change and on perceived need for help, rather than on aspects of the 12-step program often cited as points of resistance (e.g., religious aspect and emphasis on powerlessness). Clinicians also frequently cited convenience and scheduling issues as possible obstacles to attending 12SG. Clinical implications of these findings are discussed, including the importance of fostering motivation for change, the need to assess clients' beliefs about and experiences with 12SG on a case by case basis, and to find goodness of fit between clients' needs and inclinations on the one hand, and the tools and support available within 12-step groups on the other.

Keywords

12-step; Alcoholics Anonymous; self-help; mutual-help; treatment; substance user treatment

INTRODUCTION

Participation in 12-step groups such as Alcoholics Anonymous, both during and after formal treatment, is associated with better outcomes among substance users. Twelve-step groups (12SG) are a form of mutual-help or mutual aid based on the premise that individuals who share a common behavior which they identify as undesirable can collectively support each other and eliminate that behavior.[1] One of the essential aspects of mutual-help groups, in contrast to other, more traditional forms of treatment, is the absence of professional involvement. Alcoholics Anonymous, the first and largest twelve-step organization, was

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started by a group of individuals dependent on alcohol at a time when little or no assistance was available to such persons. Subsequently, the organization contributed to the establishment of formal substance user treatment in the first part of the 20th century; over time, the medicalization of treatment services placed mutual-help organizations at the periphery of service delivery so that such organizations were sometimes viewed as competing with formal treatment and criticized for its lack of professionalism. In the last two decades, 12-step organizations have become largely integrated with most formal treatment models, thus becoming somewhat homogenized and mainstreamed (see next section; for a detailed discussion of the historical relationship between mutual-help organizations and treatment services addressing substance use, see (1)). While attending 12-step meetings is an important part of participating in these organizations, 12-step members are also encouraged to work the program and to embrace the 12-step ideology (see later discussion).

The effectiveness of 12-step groups may be somewhat limited by a high attrition rate. Moreover, a large minority of substance users never attends 12-step meetings. Little is known about reasons for dropping out or for non-attendance. Treatment professionals can play a critical role in fostering 12-step participation among their clients, yet, we know very little about professionals' attitudes and beliefs about 12-step fellowships. Several aspects of the 12-step program have been identified as potential stumbling blocks for both clinicians and substance users. Little is known about the prevalence of these beliefs or about whether they constitute obstacles to participation. In this study, treatment professionals and clients are surveyed about their attitudes and beliefs concerning 12-step fellowships toward identifying potential obstacles to participation.

According to the prevalent western view of substance use disorders, addiction is a chronic, relapse-prone disorder (2,3).[2] For many substance users, maintaining abstinence require ongoing support. Twelve-step groups constitute such a support: meetings are widely available and free of charge. Participation in 12SG during and after formal treatment has been associated with positive outcomes; while the majority of studies limit their investigation to substance use outcomes (4–6), the few that have assessed the influence of 12SG participation on a broader set of domains, such as psychological adjustment, have also reported positive findings (7,8). Several researchers have noted that, as the duration and intensity of treatment services are decreasing, one of the most important tasks for clinicians is to foster stable engagement in 12SG so that clients have a support network available once they are no longer engaged in formal clinical services (9). Role of Treatment in Fostering 12-step Participation

Clinicians can contribute to the Institute of Medicine's (10) goal of broadening the base of treatment for substance use-related problems within the community in which they work (11). The importance of collaboration between service providers and 12SG has been acknowledged by several professional organizations. For example, the American Psychiatric Association has noted that "*referral [to 12-step groups] is appropriate at all stages in the treatment process, even for patients who may still be substance user*s" (12). Further, twelve-step groups and 12-step tenets are increasingly being integrated into formal services. According to a national study by Roman and Blum (1998) on a representative sample of 450 private substance user treatment centers, 90% of the facilities based their treatment on 12-step principles and variations of this model, with nearly one half of the remaining 10% incorporating 12-step principles in

[1]Twelve-step groups such as AA, NA, GA, OA, are traditionally categorized as "self-help" groups, which is misleading. A useful, and more accurate treatment paradigm taxonomy, in a field deluged with many stereotypes and myths is: professional-based treatment; mutual-help/aid and self-help or "natural recovery."

[2]The author recognizes that terms such as "addiction," "treatment," and "recovery" can be viewed in other cultures and from other perspectives on substance use as labels that may carry stigmatizing connotations. Such terms are used here because they are widely accepted as convention and understood in the field, particularly in the United States and where the English language is used in scientific literature- and should not be interpreted as an endorsement of the negative labels they sometimes convey.

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combination with other approaches, including encouraged attendance at 12-step meetings (13). The prevalence of the latter was demonstrated by results from a survey on 12-step referral practices conducted among substance user treatment program directors in the Department of Veterans Affairs health care system: 79% of patients were referred to Alcoholics Anonymous and 45% to Narcotics Anonymous (14).

Results from two studies conducted by Humphreys and colleagues speak to the important role which treatment and treatment professionals play in facilitating clients' engagement in 12SG. The first study investigated how treatment programs' theoretical orientation influences clients' participation in, and benefits derived from, 12-step groups (15). Findings indicated that clients in 12-step and eclectic treatment programs (combining 12-step and cognitive-behavioral approaches) had higher rates of subsequent 12SG attendance than did clients in the cognitive-behavioral (CB) treatment programs. Moreover, program orientation moderated the effectiveness of 12SG participation: as the degree of programs' "12-stepness" increased, the positive relationship between 12SG participation and outcome (substance use and psychosocial) became stronger. The second study extended the investigation to cost effectiveness and reported that compared to patients treated in CB programs, those treated in 12-step oriented programs had significantly greater involvement in 12-step groups at follow-up, fewer outpatient continuing care visits after discharge and fewer days of inpatient care resulting in 64% higher annual costs in CB programs (16). Psychiatric and "substance abuse" outcomes were comparable across treatments, except that 12-step patients manifested higher rates of abstinence at follow-up. The authors concluded that professional treatment programs that emphasize 12-step approaches increase their patients' reliance on cost-free mutual-help groups and thereby lower subsequent health care costs without compromising outcomes. Further evidence for the important role that treatment professionals play in fostering engagement in 12-step groups comes from an AA membership survey were one-half of respondents reported being introduced to the fellowship by a treatment professional (17). Finally, the importance of treatment professionals' role in fostering clients' 12-step participation is also underlined by a recent study where the authors reported that treatment clients' attendance at 12-step groups was consistent over a 6-month treatment episode, suggesting that the pattern of attendance established early in treatment is critical (18).

In spite of the crucial role clinicians can play in drug users' treatment, there has been very little research on their beliefs and practices (19,20). In particular, although referrals to 12-step groups are increasing (18), little is known about addiction professionals' beliefs concerning these organizations or about their experience in referring clients. Available findings suggest that addiction professionals are favorable toward 12-step groups (21). For example, results from a recent survey assessing staff members' beliefs about addiction treatment was conducted in Delaware prior to implementing NIDA's Clinical Trials Network; 82% of staff surveyed agreed with the statement "12-step groups should be used more" (82%) and 84% with "spirituality should be emphasized more" (19). Although informative, such findings are limited and additional research is needed. It is important to gain an greater understanding of what treatment professionals think and believe about 12-step organizations as these cognitions may influence referral practices and bear on client outcomes (22–24).

Attrition to 12-step Groups and Non-attendance

Although the majority of substance users report some lifetime attendance at 12SG (25), few maintain stable affiliation over time. Attrition tends to be high. The few available studies report declines in participation beginning 3 to 6 months after initiation of attendance (26–28). Alcoholics Anonymous has noted that results from successive Triennial Membership Surveys show '*a slow attrition of newcomers during the first year' and acknowledged this phenomenon as 'a challenge to AA'* (29–30). In addition to the large number of substance users who may

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stop attending 12SG, a significant minority never attends at all. For instance, in his 24-month study conducted among cocaine users, Fiorentine (31) reported that 26% of participants never attended 12-step meetings following formal treatment. To date, little is known about obstacles to participation in 12-step groups (32). Elucidating this issue has important clinical implications because empirical evidence suggests that abstinence rates decline significantly following treatment among substance users who never attend or who stop attending 12-step meetings (31). We note that in the western context where substance use and its treatment have become medicalized, 'retention' in services and in other forms of help is viewed as a desirable and positive outcome. However, much social stigma is attached to substance use and by extension, to participation in substance use services. Thus, one should consider that if help-seeking and the desire to resolve substance-use- related problems are viewed as an effort at personal growth, 'retention' in substance user services may be inconsistent with these goals because of the labeling attached to being "in drug treatment" or "in AA (or NA)."

Attitudes and Beliefs about 12-step Groups

Participation in 12-step meetings is typically voluntary, especially after treatment. Behavior is based on attitudes that rest on personal beliefs (33), and it is reasonable to suggest that substance users' attitudes and beliefs about 12-step groups play a critical role in whether they choose to participate. However, substance users' attitudes about 12-step have received scant empirical attention. Tonigan and colleagues recently wrote: "*conspicuously absent [from the literature] has been the measurement of the subjective reactions of individuals to AA related practices and beliefs*" (28). In particular, the authors pointed to the need to examine substance users' perceived helpfulness of AA to sobriety. In an investigation of predictors of engagement in formal treatment, Fiorentine and colleagues reported findings suggesting that perceived utility or helpfulness of services is critical to participation (34). Three studies have examined the association between perceived helpfulness of 12-step groups and meeting attendance among samples of illicit drug users, alcohol-dependent clients and dually diagnosed persons; they have shown a significant association between positive attitudes towards 12-step's helpfulness and attendance (28,35,36). Two large prospective studies have broadened the investigative scope beyond perceived helpfulness to embracement of 12-step ideology or disease model view of addiction (e.g., total abstinence goal, need for lifelong 12-step attendance, importance of relying on external support or "higher power"). Both research teams reported a significant association between beliefs consistent with the 12-step program and greater subsequent levels of 12-step participation (9,37). These studies greatly contribute to broadening our understanding of predictors of 12-step participation. However, they do not address directly an equally important question: What may constitute obstacles to participation in 12-step groups? Several aspects of the 12-step program have been identified as potential stumbling blocks.

Potential Obstacles to Participation in 12-step groups

In spite of being the most frequently used resource for substance use-related problems in the US (38–40), 12-step fellowships have been and remain the subject of controversy and several aspects of the recovery program have been identified as potential stumbling blocks for both substance users and clinicians (41,42). This is due to a multiplicity of factors. The 12-step program's views of addiction and recovery are derived from a blend of tenets from the Oxford Group practicing First Century Christianity, the advice of Dr. Jung to an early AA member, and the observations of Dr. Silkworth; as such, they are neither scientific nor rational (43). The program's emphasis on spirituality, surrender and powerlessness contradicts contemporary dominant western cultural norms of self-reliance and widespread secularism (44) and constitutes stumbling blocks for many (45,46). Clearly, the social premium placed on self-reliance may be more an idealized principle than an adaptive strategy, particularly in light of overwhelming empirical evidence for the critical role of social support in promoting physical and mental health and in coping with stress (47). Nonetheless, the reliance on external support

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and particularly, on spiritual support, that is one of the cornerstones of the 12-step program has been identified as a potential cultural point of resistance to these organizations (48,40). That this and related aspects of 12-step groups play a part in individuals' decision not to participate in 12SG was suggested recently by a small study conducted among 19 (white, highly educated and employed) members of Moderation Management (50). Participants consistently attributed their decision to drop out of AA after attending only a few meetings to an aversion to the spiritual focus of the program and to conflicts with AA's concepts of surrender and powerlessness.[3]

The spiritual aspect of the 12-step program is perhaps the strongest point of resistance but it is not the only one. Substance users often have questions or express concerns when 12SG are introduced - e.g., their problem is not "that bad," they know of someone who relapsed while involved in 12 step groups, they associate 12SG with "skid-row drunks" (32). Some treatment professionals may also be concerned about the "dangers" and limitations of 12-step groups (51–53). Common concerns about these groups include their lack of professionalism, lacks empirical support for their effectiveness, the risk that members become overly dependent on the group, that members get bad advice from other group members, and that the usefulness of these groups is limited in time (i.e., only needed in early recovery) or in scope (i.e., deals with only one substance while clients have multiple issues – for a review, see (41)).

Overall, many widely held beliefs about the 12-step program – whether or not these beliefs are "accurate" - may constitute obstacles to participation. While much has been written about potentially limiting or controversial aspects of the 12-step program, little research has been conducted to determine what substance users and referring clinicians think about these organizations. In particular, there has been virtually no research to determine whether controversial aspects of the 12-step program constitute obstacles to participation or on what other factors may play a role in substance users' decision to not attend 12-step groups. In this regard, it is important to include frontline clinicians in the research process as "*they develop insights that might not occur to researcher*s" (19).

This study seeks to identify potential obstacles to participation in 12-step groups by surveying substance users and referring clinicians. The research questions addressed in the present study are:

1. What are substance users and clinicians' attitudes concerning the helpfulness and usefulness of 12-step groups as a recovery resource?
2. What do substance users and clinicians perceive to be major positive and negative aspects of 12-step groups?
3. What do substance users' and referring clinicians' perceive to be obstacles to 12-step participation?

METHOD

Samples

One hundred and one clients and 102 staff members were interviewed at five separate outpatient substance user treatment programs in New York City (all programs contacted agreed to participate). The client sample was selected from the client base of the collaborating agencies using a random number table. All staff members who have clinical contact with clients were

[3]The two other areas of conflict cited in the study were (a) Feeling out of place among AA members because one's drinking problem that was less severe, and (b) being unable to relate to unemployed, homeless or otherwise "down and out" members. The authors note that Moderation Management members surveyed were predominantly an "elite" of highly educated, employed, Caucasian persons.

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recruited to participate in the study. Participation in the study was voluntary based on informed consent. The study was approved by the Institutional Review Board of the National Development and Research Institutes, Inc. (NDRI) and by the review process of the agencies where participants were recruited. Data were collected using personal interviews that were conducted at the programs and lasted approximately 40 minutes for both clinicians and clients; participants received $20 for their time. Data collection was conducted between May 2001 and January 2002.[4] Refusal rate was estimated at less than 5 percent for clients and 12 percent for staff.

Measures

The study used a questionnaire consisting of structured items and inventories (adapted from previous studies as noted in each individual section below) and open-ended questions developed from qualitative interviews conducted during the preliminary phase of the study and presented elsewhere (54). Parallel versions of the instrument were developed for clients and clinicians so that the wording of the items was similar for both groups of participants. Both versions of the instrument began with a series of questions about sociodemographic and background information (substance use, treatment and 12-step attendance history for clients; education, training and professional experience for staff members). The instrument was pre-tested for feasibility and length; minor adjustments were made for clarity in the phrasing of several items. The final Client instrument consisted of 290 items, the Clinicians version, of 267 items (*Flesch-Kincaid Grade* Level score = 7.0 for both).. Following this introductory section, the domains and measures used for this study were:

Attitudes about 12-step—a) Helpfulness of 12-step groups: “In your experience, how helpful or harmful are 12-step groups?” This item was previously used by Salzer and colleagues (55) in a study assessing mental health professionals’ views on mutual-help groups (scale ranges from 0 = very harmful, to 10 = very helpful; 5 = neither harmful nor helpful); b) Importance of 12-step groups: “How important a role do you believe 12SG can play in a comprehensive treatment system?” and “How important a role do you believe 12SG can play in the recovery process?” Rating scale ranged from 0 = not at all important, to 10 = extremely important; c) Role of 12-step groups in the recovery process: “Which of the following best describes the role 12SG should play in the recovery process?” The answer categories, reflecting the three positions identified by Farquharson’s (56) in his work with community mental health professionals were: 12SG have minimal usefulness, 12SG are a useful addition to formal treatment, and 12SG are crucial to the recovery process; and d) Level of interest in obtaining further information about 12-step groups: “How interested would you be in obtaining further training or information about 12-step groups?” (Extremely, very much, moderately, a little, not at all).

Beliefs about 12-step groups—Three open-ended questions were used to collect information about perceived benefits, limitations and potential dangers of 12-step groups: “What can 12-step groups do for people (what are the benefits)?” “What can 12-step group not do for people (what are the limitations)?” “What are the potential dangers of 12-step groups?” Codes for the open-ended items used in the study were developed on the first 30 completed interviews; based on a subsample of 25 instruments coded by two independent researchers, inter-rater reliability was r = .90.

Obstacles to participation—Information about potential obstacles to 12-step participation was collected using both open ended and structured items. First, clients and clinicians were

[4]Analyses conducted to detect any differences in the variables under study between data collected before and after Sept. 11, 2001, yielded no significant findings.

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asked a series of open-ended questions designed to elicit information about why substance users may choose not to attend 12-step groups. Clients who were not currently attending 12-step groups were asked their reason(s) for not attending and all clients, regardless of current attendance status, were asked about obstacles to 12-step attendance using items phrased in general terms (e.g., "What are some of the obstacles to *people* becoming engaged in 12-step?"). It was felt using this phrasing would elicit information that clients may be reluctant to reveal directly such as personal reasons for non-attendance (e.g., ongoing drug use, ambivalence about quitting) and aspects of 12-step meetings or of the recovery program with which clients may be uncomfortable (e.g., sharing personal information with other members, the concept of a Higher Power). Answers to these items were coded as described in the previous section.

Next, participants completed a scale consisting of items describing potential obstacles to participation. After determining through social science database searches that there was no existing instrument available to assess clients' and staff members' beliefs about 12-step groups, an instrument was developed. The instrument consists of items describing positive and negative aspects of 12-step groups; the current study uses only the negative aspect subscale. A pool of items was generated from reviews the extant literature (summarized above), as well as from pilot interviews with both clients and staff members (author's citation) and from statements previously used by Meissen and colleagues (57) in a study of future clinicians' attitudes and intentions toward mutual-help groups (e.g. "12SGs can be dangerous because the leaders are not professionally trained"). After deleting redundant items, the final list consisted of 12 items presented in the Results section (Chronbach Alpha = .74 for the client sample and .67 for the clinician sample). Respondents were asked: "Please indicate the extent to which you agree or disagree with each statement". The response categories were 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree. In an effort to maximize the richness of the information collected on potential obstacles to 12-step participation, the open-ended items were asked first to ensure that answers would not be influenced by the content of the structured items.

RESULTS

Description of Samples

Clients—Samples characteristics are summarized in Table 1. Study participants were mostly members of ethnic minority groups. Among the 26% of respondents describing themselves as Hispanic, 23% were Puerto Ricans, 2% were from the Dominican Republic and one from Costa Rica. Participants ranged in age from 18 to 59 (mean = 36, Std. Dev. = 10). Over one half (53%) did not complete high-school, 27% held a high school diploma or GED, and 20% had some college or vocation training beyond high school. The most frequently cited primary substance abuse problem was crack-cocaine (31%). Mean age of first substance use was 16 years. Eight out of ten (82%) reported using drugs or alcohol in the year preceding the interview, one-third (32%) in the past month. Over one half of participants (59%) reported that this was their first enrollment in treatment services for substance abuse problems. Two-thirds of participants (62%) reported some regular lifetime 12-step attendance (defined as "for one month or longer"); 43% reported current attendance. Alcoholics and Narcotics Anonymous were the fellowships most often mentioned among participants with lifetime attendance.

Clinicians—Participants were mostly female, African American and Hispanic (Table 1). One third held a graduate degree, 40% a bachelors' degree, 21% had some college credits, 6% a high-school diploma. Job titles were: counselor (44%), social worker (20%), case manager (17%), clinical supervisor (13%), and paraprofessional social worker (e.g., case aide – 6%). On average, participants had 5.3 years of experience in their current position (mean; St. dev. = 5.3) and a total of 7.6 years of experience in the treatment field (mean; St. dev. = 6.2). All

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clinicians reported referring clients to 12SG; on average, they reported referring three-quarters of their clients and estimated that 44 % of clients referred participated in 12 step-groups.

Attitudes about 12-step groups

Findings (summarized in Table 2) indicate that both clients and clinicians generally held highly positive views of 12-step groups. Clinicians consistently gave significantly more positive ratings than did clients and expressed higher levels of interest in obtaining further information about 12-step groups.

Beliefs about 12-step groups

First, participants were asked about the *benefits* of 12 step-groups (Table 3). Twenty-three percent of the clients did not know and did not provide an answer. Most frequent answers provided by both clients and clinicians were: the opportunity to help improve yourself and your life, help with sobriety and recovery, and fellowship with recovering peers.

Next, participants were asked what are the *limitations of 12-step groups*. Fully one half of clients did not know and provided no answer. Substance users' lack of motivation or willingness to change was cited most frequently by clients and was the second most frequent answer among clinicians ("no limitations" was the most frequent answer provided by clinicians).

With respect to *potential dangers of 12-step groups*, the most frequent answer among both clinicians and clients was "nothing" followed by "it does not address denial" (e.g., not listening to what other members say, not doing the right thing).

Obstacles to participation in 12-step groups

We first examined reasons for non-attendance at 12-step groups among clients who had reported no lifetime attendance and among clients who reported past but not current attendance. Among never attenders (N = 38), reasons for non attendance were: do not feel I need it (47%), treatment program is enough (21%), do not like or believe in groups (12%), still using or picked up (6%), unable to attend (e.g., time, health −6%), not required to attend (6%), and did not know about 12-step groups (2%). Among substance users who reported prior but no current attendance (N = 19), reasons for non-attendance were: do not like or believe in groups (22%), still using or picked up (22%), unable to attend (e.g., time, health - 22%), I got the message (22%), and it did not help (12%).

Second, we asked all client participants: "What are some of the reasons why people do not attend 12SG?" The most frequent answer was "People don't want to or are not ready to stop using" (39%), followed by "People can do it on their own" (21%) and negative view or ignorance about 12SG (15%). The other answers were: still using (8%) and being embarrassed or not wanting to be seen at 12-step group (7%). Ten percent were not sure.

Third, we asked both clients and clinicians: "What are some of the obstacles to people/clients becoming engaged in 12-step groups?" Results are presented in Table 4. Denial, lack of readiness to stop and "People, places and things" a 12-step expression referring to people and situations that are associated with or trigger substance use, were the most frequent obstacles cited by clients. Denial was also a frequent answer among clinicians. Over one-third of clinicians' answers centered on practical issues of scheduling and convenience: getting there (no childcare, lack of transportation, inconvenient meeting time or place – 27%), and time constraints/responsibilities (10%).

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Turning to the 'negative aspects of 12-step groups' scale, Principal components factor analysis with Varimax rotation produced four interpretable factors accounting for a total of 60% of the variance in the item responses. The four factors, consistent with prior literature identifying possible points of resistance to 12-step groups, were labeled "Negative consequences of participation," "Recovery stage limitation," "Religion and powerlessness" and "Lack of professionally trained leadership." The individual items and factor loadings are presented in Table 5. The items forming the four factors generally had moderate levels on internal reliability as measures by Chronbach Alpha (Negative consequences of participation, alpha = .62, Recovery stage limitation, alpha = .65, Religion and powerlessness, alpha = .63 and Lack of professionally trained leadership alpha =. 57). Independent t-tests conducted to compare substance users' and staff members' four factors scores were all significant ($p < .01$). For ease of interpretation, significance tests between the two groups' ratings are presented for the individual items rather than for the factor scores. Data show that generally, clients are significantly more likely than are clinicians to agree with statements on the negative aspects of 12-step groups. This is true for the items concerning the recovery stage limitation of 12-step groups, emphasis on religion and powerlessness and for lack of professionally trained leadership. The only dimension on which clinicians were equally or more likely than clients to express agreement with the statements was that concerning risks of 12-step participation, particularly the risk of becoming retraumatized or triggered.

DISCUSSION

The first research question was "What are substance users and clinicians' attitudes concerning the helpfulness and usefulness of 12-step groups as a recovery resource?" Treatment clients and clinicians surveyed held positive views of 12-step groups' helpfulness, importance in the recovery process as well as in a comprehensive treatment system. These findings replicate earlier reports summarized in the Introduction (19,36).

The second research question was: "What do substance users and clinicians perceive to be positive and negative aspects of 12-step groups?" Both groups of participants cited peer support; help with recovery and the opportunity to improve one's life as the major benefits of 12-step groups. The major limitation of 12SG, cited by both groups of participants, can be succinctly expressed by the 12-step saying, 'it works if you work it.' That is, 12-step groups cannot help persons who are not ready or willing to seek help (see later discussion). Indeed, nearly half of the clients who were not attending 12SG said they did not feel they needed it and another twenty percent felt the treatment program was sufficient. While some substance users may be able to recover without the support of 12-step fellowships (58,59), most are not; 12-step groups are often cited as an important source of support among individuals who have achieved stable recovery (60). Yet in the present study, less than one-half of clients were attending 12SG and clinicians estimated that less than half of the clients they refer to 12SG become affiliated. This underlines the importance of addressing the third research question: "What do substance users and referring clinicians perceive to be obstacles to 12-step participation?"

In answers to the open-ended items, lack of readiness or motivation for change was cited as a major obstacle to 12-step participation by both substance users and by clinicians. Motivation has previously been identified as a critical factor in both engagement in and outcome of formal substance user treatment interventions as well (61). Over one-third of clinicians also cited practical issues of convenience (e.g., lack of transportation or child care) and scheduling as potential barriers to 12SG participation; relatively few clients cited these concerns. In the United States, 12-step meetings are generally thought be widely available to all who wish to attend because the 12-step fellowships hold numerous meetings, especially in large cities such as New York City where this study was conducted. However, it may be that practical matters

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such as not having access to child care or to transportation constitute obstacles that tend to be overlooked by researchers. [We note recent findings by Mankowski and colleagues (9) reporting a significant association between "geographical density" of 12-step meetings and greater levels of participation]. Present findings on this issue emphasize the importance of including frontline clinicians in the research process as they can contribute valuable insights that may otherwise remain unexplored.

Few study participants mentioned any of the "controversial" aspects of the 12-step program reviewed earlier in their spontaneous answers concerning limitations of 12-step groups or obstacles to participation. When participants were asked to indicate their level of agreement with statements describing these aspects of the 12-step program, findings varied across broad dimensions. Over one-half of both substance users and clinicians agreed that "the religious aspect of 12-step groups is an obstacle for many" and nearly one-half of clients agreed with "the emphasis on powerlessness can be dangerous." Consistent with recommendations of the American Psychiatric Association that referral to 12-step groups is appropriate at all stages in the treatment process (12), few participants from either group endorsed the belief that the usefulness of 12-step groups is limited to a specific stage of recovery. Items concerning the lack of professionally trained leadership received moderate levels of agreement. Of note is the finding that significantly more substance users than clinicians agreed with the statement "12SG should seek professional guidance." This is consistent with the pattern reported earlier (Attitudes section) where substance users consistently expressed less favorable – and here, more negative - views of 12-step groups than did clinicians. The only exception to this pattern emerged in findings concerning potential risks of participation in 12-step groups; in particular, nearly twice as many clinicians as clients expressed agreement with the statement that "clients can get retraumatized or triggered in 12-step groups." This difference between the two groups of participants may be due in part to the fact that clinicians based their answers on years of professional experience with large numbers of clients and were therefore more likely to have observed instances were clients were triggered as a result of attending a 12-step group. Clients' answers, on the other hand, are likely to have been based on their personal experience and/or that of a few members of their social network and thus to be more limited. This difference in perspectives may also partially explain the consistent pattern of findings indicating that clinicians are significantly more positive about 12-step than are clients.

Present results have important clinical implications. First, a sizable proportion of clients had little experiential knowledge of 12-step groups. Nearly four out of ten reported no prior attendance and a large minority was unable to mention benefits or limitations of 12SG. This suggest that there is a strong need for clinicians to inform and educate clients about 12-step groups. In the present sample, fifty percent of substance users expressed relatively little interest in obtaining further information about 12-step groups. It is not possible in this study to determine whether that is because they do not feel the need for such groups (and thus need no information-see below) or because they feel they "know all about it." Because 12-step concepts are ubiquitous in the treatment context and common lore among substance users, it is important that clinicians open the dialogue with clients about prior experience with 12-step groups as well as about what they know and believe about these groups and where these cognitions come from (e.g., personal experience or hear say?). Substance users are often ambivalent about recovery, especially early on, and may be quick to form an opinion about 12-step groups based on limited experience or friends' accounts.[5] Clinicians should elucidate such questions, emphasize the importance of keeping an open mind and of attending different types of meetings (e.g., round robin meeting, meetings for beginners, open and closed meetings, as well as the many specialized meetings such as for women, gays and lesbians, veterans etc. as appropriate) as some formats are likely to be a better fit than others. In that respect, we note that although 12-Step group meetings share a general structure, philosophy and format, they also may be sufficiently flexible to reflect the local ecology and the different needs and interests of

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participating community members (62). Consequently, 12-step groups may be equally utilized and effective because they attend to the needs and interests of the gender and ethnic populations it serves (63). Thus processes of engagement, participation, retention, attrition and effectiveness are likely to be influenced not only by the general tenets and format of the 12-step program (e.g., working the 12-steps, peer support, emphasis on honesty and introspection) but also by the specific 12-step meeting(s) clients attend. This suggests that in addition to familiarizing themselves with the 12-step model, clinicians would be well-advised to be informed about the individual group meetings that are held in the communities (e.g., membership characteristics, group norms).

When discussing 12-step participation, specific clients' concerns and misconceptions should also be identified and addressed on a case-by-case basis. Overall is it paramount that clinicians work in collaboration with clients to find goodness of fit between clients' needs and inclinations on the one hand and the tools and support available within 12-step groups on the other (11, 64). The author acknowledges that such "matching" of individual needs and circumstances to specific types of help, while highly desirable, is difficult to implement in practice and rarely is in an integral part of treatment planning, implementation and/or evaluation. Services that are most often delivered in group sessions do not allow for individualization of treatment orientation or consideration of individual life and/or recovery stage. When feasible, individual sessions between client and clinician should include a discussion of prior participation in and beliefs about 12-step groups so as to maximize the likelihood that clients will consider such organizations as a resource in their change process. Finally, in discussing attendance at 12-step groups, it is important for treatment professionals to look beyond clinical issues (e.g., readiness for change-see below) and to address clients' socio-environmental context on a case-by-case basis as some obstacles to 12-step attendance may be overlooked (e.g., availability of childcare or money for transportation).

The second point of clinical relevance concerns the finding that aspects of the 12-step program previously identified as potential points of resistance, such as the spiritual emphasis, were rarely mentioned spontaneously by either substance users or by clinicians. Instead, lack of motivation to enter recovery and/or reluctance to recognize that recovery requires external support ("I don't need it") appears to be a major barrier to affiliation with 12-step groups. Caldwell (11) has discussed lack of change readiness as a possible obstacle to 12SG participation. The change process involves a fairly long initial stage in which denial about addiction needs to be broken down (43). Individuals who do not believe they have a problem or who believe that that their problem is not severe enough to require help are not likely to seek help. Asked about reasons why people may not attend 12SG, twenty percent of substance users said that "people can do it on their own" and only one-third of clients viewed 12SG as crucial to the recovery process (vs. one-half of clinicians). Denial of a problem or of a problem's severity is a major barrier to seeking and obtaining help. Decrease in denial during treatment is a significant predictor of 12SG attendance afterwards (65). Commenting on high rates of early attrition, AA has suggested that it may be that "some individuals are not convinced of their addiction" (29).

The only requirement for 12-step membership is "the honest desire to stop" substance use (66). Given that desire, the 12-step program of recovery suggests that admitting powerlessness

[5]The term "recovery" as used most often in the literature, generally refers broadly to positive outcome among substance users but is rarely defined. While a detailed discussion of the concept of recovery is beyond the scope of this study, we note that 'recovery' is not a finite event but rather, a process that often begins with multiple attempts to change and may ultimately include total abstinence from substance use. More importantly, 'recovery' entails a lifelong complex, dynamic and multidimensional effort toward self-change. Further, the term is also bound in western culture and especially, in the ideology of 12-step programs, as members typically identify as being "in recovery' whereas persons who resolved substance use-related problems through other means such as unassisted (natural) resolution may not readily identify with that term.

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over drugs and alcohol (that is, admitting that one can not recover by will power alone) is the first step toward recovery. Current data suggest that low levels of motivation to change (desire to stop) and the belief that one may not need external help to recover (i.e. not being powerless over a substance or substance use) represent significant reasons why substance users may elect not to participate in 12-step groups. Because findings also indicate that substance users view 12-step groups as a helpful recovery resource, interventions designed to enhance motivation for change (67) and recognition of the need for external support are suggested as means of fostering 12-step participation. Further, a number of factors have been identified as predictors of help-seeking among substance users; while most studies have investigated predictors of help-seeking in formal treatment services, findings may also help focus clinical strategies designed to enhance participation in 12-step groups during and after treatment services. Predictors of help seeking include greater severity of dependence, greater substance-related health and psycho-social problems, use of illicit drugs (vs. alcohol), especially heroin and cocaine, greater network encouragement to seek help and social pressure to cut down, belief that one is unable to quit on one's own facilitated help-seeking and belief in the efficacy of services or other form of help (68–74 It is important to note that 12-step groups may not be suited to all substance users (36) so that non-attendance or disengagement should not necessarily be interpreted as a lack of commitment to the recovery process. A number of addiction recovery mutual-help groups have emerged in an effort to provide support to individuals who find 12-step groups' goals or ideology unsuitable. These groups include Secular Organization for Sobriety (SOS), Rational Recovery, Women for Sobriety's (WFS) and Moderation Management(50,75). However, because of the limited availability of meetings held by the organizations and the wide availability of 12-step meetings, it is important to gain a greater understanding of why some substance users do not participate. We note that because findings from the current study suggest that the main obstacles to participation in 12-step groups are not 12-step specific but rather, center on clinical issues (e.g., motivation for change), present results may apply to participation in other mutual aid groups as well. Additional research is greatly needed in this area.

This study has several limitations that should be considered in interpreting the results. In addition to the use of relatively small samples of convenience, clients' prior and current rates of 12-step attendance were lower than reported elsewhere (25). The relatively low attendance rates may be explained in part to the high percentage of participants who were receiving addiction services for the first time. In addition to these sample limitations, other study limitations point to directions which future research might take in that area. This study focused on identifying obstacles to participation in 12-step groups. It did not examine the association between clients' stage of recovery, 12-step related attitudes and 12-step attendance, nor did it consider staff's recovery status in relationship to attitudes about 12-step groups. One study examining the role of staff' recovery status on beliefs about addiction reported a positive but non-significant association between being in recovery and endorsing the disease model view of addiction (22). Another important question that this study did not examine is that of the association between staff's attitudes about 12-step groups and referral practices. In spite of these limitations, this early study constitutes an important step toward identifying and addressing obstacles to participation in 12-step groups. It is the authors' hope that findings reported here will contribute to focusing additional research on this important topic. Of particular interest would be cross-cultural comparisons of clinicians and substance users' view of 12-step groups and of other mutual-help recovery organizations, as well as comparisons between urban and rural geographical regions where the availability of services and views on substance use may vary significantly.

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Table 1

Selected Description of Samples

Clients (N = 101)		Clinicians (N = 102)	
Male	50%	Male	29%
African American	59%	African American	61%
Hispanic	26%	Hispanic (Puerto Rico)	23%
Puerto Rico	23	Education	
Dominican Republic	2	Graduate degree	34%
Costa Rica	1	Bachelors' degree	40
Primary substance		HS/some college	26
Crack-cocaine	31%	Professional experience	
Marijuana	28	In current job (mean yrs, SD) 5.3 (5.3)	
Powder cocaine	17	In treatment field	7.6 (6.2)
Alcohol	15	Referral to 12-step (estimated mean %)	
Heroin	8	Clients referred to 12-step	75%
Substance use past year	82%	Referred clients who become affiliated	44%
Substance use past month	32%		
Twelve-step attendance			
Lifetime	66%		
Current	43%		

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Table 2

Ratings of 12-step groups among Outpatient Drug User Treatment Clients and Clinicians[a]

	Clients *(N =101)*	**Clinicians** *N = 102)*
Helpfulness of 12-step groups[b] Mean (S.D.)	8.02 (2.14)	9.57 (1.17)**
Importance of 12-step groups in comprehensive treatment system[c]	7.86 (2.30)	9.27 (1.40)**
Importance of 12-step groups in the recovery process[c]	8.70 (1.84)	9.52(1.06)**
Role 12-step groups should play in the recovery process **		
12-step groups are of minimal usefulness	5%	0%
12-step groups are a useful addition to formal treatment	62%	46%
12-step groups are crucial to the recovery process	33%	54%
Interest in obtaining further training or information about 12-step groups? **		
Not at all/a little	29%	7%
Moderately	21%	7%
Very much/extremely	50%	86%

[a] Independent sample t-tests were used to compare continuous variables; Mantel-Haenszel tests for linear association were used for ordinal categorical variables.

* $p < .05$

** $p < .01$.

[b] 0 = Very Harmful to 10 =Very Helpful.

[c] 0 = Not at all to 10 = extremely.

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Table 3

Perceived Benefits, Limitations and Dangers of 12-step groups among Outpatient Drug User Treatment Clients and Clinicians

Benefits of 12-step groups……	**Clients** ***N =101***	**Clinicians** ***N = 102***
Opportunity to improve yourself and your life	24%	25%
Support, fellowship with peers	18	37
Help with sobriety and recovery	20	30
Emotional well-being	8	0
Role models/positive environment for a drug-free life	0	8
Remembering where you came from	5	0
Misc. other	2	0
Don't know, not sure	23	0
Limitations of 12-step groups….		
No limitations	7%	29%
Denial/You have to want it/need motivation	31	25
Cannot change everything in your life	7	0
Cannot provide concrete services	4	0
Negative mentions (e.g., triggers relapse, cahotic)	0	14
It is not for everyone (e.g, on medications)	0	10
Negative comparisons to formal treatment	0	10
Convenience	0	3
Religious aspect	0	2
Confidentiality issues	0	2
Clients limitations (insecure, anxious)	0	5
Don't know, not sure	51	0
Potential dangers of 12-step groups	*N =101*	*N = 102*
Nothing	33%	44%
Not hearing what is said, does not address denial	13	19
Expecting too much /Not recognizing need for other kinds of help	6	0
Risk of confronting sensitive issues without professional help	2	9
Can trigger relapse	5	4
Breach confidentiality/Lack of anonymity	3	2
Getting bad feedback/listening to wrong person	3	3
Members can become overly dependent on the group	0	4
No professional supervision/Groups not monitored	0	3
Attend groups for social aspects only, e.g. meet male/female	0	3
Availability/instability of groups	0	2
Being mandated to go	0	1
Not being able to identify with other members	0	1
Misc. Other	5	5
Don't know	30	0

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Table 4

Obstacles to Participation in 12-step groups: Clinicians' and Clients' Perspective

	Clients *N = 101*	**Clinicians** *N = 102*
Denial, lack of motivation	14%	25%
Using, not ready to stop	21	8
People, places and things	16	0
Getting there (no childcare, transportation, convenience of meetings)	0	27
Time constraints/responsibilities	7	10
Negative view, ignorance of 12SG	5	8
Confidentiality, visibility	5	1
Clients' limitations and problems (e.g., anxious, low self-esteem)	0	8
Nothing	5	3
Having to go alone	0	5
Misc.	0	5
Don't know not sure	27	0

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Table 5

Negative Aspects of 12-step groups Scale: Clients and Clinicians Percent Agree/Strongly Agree and Factor Structure

	Clients N = 101	Clinicians N = 102	Factor Loading
Stage of recovery limitation			
Can't benefit from 12SG early in recovery	18%	3%**	.78
12SGs only helpful early in the recovery process	17	4**	.66
Need to achieve sobriety before starting 12SGs	23	7**	.66
Risks of participation			
Can get retraumatized or triggered in a 12SG	35%	64%**	.86
12SGs can lead to pick up or relapse	34	38	.75
Can become dependent on 12SGs	55	67	.61
Religion and powerlessness			
12SGs can be too intense for some people	68%	56%**	.79
Religious aspect of 12SGs is an obstacle for many	61	30**	.63
Emphasis on “powerlessness” can be dangerous	48	29**	.63
Lack of professionally trained leadership			
12SG meeting leaders dominate the rest of the group	21%	16%*	.74
12SG should seek professional guidance	56	36**	.62
12SGs can be dangerous because the leaders are not professionally trained	26	14**	.64

Mantel-Haenszel test for linear association

** p<.01

* p<.05