

Regular article

Dropout from 12-step self-help groups: Prevalence, predictors, and counteracting treatment influences

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Abstract

Attendance at 12-step self-help groups is frequently recommended as an adjunct to professional substance use disorder (SUD) treatment, yet patient dropout from these groups is common. This study assessed the prevalence, predictors, and treatment-related factors affecting dropout in the first year following treatment for 2,778 male patients. Of these, 91% (2,518) were identified as having attended 12-step groups either in the 90 days prior to, or during, treatment. At 1-year followup 40% had dropped out. A number of baseline factors predicted dropout. Importantly, patients who initiated 12-step behaviors during treatment were less likely to drop out. Further findings suggest patients at highest risk for dropout may be at lower risk if treated in a more supportive environment. Clinicians may decrease the likelihood of dropout directly, by screening for risk factors and focusing facilitation efforts accordingly, and indirectly, by increasing the supportiveness of the treatment environment, and facilitating 12-step involvement during treatment. © 2003 Elsevier Inc. All rights reserved.

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1. Introduction

Substantial evidence indicates that individuals suffering from substance use disorders (SUD) who become involved in recovery-focused, self-help groups, such as Alcoholics Anonymous (AA)/Narcotics Anonymous/Cocaine Anonymous, experience better outcomes in many domains of functioning (e.g. Emrick, Tonigan, Montgomery, & Little, 1993; Ouimette, Moos, & Finney, 1998; Project MATCH Research Group, 1997, 1998; Tonigan, Toscova, & Miller, 1996). Thus, staff in most private and public treatment sectors recommend that patients attend self-help groups (Humphreys, 1997; Roman & Blum, 1998) and both the American Psychiatric Association (APA, 1996) and the Veterans Health Administration (VHA, 2001; <http://www.oqp.med.va.gov/cpg/SUD>) recommend self-help group involvement as an important adjunct to treatment.

Nevertheless, a substantial proportion of patients recommended to join self-help groups do not attend at all and many

drop out before benefits may be realized. For example, even in the 12-step facilitation (TSF) treatment condition in Project MATCH (1993), which heavily emphasized and monitored AA meeting attendance and involvement, rates of attendance and involvement declined sharply after the end of treatment. Specifically, in the outpatient TSF condition, 41% of clients who initiated AA attendance during treatment discontinued attendance during the following 9 months (Tonigan et al., in press).

Factors associated with dropout from SUD treatment have been examined in numerous studies (e.g. Hiller, Knight, & Simpson, 1999; Rabinowitz & Marjefsky, 1998; Simpson & Joe, 1993). In addition, studies have examined predictors of self-help attendance and affiliation (Humphreys, Mavis, & Stoffelmayr, 1991; Kelly, Myers, & Brown, 2000; Tonigan et al., 1996; Weiss et al., 2000). However, as far as we know, no studies have examined factors associated with dropout among patients who attended 12-step self-help groups just prior to, or during treatment. Greater knowledge of the individual factors associated with dropout from 12-step self-help groups and about treatment-related influences that reduce the likelihood of dropout could help increase clinician awareness about the predictors of dropout and lead to more effective and efficient targeting of self-help facilitation efforts.

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1.1. Individual characteristics that place patients at risk for self-help dropout

Studies have found that specific demographic and clinical variables are related to dropout from SUD treatment. For example, younger age (Copeland & Hall, 1992; Roffman, Klepsch, Klepsch, Wertz, Simpson, & Stephens, 1993) not being married (Simpson & Joe, 1993) and Caucasian ethnicity (Wickizer et al., 1994) are related to a higher likelihood of dropout from SUD treatment. Among clinical variables, lower levels of substance-related problem recognition and motivation for treatment (Leigh, Osborne, & Cleland, 1984; Simpson & Joe, 1993; Smart & Grey, 1978) and more social isolation (Rabinowitz & Marjefsky, 1998) are associated with a higher likelihood of treatment dropout. Other variables also are related to treatment dropout, such as the severity of addiction and problematic consequences, but the direction may vary by type of population under study (Mertens & Weisner, 2000; Smart & Grey, 1978).

It is not known whether these or similar variables are associated with dropout from 12-step self-help groups, or whether other unique factors are responsible. For example, belonging to a social network comprised of close friends with similar substance-related problems may increase the risk of dropout from abstinence-oriented fellowships, such as AA. Furthermore, compared with more religious people, less religious individuals may not assimilate as readily into “spiritually” based organizations, such as AA, and so be more likely to drop out. Similarly, patients’ beliefs about whether SUDs are “diseases” or “psychosocial habits” may also affect dropout from self-help groups. In 12-step fellowships, for example, individuals whose beliefs or experiences are less allied with the disease-model of addiction may be more likely to drop out. Although they did not examine dropout specifically, Ouimette and colleagues (2001) found that patients with views that more closely matched 12-step philosophy (e.g., those holding disease model beliefs) were more involved in 12-step self-help groups following intensive treatment.

1.2. Treatment characteristics that might counteract individual dropout-risk factors

Given prior research that has found salutary associations between ongoing 12-step self-help involvement and substance use outcomes (e.g. Emrick et al., 1993; Tonigan, Connors, & Miller, in press), we need more knowledge about specific factors, modifiable during treatment, that may counteract the risks of patient dropout from self-help groups. For example, counselor referral recommendations to attend self-help groups may decrease the likelihood of dropout. Also, aspects of the treatment environment, such as the degree of cohesion, support and spirituality, may also be related to the likelihood of dropout by creating an environment more conducive to meeting treatment goals. In

addition, the extent to which patients begin 12-step self-help involvement (e.g., acquire a sponsor) during treatment may counteract these individual risks.

One randomized controlled study found that when patients were proactively linked with an existing community self-help participant by their therapist, rather than simply being provided with information and encouragement to attend 12-step self-help groups, the likelihood of self-help attendance was significantly improved (Sisson & Mallams, 1981). Specifically, in the encouragement-only condition no patient attended a single 12-step meeting during the 4 weeks following referral, whereas in the personalized contact condition (i.e., temporary sponsor) every patient attended at least one meeting. Although, this study focused on beginning attendees and not current attendees, the importance of a personal connection to short-term involvement is clear. Thus, for individuals without an AA sponsor, acquiring one during treatment may reduce the likelihood of dropout.

Similarly, acquiring other 12-step fellowship contacts and friends during treatment may facilitate further assimilation into 12-step self-help groups. Other important aspects of 12-step self-help programs, such as reading 12-step literature, may also decrease the risk of dropout by deepening understanding of fellowship and program dynamics. Completing work on the 12 steps may provide early positive experiences of the potentially beneficial aspects of utilizing 12-step recovery principles, thus, reinforcing further self-help utilization and decreasing the risk of dropout.

The aims of this study are fourfold: (1) to estimate the prevalence of dropout from 12-step self-help groups for current attendees; (2) to compare dropouts to ongoing attendees on substance use outcomes; (3) to examine the individual (e.g. age, ethnicity, religious background etc.) predictors of dropout; and (4) to examine how treatment-related characteristics (e.g. treatment environment, clinician referral) or behavior changes initiated during intensive treatment (e.g., acquiring a sponsor, reading self-help literature), may lower the risk of dropout at 1-year followup.

2. Methods

2.1. Participants

All male patients at 15 Veterans Administration (VA) SUD residential treatment programs, who were sufficiently detoxified, were invited to participate in an evaluation of treatment effectiveness. The inpatient treatment was designed to last between 21 and 28 days; it used individual and group therapy to assist patients in meeting their treatment goals and was multidisciplinary in staffing. Continuing aftercare and self-help involvement was encouraged (see Ouimette, Finney, & Moos, 1997, for a more detailed description). Participants provided informed consent and study procedures were in accordance with the institutional

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