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The Impact of Alcoholics Anonymous on other substance abuse related Twelve Step programs

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Abstract

This chapter explores the influence of the AA model on self-help fellowships addressing problems of drug dependence. Fellowships that have adapted the 12-step recovery model to other substances of abuse are reviewed; next similarities and differences between AA and drug-recovery 12-step organizations are examined; finally, we present empirical findings on patterns of attendance and perceptions of AA and Narcotics Anonymous (NA) among polydrug dependent populations, many of whom are cross-addicted to alcohol. Future directions in 12-step research are noted in closing.

Keywords

12-step; self-help; mutual aid; recovery; addiction

1. Introduction

Since its inception in the U.S. in 1935, Alcoholics Anonymous grown to become the largest and most well-known self-help organization for alcohol problems not only in the US but worldwide. *The Big Book of Alcoholics Anonymous*, AA's Basic Text laying out the 12-step program of recovery (Alcoholics Anonymous World Services Inc., 1939-2001) has been translated in 28 languages, spreading worldwide the message of this ”design for living that works.” The AA recovery program has also been widely adapted to other behaviors (e.g., drug use, gambling, overeating. eating, sex), cultures (Humphreys, 2004; Makela et al., 1996) and belief systems (e.g., Christianity); 258 fellowships use the 12-steps or the name “Anonymous” (Kurtz, 1997) and there are 94 “verified” twelve-step fellowships (White & Madara, 1996). In this chapter, we explore the influence of the AA model to self-help fellowships addressing problems of drug dependence; first, we review the fellowships that have adapted the 12-step recovery model to other substances of abuse; next similarities and differences between AA and drug-recovery 12-step organizations are examined; finally, we present empirical findings on patterns of attendance and perceptions of AA and Narcotics Anonymous (NA) among polydrug dependent populations, many of whom are cross-addicted to alcohol.

2. Twelve-step fellowships focusing on recovery from drug dependence

Following the increasing popularity of AA after the publication of the first edition of the Big Book (Alcoholics Anonymous World Services, Inc., 1939-2001) and the Twelve Steps and the

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Twelve Traditions, (Alcoholics Anonymous World Services. Inc., 1952) the 12-step recovery program became increasingly recognized as a useful recovery resource for persons wishing to overcome substance dependence. AA meetings, however, may not have been suited for those dependent on substances other than alcohol and the 12-step recovery program started to be adapted to provide support for persons wishing to address dependence on substances other than alcohol. The advent of these specialized fellowships is likely multi-determined. First, one of the key principles of AA is "*singleness of purpose*," most evidently expressed by a statement frequently made at the opening of AA meetings: "in keeping with AA's singleness of purpose, please limit your sharing to alcohol." While many drug users may also have used alcohol, those who do not identify alcohol as their primary problem substance may not be able to maximally benefit from support groups where alcohol is the primary topic of conversation. Moreover, a second key aspect of the 12-step program that necessitated specialized fellowships for dependence on substances other than alcohol is the importance of *identification with peers* who seek a solution to a shared problem. Individuals dependent on drugs, particularly illicit drugs, are often forced into a lifestyle that differs significantly from alcohol-dependent persons because of the criminalized aspect of drug use (acquiring, possessing and using drugs). While alcohol users need only a few dollars to buy a bottle legally at the corner store, drug dependent persons by definition are engaging in illegal activities in the process of obtaining the substance of dependence. The following section briefly describes the major drug recovery 12-step fellowships based on available information from each of these organizations.

2.1. Narcotics Anonymous (NA)

Narcotics Anonymous (NA) is the largest and best known of the 12-step fellowships addressing recovery from *drug* addiction. Officially founded in 1953, NA started in the Los Angeles area in the late 1940s. The idea for creating a 12-step program specifically to help drug addicts had emerged several times. In early 1947, a group of drug addicts began to meet as part of a treatment center in Lexington Federal Prison in Lexington, Kentucky. This group, based on the 12 steps of A.A., called itself NARCO or Addicts Anonymous, and continued to meet weekly for over twenty years. In 1948, one of the graduates from the NARCO program moved to New York City and started a similar group in the New York Prison System. This was the first group to be called "Narcotics Anonymous;" the group dissolved soon after it was founded but similar, independent groups sprang simultaneously in other parts of the US, suggesting that there was a need for such an organized program.

Narcotics Anonymous was founded (as AANA) in California in 1953; most founding members had recovered in AA. This group differed from its predecessors in that it specifically attempted to form a mutual support group. The first documented meeting occurred August 17, 1953. In September of that year, AA granted the group permission to use the A.A. steps and traditions, but not the A.A. name. The organization then officially changed its name to *Narcotics Anonymous*. This first N.A. publication, called the "Little Yellow Booklet," containing the 12 steps and early drafts of several pieces that would later be included in subsequent literature, was issued in 1954. The initial group had difficulty finding places that would allow them to meet, and often had to meet in people's homes. One of the most difficult places for NA to become established was in New York state where the Rockefeller drug laws had made it a crime for drug addicts to congregate for any reason, making N.A. in effect, illegal. Addicts would have to cruise around meeting places and check for surveillance, to make sure meetings would not be busted by police; meetings became known as 'bunny meetings' as they 'hopped' from place to place to avert being located (personal communication, Garth P., Sept.5, 2002, Montreal, Canada). Following a somewhat unstable period including several months in 1959 when there were no meetings held at all, the founding members dedicated themselves to restarting NA. In the early 1960s, meetings began to form again and grow. The N.A. White Booklet was written in 1962, and became the heart of N.A. meetings and the basis for all

subsequent NA literature. NA was called a “hip pocket program” because the entire literature could fit into a person's hip pocket. This booklet was republished in 1966 as the NA White Book, and included the personal stories of many addicts (a format similar to that of the AA Big Book). The first NA phone line started in 1960, and the first “H&I” group was formed in 1963; H&I, Hospitals and Institutions, is an NA sub-committee that carries the recovery message into institutions where people cannot get to an outside meeting such as hospitals and prisons (AA operates a similar service). That year a “Parent Service Board” (later renamed the World Service Board) was formed to ensure that NA stayed healthy and followed the 12 traditions. The NA program grew slowly in the 1960s, learning what was effective and what was not as relapse rates and friction between NA groups began to decrease. The 1970's heralded a period of rapid growth for NA, perhaps coinciding with a social context in the US where drug use was becoming if not more socially acceptable at least more popular and celebrated in the pop culture of the times. In 1970, there were only 20 regular, weekly meetings nationwide. Within two years, the movement spread to Europe and Australia; it has continued to grow since, becoming what is today a worldwide organization. In 2007, there are over 25,065 groups holding over 43,900 weekly meetings in 127 countries including Western and more recently, Eastern Europe, South America, Asia, Australia and New Zealand, Africa and the Middle East. The first N.A. World Conference was held in 1971, and others have followed every two years. A World Service Office was officially opened in 1977. The first edition of the NA Basic Text was published in 1983 which contributed to tremendous growth; the 6th edition of the NA Basic Text is being released in 2008; NA literature is now available in 55 different languages with 115 newly translated items.

2.2. Other drug-related 12-step recovery fellowships

Unlike AA which is substance specific, Narcotics Anonymous is open to all drug addicts, regardless of the particular drug or combination of drugs used. Following the growth of the NA fellowship, other 12-step organizations developed around a single problem substance. Note however that in keeping with 12-step principles, these fellowships promote *abstinence from all mind altering substances including alcohol*, not solely from the specific substance that is their primary focus. The development and chronology of these organizations somewhat reflects specific substance use patterns in the US. Each of these organizations is independent according to a structure described in a later section. Table 1 summarizes available knowledge about the estimated size of each fellowship discussed below.

Cocaine Anonymous (CA) was founded in 1982 in Hollywood, California and currently holds meetings in most US states as well as in Canada and Mexico, New Zealand, many western European countries, Indonesia and Hong Kong, in addition to ongoing online meetings.

Marijuana Anonymous started in a number of states at almost simultaneously around 1986-87 by “addicts [who] didn't feel comfortable sharing about their problems in the other programs aimed at chemical dependencies, and in some meetings, they were actually told that they couldn't share. The early members of MA found that, for the most part, marijuana is a ’high bottom’ drug and they had a hard time identifying with some of the heavier substance abusers who had lost everything they had” (Marijuana Anonymous, 1992). Marijuana Anonymous meetings are held is almost all US states as well as in Canada, Australia, New Zealand, Denmark Great Britain, the Netherlands and Scotland; online meetings are also available.

Crystal Meth Anonymous (CMA) started September 1992 in Los Angeles, California and currently holds meetings in most US states as well as in Canada, Australia and New Zealand (Crystal Meth Anonymous, 2007). Similar to the other recovery programs discussed here, the CMA program is adapted with permission from the 12 Steps and 12 Traditions of Alcoholics Anonymous.

Most recently, *Heroin Anonymous* (HA) started in Phoenix, Arizona on August 12, 2004; currently, 24 meetings are held throughout Arizona, Texas, Michigan, California and Illinois. (Heroin Anonymous, 2004)

In addition to these substance specific groups, we are also aware of a handful of Christian 12-step-based recovery organizations (e.g., Free-N-One Recovery) although they appear to be quite localized (mostly in California) and little information is available. These organizations encourage members to look to Jesus Christ as their higher power. Overcomers Outreach (OO) describes itself as a bridge between traditional 12-step recovery groups and the church and has adapted the AA 12-step to incorporate religious scriptures.

2.3. 12-Step addiction recovery fellowships for special populations

The 12-step recovery program promotes abstinence from all mind altering substances and although the World Services of each fellowship does not pronounce itself on the use of prescribed medications, individuals who need pharmacotherapy to manage psychiatric symptoms or to opiate dependence often do not feel welcomed at traditional 12-step meetings where other members often misinterpret the use of medications as not being 'clean.' This is unfortunate as it deprives individuals in need of ongoing recovery support from the many demonstrated benefits of 12-step participation. As a result, 12-step organizations have developed specifically to offer recovery support to persons who are dually-diagnosed with a substance use disorders and a mental illness, as well as for individuals who are maintained on methadone to treat opiate dependence.

2.3.1. 12-Step Group for Dually-Diagnosed Persons—Lifetime comorbidity of psychiatric illness and chemical dependency is high – it has been estimated at 59% (Kessler, 1997). Individuals dually-diagnosed with both these issues face more recovery challenges that those with a "single" disorder (Laudet, Magura, Vogel, & Knight, 2000a). The American Psychiatric Association advised that individuals who are on psychoactive medications for a co-morbid psychiatric disorder be referred to groups where pharmacotherapy is recognized and supported as useful treatment, rather than regarded as another form of substance abuse (American Psychiatric Association, 1995). Yet, the benefits of 12-step participation are not always available to them; some dually-diagnosed members report receiving misguided advice about psychiatric illness and the use of medication, that are seen as "drugs" (Hazelden, 1993), although this is not the official view of AA or NA (Alcoholics Anonymous World Services, 1984). Identifying and bonding with other members may be difficult for dually-diagnosed individuals if they feel different from other group members and acceptance, a cornerstone or 12-step fellowship, may be lacking. Dually-diagnosed persons who are newcomers to 12-step meetings often find them alienating and unempathetic and 12-step groups are generally underutilized by persons with a comorbid mental health disorder (Drake, McLaughlin, Pepper, & Minkoff, 1991). Noordsy and colleagues identified several themes emanating from dually-diagnosed individuals' experience when attempting to use 12-step as a recovery resource, including avoiding initial attendance, dropping out or finding it hard to make a regular commitment, and difficulties identifying with other members the authors concluded that not many dually-diagnosed individuals use self-help consistently over time (Noordsy, Schwab, Fox, & Drake, 1996). However, other studies have reported high levels of regular AA attendance among the dually-diagnosed, generally comparable to those found among "single" disorder clients (Bogenschutz & Akin, 2000; Kurtz et al., 1995; Pristach & Smith, 1999). There is a prevalent belief and as a result, dually-diagnosed persons are less likely to be referred to 12-step than are 'single disorder' substance users (Humphreys, 1997). This belief results in missed opportunity to give clients an effective recovery resource. However, a growing body of research suggests that such individuals can and do benefit from participation in self-help (Jerrell & Ridgely, 1995; Moos, Finney, Ouimette, & Suchinsky, 1999; Ouimette, Finney, &

Moos, 1997; Project MATCH Research Group, 1997; Satel, Becker, & Dan, 1993). The recognition of the limitations of single focus 12-step groups for dually-diagnosed individuals has led to the development of several “dual-recovery” self-help groups.

AA holds special meetings for alcohol-dependent individuals who have a co-occurring a mental disorder. In addition, fellowships have emerged specifically to address dual-recovery needs, most notably Dual Recovery Anonymous-DRA, Hazelden, 1993 and Double Trouble in Recovery - DTR. These groups provide members with an opportunity to discuss both substance use and mental health issues, including the use of medications, in an accepting and psychologically safe forum.

Double Trouble in Recovery (DTR) started in New York State in 1989 and currently has over 200 groups meeting in 14 US states, with the largest number in New York State and growing memberships in Georgia, Colorado, New Mexico and New Jersey. New DTR groups start at the initiative of consumers and that of professionals who believe that mutual help fellowships are a useful addition to formal treatment. DTR developed as a grassroots initiative and functions today with minimal involvement from the professional community. Groups meet in psychosocial clubs, supported residences for mental health clients, day treatment programs for mental health, substance abuse and dual-diagnosis, hospital inpatient units and community-based organizations. All DTR groups are led by recovering individuals (Vogel, Knight, Laudet, & Magura, 1998). At this writing, this relatively new fellowship is in the process of formalizing its own 12-step dual-diagnosis recovery program, including efforts to encourage sponsorship and step work among its members. DTR members' primary problem substances are cocaine and alcohol, and the most prevalent psychiatric diagnoses schizophrenia (43%), bipolar disorder (25%), and unipolar (major) depression (26%) (Laudet, Magura, Vogel, & Knight, 2000b).

Dual Recovery Anonymous (DRA) started in 1989 in Kansas City. DRA's educational recovery materials began to be distributed by the Hazelden Foundation in 1993 which greatly contributed to the growth of the organization that currently holds meetings in most US states as well as in Canada, Australia, New Zealand, India and Iceland. Information about membership characteristics does not seem to be available at this writing.

2.3.2.12-step recovery groups for individuals receiving Methadone maintenance —Methadone is a synthetic narcotic that relieves the craving for heroin. Methadone enables the former heroin addict to feel well and unimpaired by side effects, and to be free of heroin hunger. Methadone maintenance (MM), a form of substitution therapy, is an abstinence-based treatment for opiate addiction. Individuals on methadone maintenance are typically not permitted to ‘share’ (speak) at 12-step meetings, especially in NA, where methadone may be viewed as a “drug” (McGonagle, 1994). *Methadone Anonymous* started in 1991 in Maryland for individuals on prescribed methadone who wish to pursue recovery through the 12-step program; meetings are held in methadone maintenance treatment programs between one and three times weekly. A small survey of the Methadone Anonymous membership at one treatment program in New York City indicated that members were evenly split in terms of gender; they averaged 40 years of age. Three quarters were attending Methadone Anonymous voluntarily, the others were mandated by the program's staff. In addition to heroin, members had a history of alcohol and other drug use including cocaine, marijuana, prescription opiates and stimulants. Average (mean) length of participation in Methadone Anonymous was 16 months, ranging from 1 to 66 months (Glickman, Galanter & Dermatis, 2001).

3. Similarities and differences between AA and drug-recovery fellowships

All 12-step fellowships regardless of the problem behavior they address, are based on and adapted from the 12-step recovery program of Alcoholics Anonymous set forth in the Big Book and the 12 Steps and 12 Traditions (Alcoholics Anonymous World Services, Inc., 1952; Alcoholics Anonymous World Services, Inc., 1939-2001). The only critical difference among these fellowships are the specific substance(s) members identify as their problem, and a corresponding adaptation of Step One ("*we admitted that we were powerless over [substance] – that our lives had become unmanageable*") and Step Twelve ("*Having had a spiritual awakening as a result of these steps, we tried to carry this message to [substance] addicts, and to practice these principles in all of our affairs*"). The Narcotics Anonymous recovery program encompasses all drugs of abuse rather than a specific one so that NA's Step One reads "powerless over *our addiction*" and Step Twelve, "*we tried to carry this message to addicts."*

In addition to similar steps, all 12-step fellowships, be they for alcohol, drugs or other problem behaviors (sex, gambling, shopping, smoking, overeating) share the following: meeting format, recovery program and membership and organizational structure.

3.1 Meeting format

Twelve-step meetings are held throughout the community and are available 7 days a week, virtually 24 hours a day in large metropolitan areas. Meetings are typically held in public venues including libraries, places of worship, and YMCAs, where the fellowship typically pays a token contribution to use the room weekly or more often for meetings. Meetings range in size from two or three individuals in small communities to several hundreds in metropolitan areas. Similar to AA, the larger fellowships (e.g., NA and CA) hold different types and formats of meetings including open and closed meetings, discussion meetings (often 'round robin" where every member present can 'share' for a few minutes), speaker meetings (one or two people share their stories from a podium), Step meetings and Big Book meetings. There are also meetings with a special focus such as for Latinos, women, gay and lesbians, newcomers, old-timers, and veterans. Meetings typically adhere to a prescribed format including 12-step readings (the Preamble, How and Why, the 12-steps at the start of the meeting) and a reciting of the Serenity prayer at the end for members who wish to do so.

3.2. Recovery program

The 12-step recovery program is predicated on abstinence from the problem substance of abuse and to a lesser extent, from all substances of abuse. The program encourages members to look outside themselves for strength (a Higher Power) and to embrace spiritual values and practices that are outlined in the 12-step themselves. The suggested recovery program includes meeting attendance and participation in 'recovery work' often referred to in the scientific literature as 12-step 'involvement' or 'affiliation.' This includes reading 12-step recovery literature, having between-meeting contact with other 12-step members, working the steps, having a sponsor, sponsoring other members, doing service (12^{th} step activities, that range from making coffee and setting up chairs at meeting sites to serving as secretary, chair or treasurer of a meeting, 'bringing' meetings to hospitals and jails, carrying the message to others). The 12-step program of recovery is sometimes described as "a simple program for complicated people." Its suggested prescription for sobriety, mental and spiritual well-being, referred to as "the AA six pack" is deceptively simple: don't use no matter what, go to meetings, ask for help, get a sponsor, join a group, and get active. Thus, while relying on a higher power, 12-step group members are also encouraged to take responsibility for their recovery by working the program and "doing the footwork."

The essential keys to recovery, symbolized by the acronym HOW, are honesty (with self and others), open-mindedness (to explore new ways of thinking and behaving) and willingness (to acquire new behaviors and thought patterns). Honesty about one's addiction is most evident at 12-step meetings where members introduce themselves before speaking by saying: “My name is _____, I'm an addict.” This is to counter denial, the hallmark of addiction, “the disease that tells you you don't have it.” The 12-step program has a strong spiritual component that encourages members to rely on a power (an outside entity) greater than themselves, be it the 12-step group meeting they attend, their sponsor, the God of an organized religion or simply an external force. Mindful of the willful nature of the alcoholic, the AA founders presented the 12-step program of recovery as a set of tools and suggestions that they had used to recover, rather than as a prescription to sobriety. The subtitle of the *Big Book* is: “How many thousands of men and women have recovered from alcoholism” (Alcoholics Anonymous World Services. Inc., 1939-2001).

3.3.Membership and Organizational structure

Twelve-step membership is informal. The only requirement is a desire to stop using the addictive substance (s); a member becomes a member simply by expressing this desire (as set forth by the 3rd tradition). Membership records are not kept. A key principle for 12 Steps group is *anonymity*, according to the 12th tradition. Thus members can attend meetings without fear that their addiction or what they discuss (‘share’) will be revealed to anyone outside the group (“what is said in this room stays in this room”). There are no costs associated with 12 Step membership although groups do accept voluntary contributions to meet their expenses (‘passing the basket’).

As individual members are encouraged to seek recovery by working the 12-step program, 12-step fellowships are guided in their structure and affairs, by the 12 traditions originally developed by Bill W. and the early membership of AA to preserve the unique nature of AA while allowing for an independent and thriving recovery organization (Alcoholics Anonymous World Services. Inc., 1952). Twelve step fellowships are true mutual aid societies; there is no ‘leader’ running the organization or making decisions for the membership. This is consistent with the 2nd tradition (“*For our group purpose, there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern*”). Moreover, 12-step fellowships are non professional (8th tradition): each group is self-supporting and autonomous. However as membership grows, a structure develops based on that of AA World Services, that includes local, regional and national service boards or committees “*directly responsible to those they serve*” (9th tradition). The level of structure of each organization varies depending on the organization's size, with larger ones being more structured; NA being by far the largest and most structured 12-step drug recovery fellowship, holds bi-yearly world conventions held in different countries.

3.4. Characteristic of membership in 12-step recovery fellowships for alcohol and drug dependence

No attendance records are kept at 12-step meetings, so it is traditionally challenging to obtain specific information about 12-step membership. Table 1 (see earlier) presents available information on the estimated size of US membership for AA and drug-related 12-step fellowships. Some of the fellowships such as NA conduct membership surveys at their World conventions; results must be interpreted with caution as they reflect the characteristics of members who choose to complete the voluntary surveys and may not accurately describe membership as a whole. Nonetheless it is interesting to compare NA membership with that of AA. AA was founded by middle aged professional Caucasian men and has traditionally been regarded as populated by Caucasian men; until drug use became more prevalent in the late 1960's, this was largely true. This is changing as the popularity of 12-step has grown and is

being disseminated in substance abuse treatment programs, most of which, in the US, are based on 12-step principles (McElrath, 1997). The proportion of women who are AA members rose from 22% in 1968 to 34% in 1998 (Alcoholics Anonymous World Services, 1998). Further, alcohol and drug use disorders often co-occur (Kessler et al., 1997) and it is often heard in addiction professional circles that there are almost no more ‘pure’ alcoholics. Interestingly, AA membership surveys showed an increase in AA members cross-addicted to drugs from 31% in 1983 to 42% in 1989; the question is no longer asked in AA surveys (Alcoholics Anonymous World Services, 1998) but this suggests that cross addicted individuals may attend both alcohol- and drug 12-step fellowships, a topic that is addressed in the next section. Results of the most recent AA and NA membership surveys are presented in Table 2 for comparison. (Alcoholics Anonymous World Services, 2004;Narcotics Anonymous World Services, 2005) The NA membership is on average, 10 years younger than the AA membership, with seven out of ten Caucasians compared to nine out of ten in AA, and three times as many African Americans in NA than in AA. Two third of AA members are men compared to a little over half in NA. Surprisingly, the employment rate is higher in NA likely due to the greater percentage of retired members in AA. Average length of continuous sobriety is comparable in the two fellowships.

Cocaine Anonymous also publishes some membership data on its website (Cocaine Anonymous, 2003) As of 2001, the most recently available data, CA's membership was two third men, with over 40 % of the members between the ages of 35 and 44 years old and over 25% older; nearly two-third of members are of Caucasian ancestry and over a quarter are African Americans. Most CA members have also used drugs other than cocaine (or crack), 40% had injected cocaine; over 40% of CA members have been sober for a year or less, 25% for one to five years and a quarter for over five years.

4. Utilization of and experiences with drug recovery 12-step fellowships among drug-dependent populations

In spite of the increasing popularity of 12-step fellowships for drug dependence AA remains the best known 12-step recovery fellowship. Little is known of attendance patterns or experiences with 12-step fellowships among drug-dependent populations in spite of the number of individuals involved. Best and colleagues surveyed clients in drug-and alcohol inpatient detoxification services about their experiences and views regarding AA and NA (Best et al., 2001); although there were no differences in history of AA/NA attendance, drug users, compared to alcohol users, reported significantly more positive attitudes towards AA/NA, more willingness to attend during their inpatient treatment and greater intention to attend following completion of their detoxification.

Because many drug abusers are cross-addicted to alcohol (Kessler et al., 1997), the issue of choice of fellowship (NA or/and AA) among drug dependent persons is interest. There is a growing body of research on the effectiveness of 12-step participation among drug dependent persons (Christo & Franey, 1995; Fiorentine, 1999) but little is known about whether or why they choose to participate in AA, NA or in both. Information on clinicians' referral to 12-step for substance abuse treatment patients obtained in a 1997 survey of conducted in the Veterans' Administration system of care revealed that 79.4% of patients were referred at AA, 44.9% to NA and 24.3% to CA (Humphreys, 1997). There is considerable variation across AA meetings in term of environment and social interaction (Montgomery, Miller, & Tonigan, 1993); while some strictly enforce the singleness of purpose (see above) and bar sharing on drugs, others may be more flexible and suit well the needs of cross addicted persons. Moreover, it may be that the focus on one substance (or a class of substances such as in NA) that has been recommended by some (Washton, 1988), it is not viewed by substance users as critical to the success of 12-step participation. Rather, identification with other members may be based on

similarities in individual characteristics (e.g., gender, race) or on past history. Twelve-step groups have been described as “social worlds” (Humphreys, Mankowski, Moos, & Finney, 1999); an important part of 12-step fellowships is what happens among members outside of meetings - coffee after the meeting, regular telephone contacts. Over time, choice of fellowship may be determined by social affinity with the peer groups rather than by substance focus. Alternatively, some individuals may choose to attend both NA and AA to obtain different perspectives on their addictions and on recovery. Some have put forth that persons dependent on substances other than alcohol sometimes feel out of place in AA (McIntire, 2000). However, what little empirical evidence is available on AA attendance among drug dependent populations suggests that this may not be the case. Weiss and colleagues examined participation in AA and NA in a sample of cocaine dependent clients of outpatient treatment: 70% attended AA, 63% attended NA and 13% CA. Forty percent attended AA plus NA, 19% AA only 19% and 15% NA (Weiss et al., 2000). Dual addiction to cocaine and alcohol was associated with greater likelihood to attend AA plus NA (41% vs. 28%) or AA only (22% vs. 12%). We have conducted several studies among polysubstance users whose primary problem substance are crack and/or heroin and examined their patterns of attendance in AA and NA. One study recruited 354 former drug users in remission from one month to over ten years in New York City in 2003-2004; participants are members of ethnic minorities, 56% men with an average age of 43, with chronic and severe dependence and long addiction and treatment ‘careers” At intake, 90% reported having attended 12-step meetings, 87% had attended NA, 72% had attended AA. (Laudet, Morgen, & White, 2006) A second study recruited 205 participants within a week after admission in outpatient treatment at two publicly funded substance abuse treatment programs in New York City between 2003 and 2004: 79.4% had a history of 12-step participation: 35.6% had attended NA only, 5.4% had attended AA only and 37.7 had attended both AA and NA (Laudet, Stanick, Carway, & Sands, 2004). Greater dependence severity as assessed by the Lifetime Non-alcohol Psychoactive Substance Use Disorders subscale of the Mini International Neuropsychiatric Interview (M.I.N.I) (Sheehan et al., 1998) was associated with attending both AA and NA in this drug-dependent sample, and there was a significant association between citing alcohol as a problem substance and attending both AA and NA (relative to not citing alcohol as a problem substance – Table 3).

In spite of these high rates of 12-step participation, we have documented high rates of attrition from both AA and NA among drug-dependent samples (Laudet, Stanick, & Sands, 2007). For example, in the outpatient sample, among clients who had attended 12-step at intake, 85% reported having attended NA and dropped out for a month or longer, and 91% reported a similar patterns for AA; mean number of interrupted attendance for a month or longer since attendance began was 6 (6.1 in NA, 5.4 in AA) (Laudet et al., 2004). These findings suggest that patterns of attendance in 12-step among drug users are similar to the ‘revolving door’ treatment careers reported by Dennis and colleagues (Dennis, Scott, Funk, & Foss, 2005) and probably coincide with treatment episodes. In light of this intermittent pattern of 12-step attendance among drug dependent persons, we used qualitative methods to elucidate participants' experiences with AA and NA. With respect to reasons for attending AA or NA among ‘ever attenders,’ a greater percentage of NA participants cited “promotes recovery/sobriety” than did AA members; the most often cited reasons for attending AA among drug-dependent AA attenders was that it provides support, acceptance and fellowship (58%), an answer also provided by one third of NA attenders (Table 4a). We also asked participants who had attended both AA and NA (N = 78) whether and how the two fellowships differ (Table 4b). One third said there is no difference between the two fellowships; one out of five reported better identification with members in NA than in AA, which is expected, and one out of five said that there is more recovery (longer recovery, more experienced members) in AA than in NA. NA was also perceived as more inclusive than AA by twice as many participants. Finally, we asked participants what they disliked about AA and about NA (participants with AA or NA exposure only were asked about only about the fellowship they had attended, participants with exposure to both were asked

about each). One third (35%) of those who had attended NA disliked nothing about it, and one half (52%) of ever AA attenders disliked nothing about AA. The most frequently cited disliked aspects of NA was that fellow members are ‘phony’ because they were involved in drug use or drug trade (28%); 13% found NA repetitious and boring, and 11% did not like the meeting format. Among AA attenders, disliked aspects of AA mentioned by 5% or more of those asked were other members (13%), meeting format (9%) and the limited focus on alcohol (6%). We note that the qualitative methodology records participants' spontaneous answers so that the findings presented here cannot be interpreted as true comparisons (that is, participants were not asked to rate AA and NA on the dimensions presented in Tables 4a and 4b).

5. Conclusions and future directions

The 12-step recovery model pioneered by Alcoholics Anonymous more than seventy years ago is alive and growing in its adaptations for drug-dependent populations. Perhaps because many drug users are addicted to more than one substance (or identify more than one substance as problematic), Narcotics Anonymous, that speaks to drug addiction overall, has, at this writing, attracted more members than have newer fellowships that address a single substance (e.g., Cocaine Anonymous). Also note that the more recent establishment of drug-specific fellowships along with lower availability of meetings may also explain their smaller membership. The 12-step recovery model was developed in the US and has since permeated American culture and the service delivery system. Unlike other countries such as Australia and most of Western Europe, the US have adopted an abstinence-based response to drug dependence, making 12-step recovery an ideal recovery resource and aftercare modality. We note however that even in countries that have adopted a harm minimization paradigm such as Australia, we have found that the majority of individuals with a chronic history of polysubstance use choose total abstinence from all mind altering substance as their personal recovery goal and report 12-step utilization patterns that do not significantly differ from that of their US counterparts (Laudet & Storey, 2006) although the NA fellowship is significantly smaller than in the US (Toumbourou, Hamilton, U'Ren, Stevens-Jones, & Storey, 2002).

To date, the growing literature on 12-step participation among drug-dependent persons has failed to examine separately participation in AA and in NA, typically speaking of “12step” or ‘self-help” participation instead. Information is needed on the differential effectiveness of AA and NA among drug dependent persons to inform clinicians' referral and service delivery. We have shown that the mere presence of a 12-sep group onsite in outpatient treatment, a cost-free strategy easily implemented through AA or NA's H&I for any treatment program that requests it, enhances nearly three-fold the likelihood of 12-step engagement during treatment as well as nearly six times the likelihood of continuous abstinence from drug one year after treatment ends (Laudet et al., 2007). In our remitted sample of polysubstance users, continuous 12-step attendance over the three year study duration was associated with odds two to five times greater of sustaining continuous drug abstinence over three years, compared to less than continuous participation (Laudet & White, 2007). However as discussed earlier, there is high attrition which critically affects the potential effectiveness of 12-step as a recovery resource. While there are many reasons for 12-step attrition, it is likely to be minimized if participation is experienced as useful. Thus learning whether and how choice of fellowships (AA and/or NA) affects the effectiveness of 12-step participation among drug dependent persons is of high clinical significance.

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Appendix

Online resources for drug addiction recovery 12-step fellowships

Cocaine Anonymous (CA) http://www.ca.org/

Crystal Meth Anonymous (CMA) http://www.crystalmeth.org/

Double Trouble in Recovery (DTR) http://www.doubletroubleinrecovery.org/index.htm

Dual Recovery Anonymous (DRA) http://www.dualrecovery.org/

Heroin Anonymous (HA) http://www.heroin-anonymous.org/

Marijuana Anonymous (MA) http://www.marijuana-anonymous.org/

Overcomers outreach http://www.overcomersoutreach.org/

Recoveries Anonymous (RA) http://www.r-a.org/

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Table 1

Estimated size of membership of AA and of drug-related 12-step recovery fellowships in the US[1]

	Membership
Alcoholics Anonymous	1,190,637
Narcotics Anonymous	185,000
Cocaine Anonymous	15,000
Marijuana Anonymous	10,000
Heroin Anonymous	Not known
Double Trouble in Recovery	3,000

[1] Data are drawn from White and Madara, (White & Madara, 1996) Humphreys (Humphreys, 2004) and from the individual organizations' websites listed in resources at the end of this chapter.

Table 2

Characteristics of Alcoholics and Narcotics Anonymous General memberships

	AA[2]	NA[3]
Men	65%	55%
Age (mean years)	48	38.9
Under 21	1.5%	3%
21 – 31	7.9%	12%
31-40	18.2%	31%
41-50	33.0%	40%
Over 51	39. 4	13%
No answer	---	1%s
Race/ethnicity		
African American	3.3%	11%
Caucasian	89.1%	70%
Latino/Hispanic	4.4%	11%
Other	3.3%	8%
Profession		
Employed	71%	81%
Retired	14%	3%
Student	3%	5%
Homemaker	2%	3%
Unemployed/disable	12%	7%
No answer		1%
Length of continuous abstinence (in years)	8.0	7.4

[2] "More than 7,500 A.A. members from the U.S. and Canada participated in a random survey of the membership." AA 2004 membership survey, AA World services, 2005.

[3] From survey "returned by almost half of the 13,000 attendees at the 2003 NA World Convention held in San Diego, California" (NA World Services, 2005)

Table 3

Utilization of AA and NA among drug users as a function of dependence severity and alcohol problem

	Ever %	Dependence Severity Mean	Alcohol among problem substances[4] No %	Yes %
Neither NA or NA	21.6	5.5	25.9	12.3*
NA only	35.3	7.8*	43.2	18.5***
AA only	5.4	8.2	1.4	13.8***
Both AA and NA	37.7	8.6*	29.5	55.4
Helpfulness NA	- -	- -	3.5	3.3 n.s.
Helpfulness AA	- -	- -	3.4	3.9 n.s

* p<.05;

*** p<.001

[4] Chi Square

Table 4

Table 4a. Reasons for attending Narcotics and Alcoholics Anonymous among drug dependent persons[5]

	Narcotics Anonymous (N=150)	**Alcoholics Anonymous (N=88)**
Promotes recovery/sobriety	59%	41%
Support/acceptance/fellowship	33%	58%
None (did not get anything out of it)	18%	10%
Mandated/pressured	11%	6%
To make friends, to check it out	4%	4%
Step work, spirituality	3%	8%

Table 4b. Perceived Differences between Narcotics and Alcoholics Anonymous among drug users[6]

	Narcotics Anonymous	**Alcoholics Anonymous**
No difference	29%	31%
Better Identification with members	21%	14%
More inclusive, empathic, accepting	14%	7%
More recovery, spirituality, experienced members	0%	22%
More honest, less phony	0%	11%
Different meeting format	5%	0%
More helpful	7%	0%
Prefer other fellowship	7%	1%
Prefers this group (non-specific)	0%	3%
Insufficient experience with other fellowship to tell	17%	1%
Don't know/not sure	0%	10%

[5] May add up to over 100% because up to 3 answers were coded

[6] Among participants who have attended both AA and NA (N = 78)