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An Exploratory Investigation of the Association between Clinicians' Attitudes toward Twelve-step Groups and Referral Rates

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Abstract

Affiliation with 12-step groups has been consistently linked to the achievement of abstinence among persons experiencing alcohol and other drug problems. Clinicians play a critical role in fostering clients' engagement in 12-step, yet, little is known about clinicians' attitudes and beliefs about 12-step groups, or about the association between such beliefs and referral practices. This exploratory study investigates this association to gain a greater understanding of determinants of referral practices. Participants were 100 clinicians working within outpatient treatment programs in New York City. Participants held highly positive views of 12-step groups in terms of helpfulness to recovery, but a large percentage endorsed items describing potential points of resistance to 12-step groups, in particular the emphasis such groups place on spirituality and powerlessness. More positive attitudes were associated with greater rates of referral, while resistance to the concepts of spirituality/powerlessness was associated

with lower rates of referral. Implications of findings for clinical settings are discussed as well as a research agenda designed to more fully elucidate determinants of clinicians' 12-step referrals.

Key words: 12-step, self-help, referrals, attitudes, beliefs, clinicians, staff.

Introduction

Affiliation with twelve-step groups such as Narcotics Anonymous, both during and after treatment has been identified as a cost-effective and useful approach to promoting abstinence among persons experiencing alcohol- and other drug-related problems (Fiorentine & Hillhouse, 2000, Humphreys & Moos, 2001; Miller et al., 1997; Montgomery et al., 1995; Morgenstern et al., 1997; Project MATCH Research Group, 1997a; for reviews: Kownacki & Shadish, 1999; Tonigan et al., 1996). As a result of such findings, professional helpers across many disciplines are being trained to understand and to collaborate with mutual aid groups (Kurtz, 1997). This trend is

likely to grow in the addiction treatment arena as severe and persistent substance problems are conceptualized as chronic disorders best managed with the time-extended disease management techniques used in the treatment of other chronic conditions, such as hypertension, diabetes, asthma and chronic pain (McLellan, Lewis, O'Brien, and Kleber, 2000; White, Boyle and Loveland, 2002).

Role of Clinicians in Fostering 12-step Participation

Clinicians have long been recognized as playing a key role in substance users' treatment outcome (Najavits, 2002). Findings from a number of empirical studies indicate that clinicians appear to have more impact on client outcome than either type of treatment or patient baseline characteristics (e.g., Luborsky, McLellan, Diguier, Woody & Seligman, 1997; McLellan, Woody, Luborsky & Goehl, 1988; Najavits, Crits-Christoph & Dierberger, 2000; Project MATCH Research Group 1998). As access to and duration of formal services are reduced due to fiscal austerity and aggressive managed care, clinical outcomes may be increasingly influenced by the degree to which treatment programs actively support clients' transition into the post-treatment phase of recovery, including affiliation with 12-step or alternative mutual aid structures (Humphreys et al., 1999; Mankowski et al., 2001). Substance users' ambivalence about abstinence is a normal part of the recovery process (Miller & Rollnick, 1991), and clients entering addiction treatment may dismiss or reluctantly comply with the suggestion they attend mutual support groups. Findings from a recent study of attitudes about 12-step groups among substance users enrolled in outpatient treatment suggest that a large percentage of clients have little experiential knowledge of 12-step groups. Twenty-five percent of the clients surveyed were not sure about the potential benefits of 12-step groups and half did not know whether 12-step groups

had any limitations or drawbacks (Laudet, 2003). Clinicians can play an important role educating clients about recovery mutual aid groups, redress misconceptions and concerns about such groups, suggest particular group meetings (e.g., meetings for newcomers or specialized meetings for women, gays and lesbians or veterans to name only a few), review different 12-step fellowships (e.g., Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) and alternative recovery support structures (e.g., Women for Sobriety, Secular Organization for Sobriety, church-based recovery ministries).

The importance of referring clients to 12-step groups has been acknowledged by government agencies and by several professional organizations in their practice guidelines for substance-related problems. In 1988, the organization of the Surgeon General's Workshop on Self-Help and Public Health was designed to stimulate recommendations for how the self-help movement and the formal public health system might be mutually enhanced. The American Psychiatric Association (1995) has recognized the role of 12-step groups as an adjunct to treatment and noted that "referral is appropriate at all stages in the treatment process, even for patients who may still be substance users" (p. 11). More recently, the Practice Directorate of the American Psychological Association (1999) has issued similar guidelines describing 12-step groups as "a crucial part of any recovery program" and "a life-long resource for recovery after treatment ends."

In spite of the critical role clinicians can play in facilitating clients' engagement in 12-step fellowships, little is known about referral practices or their determinants. What little evidence is available about referrals suggests that clinicians do refer most of their substance-using clients to 12-step groups. For example, a large survey of treatment programs in the Veterans' Administration system indicated that 79% of clients were referred to Alcoholics

Anonymous, 45% to Narcotics Anonymous and 24% to Cocaine Anonymous (Humphreys, 1997). Further evidence for the important role that clinicians play in fostering 12-step engagement comes from an AA membership survey where one-half of respondents reported being introduced to the fellowship by a treatment staff (Alcoholics Anonymous World Services, 1998). Finally, the importance of treatment professionals' role in fostering 12-step participation is also underlined by a recent study concluding that the early pattern of 12-step attendance predicted continued meeting attendance over the course of six months of treatment (Weiss, Griffin, Gallop, Luborsky, Siqueland, Frank, et al., 2000).

Clinicians' Attitudes and Beliefs about 12-step Groups

With little known about clinicians' 12-step referral practices, even less is known about the basis for referral. Among the key determinants of human behavior are attitudes and beliefs (e.g., Fishbein, 1979). In a study conducted among graduate clinical psychology and social work students, Meissen, Mason and Gleason (1991) reported that attitudes about self-help groups predicted intention to collaborate with such organizations. In the addiction services field, little is known about clinicians' views of 12-step programs. Available findings suggest that they are generally favorable to 12-step groups (Freimuth, 1996; Laudet 2003). 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 that "12-step groups should be used more" (82%) and 84% that "spirituality should be emphasized more" (Forman, Bovasso, and Woody, 2001). These findings are interesting but limited—only a few general items are used to assess attitudes about 12-step in the context of studies with a broader investigative focus.

It is especially critical to learn more about what addiction services clinicians think and feel about 12-step groups because in spite of being the most frequently used resource for substance use-related problems in the US (Kurtz, 1990; Room and Greenfield, 1993; Weisner, Greenfield, and Room 1995) these fellowships have been and remain the subject of controversy. Several aspects of the 12-step recovery program have been identified as potential stumbling blocks for both substance users and clinicians (Chappel and DuPont, 1999; Laudet, 2000a). This is due to a multiplicity of factors. The program's emphasis on spirituality, surrender and powerlessness contradicts contemporary dominant western cultural norms of self-reliance and widespread secularism (Davis and Jansen, 1998) and constitutes stumbling blocks for many (Connors and Dermen, 1996; Klaw and Humphreys, 2000). Other points of resistance toward the 12-step program among treatment professionals include their lack of professionalism, lack of 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 Chapel and Dupont, 1999). Some treatment professionals may also be concerned about the "dangers" and limitations of 12-step groups (e.g., Kurtz, 1997). Although many of these concerns and beliefs may be inaccurate or unfounded (e.g., Chapel and Dupont, 1999), they are widely held, may influence clinicians' referral practices and thus deserve empirical investigation. The purpose of this study is to explore clinicians' beliefs and attitudes about 12-step groups, and the association between these beliefs and referral practices.

Materials and Methods

Sample Study participants (N = 100) were recruited at five large inner-city outpatient drug-free (i.e., non-methadone) community licensed addiction treatment programs in New York City. All programs contacted agreed to participate. As in Humphreys' study of clinicians' referral to self-help (1997), all staff members who have clinical contact with clients were recruited to participate in the study. The study was introduced to staff as "a survey among professionals in the substance abuse treatment field [designed] to learn of their views about treatment and about other recovery resources." Participation was voluntary based on informed consent and it was anonymous (participants' names were not collected). The study was approved by NDRI's Institutional Review Board and by the review processes of the participating agencies. A federal Certificate of Confidentiality was obtained to protect data from intrusion. Data were collected using personal interviews conducted at the programs and lasting some 40 minutes; participants received \$20 for their time. Data collection was conducted between May 2001 and January 2002. Refusal rate was estimated at 12 percent.¹

Measures As mentioned earlier, there has been little empirical work on clinicians' views of 12-step. As a result, no standardized measures have been developed. Where feasible, we used items adapted from previous studies in related fields (adaptation consisted of changing wording from 'self-help groups' to '12-step groups'). Where no such measure was available, we developed items for this study as described below. In addition to participants' sociodemographic and background information (e.g., gender, race, education and professional training, length of current job tenure), the domains and measures used for this study were:

Attitudes about 12-step groups: (1) *Helpfulness of 12-step groups* was assessed using an item from Salzer et al.'s (1994) study of mental health clinicians' attitudes toward self-help groups: "In your professional judgment, how helpful/harmful are 12-step groups?" Scale: 0= Very Harmful, 10 = Very Helpful. Two other items were used: (2) How important a role do you believe 12-step groups can play *in comprehensive treatment system?* Rating scale ranged from 0 = not at all important, to 10 = extremely important; (3) "How important a role do you believe 12-step groups can play *in the recovery process?*" Same rating scale as previous item.

Beliefs about the controversial aspects of 12-step groups. We used a scale developed for this study and described in greater details elsewhere (Laudet, 2003). Briefly stated, a pool of items was generated from reviews the extant literature as well as from pilot interviews with both clients and staff members (Laudet, 2000b) and from statements previously used by Meissen and colleagues (1991) in a study of future clinicians' attitudes and intentions toward mutual-help groups (mentioned in the Introduction – e.g. "12 step groups can be dangerous because the leaders are not professionally trained"). After deleting redundant items, the final list consisted of 9 items presented in the Results section (Chronbach Alpha = .66). 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. Principal components factor analysis with Varimax rotation produced three interpretable factors accounting for a total of 57% of the variance in the item responses. Consistent with prior literature on possible points of resistance to 12-step groups, the factors were labeled "Risks of participation,"

¹ Exact refusal rate is unavailable as the study's field records for the period of May-August 2001 were lost in our World Trade Center offices.

“Religion and powerlessness” and “Untrained leadership.” The individual items and factor loadings are presented later in this paper.

Referral rate: Participants were asked *whether* they refer any of their clients to 12-step groups; clinicians who answered positively were asked *the percentage of clients they refer* to these groups. This variable, labeled “referral rate,” is what is used in the analyses.

Interest in additional information about 12-step Several researchers have put forth that clinicians’ knowledge of 12-step is often limited and that more training is needed toward a better understanding of 12-step and greater insight into its meaning (e.g., Caldwell, 1999; Caldwell & Cutter, 1998; Davis & Jansen, 1998; Humphreys et al., 1999; Wollert, 1999). In 1987, Kurtz and Cambon identified lack of information and understanding as the “most important factor in social workers’ reluctance to refer clients to 12-step.” More recent reviews of both professional social work journals (Davis and Jansen, 1998) and graduate university curricula in social work (Wollert, 1999) point to the absence of information about 12-step. Therefore, we wanted to assess their level of interest in obtaining additional information about these organizations and their recovery programs. We asked each participant, “How interested would you be in obtaining further training or information about 12-step groups?” The item was answered on a Likert-type scale where a higher score indicates higher interest (response categories: not at all, a little, moderately, very much, extremely).

Results

Sample Background

Sample characteristics are presented in Table 1. The sample was an experienced group of clinicians with diverse levels of educational attainment. Participants were mostly non-white females. Job titles were: counselor (44%), social worker (20%), case manager (17%), clinical supervisor (13%), and

paraprofessional social worker (e.g., case aide – 6%).

[VIEW TABLE 1](#)

Attitudes towards 12-step groups

Participants generally held highly positive attitudes toward 12-step groups (Table 2) in terms of their helpfulness and importance to treatment and to the recovery process.

Beliefs about controversial aspects of 12-step groups. Percentage of participants who agree or strongly agreed with each of the statement are presented in Table 2. With the exception of two of the three items in the ‘Untrained leadership’ subscale, all the items received agree/strongly agree ratings from at least one third of participants. The three items endorsed by the largest proportion of clinicians were: risk of becoming dependent on 12-step groups (69% agree/strongly agree), risk of getting retraumatized or triggered to relapse (67%) and intensity of 12-step groups (57%).

[VIEW TABLE 2](#)

Referral Rates

All clinicians reported referring at least *some* clients to 12-step groups; the percentage of clients referred as reported by participants (referral rate) ranged from 10% to 100% (mean = 76%, St. Dev. = 36.8%).

Interest in 12-step Information

Participants expressed very high interest in obtaining such information: 37% were “extremely” interested and 49% “very much”; 7% ‘moderately, 6% a little and 1% “not at all”).

Bivariate Association among 12-step attitudes, beliefs and referrals

The three attitudinal items were strongly correlated ($r = .80$ between importance of 12-step groups to treatment and to recovery, $r = .49$ between helpfulness rating and importance to treatment and $r = .62$ between helpfulness rating and importance to recovery, all p

values $p < .001$). Therefore, a summary measure was computed and was used in the following bivariate analyses (Chronbach Alpha reliability coefficient for this summary score = .76).

Participants who held more positive attitudes toward 12-steps (on the summary measure) reported significantly higher rates of referral ($r = .35, p < .01$). Stronger endorsement of the Religion and Powerlessness subscale of the Controversial Aspects of 12-step Scale was significantly associated with lower referral rates, indicating that participants who expressed greater concern about the emphasis on religion and powerlessness reported referring fewer clients to 12-step groups ($r = -.36, p < .01$). The other two controversial aspect factors, Risks of participation and Untrained leadership, were not significantly associated with referral rates.

Discussion

Participants held highly positive attitudes about the helpfulness of 12-step groups, about the importance of these groups to the treatment system and to the recovery process, consistent with findings reported in prior studies (Forman et al, 2001; Freimuth, 1996). Referral rates were positively correlated with attitudes whereby greater perceived helpfulness and importance of 12-step groups was significantly associated with higher referral rates. The study also assessed clinicians' views on aspects of the 12-step program previously identified as potential points of resistance for both clinicians and prospective members. Findings indicated that a large percentage of clinician participants strongly endorsed statements describing these concerns. This was particularly true for items concerning the emphasis on religion and on powerlessness. Moreover, stronger

endorsement of these items - stronger concern about these aspects of 12-step programs - were associated with lower referral rates. This finding is consistent with and extends that of a previous large-scale study conducted to examine the influence of patients' religiosity on whether they were referred to and benefited from 12-step groups (Winzelberg and Humphreys, 1999). Results showed that clients who engaged in fewer religious behaviors in the past year were referred to 12-step groups less frequently by clinicians than were clients with greater levels of religious participation. However, referrals to 12-step groups were effective at increasing meeting attendance, irrespective of patients' religious background, and all patients experienced significantly better substance abuse outcomes when they participated in 12-step groups. The authors concluded that the viewpoint that less religious patients are unlikely to attend or benefit from 12-step groups might therefore be overstated. On the other hand, it must be recognized that the 12-step emphasis on spirituality and powerlessness may be among the reasons why some substance users choose to not participate in these organizations; for example, in a small study conducted among 19 (white, highly educated and employed) members of Moderation Management, 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 (Klaw and Humphreys, 2000).² Overall, while some substance users may not want to affiliate with 12-step groups because of the spiritual emphasis, clinicians should not assume that clients who are less religious will not affiliate with or benefit from 12-step participation. Instead, referral should include

² Two other areas of conflict were cited in the study: Feeling out of place among AA members because one's drinking problem that was less severe, and being unable to relate to unemployed, homeless or otherwise "down

and out" members; Klaw and Humphreys note that Moderation management members surveyed were predominantly an "elite" of highly educated, employed, Caucasian persons.

information about how powerlessness and spirituality are applied in the context of 12-step recovery –e.g., powerlessness over drugs of abuse, not powerlessness over all aspects of one’s life; one’s definition of a Higher Power need not be religious (AA Big Book, Chap. 4: “We agnostics”, 1976). Where feasible, clinicians should also inform clients about addiction recovery mutual aid groups other than 12-step fellowships (see later discussion).

In addition to endorsing spirituality and powerlessness as potential points of resistance to 12-step programs, a large percentage of participants in the present study agreed that members can be triggered to relapse in 12-step groups and can become dependent on such groups. In a study conducted to identify obstacles to 12-step participation among substance users in outpatient treatment, few (5%) participants cited the risk of being triggered to relapse and none mentioned the risk of becoming dependent on the group when asked about potential obstacles to 12-step attendance in an open-ended format (Laudet, 2003). However when asked in a structured format using the Controversial Aspects of 12-step Groups Scale used in the present study, 35% of outpatient clients agreed/strongly agreed that 12-step participation can trigger relapse and 55% that members can become dependent on these groups. Neither question has ever been addressed empirically so it is difficult to assess how well founded such beliefs are. However, because these beliefs seem quite prevalent (among both clients and clinicians), clinicians should address them and other beliefs clients may express to determine their source (e.g., personal experience or hearsay) and to provide strategies that would minimize the risk of negative outcomes such as relapse and over-dependence on 12-step fellowships.

Finally, level of interest in obtaining additional information/training about 12-step group was very high among study participants. This finding is consistent with previous reports from a number of

different sources. For example, of the 16 recommendations that emerged from the Surgeon General's Workshop on Self-Help and Public Health (1988), the incorporation of information and experiential knowledge about the concepts and benefits of self-help in the training and practices of clinicians was given *number one priority*. The need for training on self-help was also expressed unanimously by a sample of graduate students in clinical psychology and social work who were surveyed about their understanding and attitudes toward self-help: 97% agreed or strongly agreed that they needed more training on that topic (Meissen et al., 1991). Reviews of both professional social work journals (Davis and Jansen, 1998) and graduate university curricula in social work (Wollert, 1999) point to the absence of information about self-help. Lack of information and understanding has been identified as the "most important factor in social workers' reluctance to refer clients to self-help groups" (Kurtz & Chambon, 1987). Training and information about 12-step principles is particular critical. Twelve-step concepts are ubiquitous in the addiction field: 12-step principles are often integrated in treatment orientation, some clinicians in recovery are vocal proponents of the approach and clients are often well versed in the use of 12-step slogans (“Let go and let God,” “Easy does it”). As a result, clinicians may feel they know more about 12-step recovery than they actually do because they are often surrounded by 12-step “lore.” Familiarity with 12-step slogans and with the individual 12-steps does not mean one understands them as put forth by the founders of AA and as practiced within and outside 12-step meetings. Misunderstandings and inaccurate beliefs about the 12-step program are not prevalent only among clinicians (Chappel and DuPont, 1999); they are widespread, even among long-time fellowship members. As discussed earlier, the 12-step approach has been viewed as controversial and often remains misunderstood and misinterpreted in spite

of its popularity. As a result, those working with persons experiencing substance use problems “may need more information about 12-steps to determine their own interpretation and meaning of the controversies surrounding the program” (Davis & Jansen, 1998, p. 170). Only with accurate information can clinicians educate clients effectively about various 12-step programs. Our findings indicate that clinicians express high interest in obtaining such information.

The present study has several limitations. First, referral rates were assessed by self-report; however, the rates reported here are similar to those documented by Humphreys (1997) in a large treatment survey, lending credence to their accuracy. Second, the sample size (N=100) is relatively small; further, participants (mostly women and ethnic minorities) although typical of outpatient treatment staff in New York City where the study was conducted, are not representative of the addiction treatment workforce nationwide. Third, the study relied primarily on non-standardized measures of attitudes and beliefs about 12-step groups since none have been developed to date.

In spite of these limitations, results from the present study have important implications. First, present results point to the need to take clinicians’ beliefs and attitudes into consideration when seeking to understand (or modify) their practices. Prior studies have concluded that clinicians’ practices are critical to client outcomes (e.g., Luborsky et al., 1997; McLellan et al., 1988; Najavits et al., 2000; Project MATCH Research Group 1998, Sisson and Mallam, 1981) and 12-step referral practices are likely to be particularly important for clients’ post-treatment recovery. The present study indicates that clinicians’ attitudes and beliefs may constitute an important determinant of their referral practices. Additional research is needed to elucidate what clinicians think and feel about 12-step groups as well as whether these beliefs are consistent with 12-step

philosophy and with the growing body of empirical research bearing on the effectiveness of 12-step groups, types of individuals who may need additional support to affiliate and effectiveness of various referral strategies (e.g., Sisson and Mallam, 1981).

Second, there is strong evidence, both from the present study and from previous reports, that clinicians need and want additional information about 12-step groups. This critical knowledge gap must be addressed. This would ideally take several forms including the integration of education on 12-step in academic curricula, in-service trainings at the treatment agencies, and greater coverage of the topic in professional social work and clinical journals. In addition, both AA and NA provide educational literature for professionals in written form and on their Internet sites. Of particular importance is the need to disseminate and explain empirical findings about 12-step participation (e.g., effectiveness and cost-effectiveness studies) since one of the criticisms of 12-step organization is that their effectiveness lacks empirical support (Chappel & DuPont, 1999). In order to come to their own conclusions about the controversies surrounding the 12-step program, clinicians should also be informed of the criticisms of 12-step programs. Finally, information about addiction recovery support groups that are not based on the 12-step program (e.g., Secular Organization for Sobriety, Women for Sobriety, faith-based recovery groups) including increasingly available Internet resources and literature should be reviewed by clinicians.

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Table 1- Sample Description

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Male	29%
African American	61%
Hispanic (Puerto Rico)	23%
<u>Education</u>	
HS/some college	24%
Bachelors' degree	41%
Graduate degree	35%
<u>Professional experience</u>	
In current program (mean yrs, SD)	5.6 (4.7)
In treatment field (mean yrs, SD)	7.5 (5.9)

Attitudes about 12-Step Groups

Helpfulness of 12-step groups ^a	9.6 (1.1)
Importance of 12-step in comprehensive treatment ^b	9.3 (1.4)
Importance of 12-step group in recovery ^b	9.6 (1.0)

Controversial Aspects of 12-step Groups Scale ^c

	Agree/ Strongly Agree	Factor Loading
Factor 1 Religion and Powerlessness	<u>%</u>	
12SGs can be too intense for some people	57	.77
Religious aspect of 12SGs is an obstacle for many	29	.72
Emphasis on "powerlessness" can be dangerous	29	.64
Factor 2 Risks of Participation		
Can get retraumatized or triggered in a 12SG	67	.87
12SGs can lead to pick up or relapse	39	.74
Can become dependent on 12SGs	69	.60
Factor 3 Lack of professionally trained leadership		
12SG meeting leaders dominate the rest of the group	16	.73
12SG should seek professional guidance	35	.79
12SGs can be dangerous: leaders are not professionally trained	14	.56

^aMean, SD: 0 = Very Harmful to 10 =Very Helpful.

^bMean, SD: 0 = not at all, 10 = extremely

^c 12SG = 12-step groups