Response: The Marriage of Drug Abuse Treatment and 12-Step Strategies

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Research supports the idea that involvement with 12-step fellowships is a very good way to achieve and maintain recovery, but it is not for everyone.

Robert Forman: There is a big gap between the relatively scant amount of attention researchers are giving to 12-step treatment and the fact that 80 or 90 percent of abstinence-based treatment programs are built—to a greater or lesser degree—around the 12-step format. I like that the author is throwing down a gauntlet, if you will, and saying, 'This is an area of importance.'

Keith Humphreys: NIDA's Collaborative Cocaine Treatment Study is a great place to get data on 12-step treatment for drug abuse. Also, Roger Weiss and colleagues have two papers out in *Drug and Alcohol Dependence* [Weiss et al., 1996, 2000] that are very encouraging about the positive impact of groups like Narcotics Anonymous and Cocaine Anonymous. Drs. Alexandre Laudet and Stephen Magura at the National Development and Research Institutes found a fairly high amount of affiliation among dual-diagnosed people in New York with specialty 12-step groups like Double Trouble in Recovery as well as groups like AA and NA [Laudet et al., 2000].

The literature on Narcotics Anonymous and Cocaine Anonymous is less complete than the AA literature. Preliminary signs indicate that we can generalize a great deal from one organization to the others, but many things remain to be discovered.

Scott Tonigan: The author states that 12-step providers advocate their approach because they witness its successes. Maryhaven may have exceptional success rates, but if we look at the outcomes of 12-step-oriented treatment in general, or any treatment that tries to engage patients in AA attendance, it is less encouraging. There is an AA dropout rate of about 70 percent in the first 6 months after discharge from active treatment.

Humphreys: Overall, research supports the idea that involvement with 12-step fellowships is a very good way to achieve and maintain recovery, but it is not for everyone. The author cites Morgenstern's work on optimal, partial, and nonresponders. Some people go, they work the program, but they don't get better. Clinicians need to know this and not blame or condemn these patients. Even AA acknowledges that many people will not benefit from its program.

The marriage of treatment and 12-step

Tonigan: The author seems to view formal drug abuse treatment as largely a way to foster 12-step affiliation. Since 40 to 70 percent of patients have already tried and dropped out of a 12-step program when they approach formal treatment, this amounts to saying that what 12-step failures need is more 12-step treatment. That seems illogical, but in another way it makes sense. What we have found is that, in general, these patients' level of commitment or engagement in the prescribed behaviors is low. So the challenge for treatment providers is to find some way to get them engaged and committed.

Humphreys: Sometimes 12-step treatments and 12-step support groups are confused. They share some features but are not the same. For one thing, in a support group or 12-step fellowship, there is no care provider with a legal or ethical obligation to the patient. You can just tell unmotivated patients to get the heck out until they are ready to recover. In treatment, you can't do that. You have to use some kind of incentive to keep the patient motivated.

Tonigan: The 12-step-oriented approach and other research-based treatments are often compatible, as the author points out. For example, a cognitive-behavioral therapist does little that an AA person would be likely to object to. Other than word choice, there is little difference between advising a recovering person to beware of people or things that may be 'slippery places' and telling a patient to avoid relapse 'cues and triggers.'

Forman: The 12-step-oriented programs differ from the other therapies in their focus on God and a higher

power. The article doesn't really bring out how central those things are to the 12-step treatment approach. In rigorous 12-step programs, people are taught to pray, which is very different from what's happening in cognitive-behavioral therapy.

Humphreys: There are now 12-step groups that are Jewish-focused, atheist-focused, Christian, Islamic, and so on. My colleagues and I did some work that found that people who said they were really religious and people who said they weren't religious were getting equal benefit from these programs.

Attendance and referral

Tonigan: The paper cites Fiorentine's study on the question of how much 12-step attendance should occur during treatment in order to predict posttreatment engagement in a 12-step group. Some larger studies have indicated that clinicians should aim to have their patients attend meetings on around 60 percent or more of their days in treatment if they are to anticipate 12-step adherence after discharge.

Humphreys: The author is correct in emphasizing that 12-step affiliation needs to be considered an important part of treatment. It is not something for a clinician to recommend casually. You can get manuals. The means are readily available to learn how to do a better job.

Tonigan: As the author points out, there is a clear distinction between the program, which is relatively invariant, and the practice or fellowship of AA, which varies between groups. Some groups are more supportive, others more confrontational. When you are deeply invested in a 12-step community, you can almost match clients to appropriate groups.

Forman: It helps to make a connection with the people who are in the 12-step programs in your area. Deal with the patient's potential reservations in advance, know enough about local meetings so that you can make specific suggestions—for example, smoking meetings or gay/lesbian meetings.

Tonigan: The research literature over the last 15 years is very consistent in saying that the recovery status of therapists is not a strong predictor of client outcomes, regardless of the treatment orientation. But I think a clinician has an obligation to attend some meetings, whatever his or her recovery status. Clinicians should be aware, however, that some 12-step meetings are restricted to persons in recovery, while others, called 'open meetings,' welcome interested visitors. Many clinicians go through cognitive rehearsals with clients to prepare them to respond to dialogue that might be interpreted as negative with respect to medications the client may be taking. They can also be prepared to respond to questions about their medications.

Forman: I recently published a paper on 'prescribing' 12-step [Forman, 2002]. The idea is that if we thought of 12-step programs as medication, we'd be interested in how to ensure adherence and help the patient minimize or deal with adverse effects. Adverse effects could include the patient's being put off by negative comments or being challenged about medications he or she may be taking. The high prevalence of smoking in some meetings is another adverse effect.

Research issues

Forman: The author says that it's hard to do research on AA, but it's not especially hard to study 12-step-oriented treatment.

Tonigan: I'm glad you brought that up. My colleagues and I have studied at least 11 AA groups, including some longitudinal studies. There are special concerns in researching 12-step programs, mainly to do with informed consent, but it is not as difficult as people sometimes think.

The mechanisms of change in 12-step programs is a fascinating area for further research, as the author points out. For example, we already know that alcohol-dependent individuals who practice the prescribed behaviors increase their self-efficacy in abstaining from alcohol. We have theories about how declaring oneself powerless might lead to increased control, but it would be very interesting to really explore this area.

Humphreys: In the last 10 years or so, in Project MATCH and other research, people have started to recognize more that AA isn't a service where you can just count up the number of sessions and know how big a dose of AA the patient got. It is a social organization and a way of living with a program and a fellowship, and those

things have to be measured to get an accurate assessment of what effect AA has on people.

What do we want people to be doing when they finish treatment and hit the 12-step waters?

Tonigan: Another question is this: What do we want people to be doing when they finish treatment and hit the 12-step waters? Attendance at meetings is obviously not enough, since 50 to 60 percent of patients have already been attending meetings before they enter treatment. They need to become engaged in the processes.

Given the increasing use of medications in treatment, AA members' attitudes toward medication are a subject of tremendous research interest. One recent study, by Bob Rychtarik [Rychtarik et al., 2000], found that the glass is half full. AA members report hearing negative statements about the use of medications, but they also report using them.

Humphreys: I think people sometimes mistake American attitudes for AA attitudes. In that study, 12 percent of AA members said you shouldn't be on medication, that it's weak or whatever. I bet if you stopped a hundred people on the street and asked them what they think of people taking antidepressants, at least 12 percent would say something similar. &

REFERENCES

Forman, R., 2002. One AA meeting doesn't fit all: Six keys to prescribing 12-step programs. *Current Psychiatry* 1(10):16-24.

Laudet, A.B., et al., 2000. Addictions services: Support, mutual aid and recovery from dual diagnosis. *Community Mental Health Journal* 36(5):457-476.

Rychtarik, R.G., et al., 2000. Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol* 61(1):134-138.

Weiss, R.D., et al., 2000. Predictors of self-help group attendance in cocaine-dependent patients. *Journal of Studies on Alcohol* 61(5):714-719.

Weiss, R.D., et al., 1996. Self-help activities in cocaine-dependent patients entering treatment: Results from the NIDA collaborative cocaine treatment study. *Drug and Alcohol Dependence* 43(1-2):79-86.