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Toward Enhancing Twelve-Step Facilitation among young people: A systematic qualitative investigation of Young Adults' 12-step Experiences

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Abstract

Background—Twelve-Step Facilitation (TSF) interventions designed to enhance rates of engagement with 12-step mutual help organizations (MHOs) have shown efficacy among adults, but research provides little guidance on how to adapt TSF strategies for young people.

Methods—To inform TSF strategies for youth, this study used qualitative methods to investigate the self-reported experiences of 12-step participation, and reasons for non-attendance and discontinuation among young adults (18-24 yrs; N=302). Responses to open-ended questions following residential treatment were coded into rationally-derived domains.

Results—Young adults reported that cohesiveness, belonging, and instillation of hope were the most helpful aspects of attending 12-step groups; meeting structure and having to motivate oneself to attend meetings were the most common aspects young adults liked least; logistical barriers and low recovery motivation and interest were the most common reasons for discontinued attendance; and perceptions that one did not have a problem or needed treatment were cited most often as reasons for never attending.

Conclusions—Findings may inform and enhance strategies intended to engage young people with community-based recovery focused 12-step MHOs and ultimately improve recovery outcomes.

Keywords

12-step; Alcoholics Anonymous; self-help; mutual help organizations; young adults; 12-step facilitation; qualitative research

AUTHOR CONTRIBUTIONS

Authors Labbe and Kelly designed the study. Author Labbe managed the literature searches and summaries of previous related work. Authors Labbe and Kelly undertook the qualitative analyses. Authors Labbe and Kelly wrote the first drafts of the manuscript. All authors contributed to and have approved the final manuscript.

INTRODUCTION

The social and medical cost burden associated with substance use and related disorders is immense and growing¹⁻². With the emergence of Accountable Care Organizations³ (ACOs) there are increasing incentives for health care agencies to focus on how to keep people in remission longer and in a more cost-efficient manner⁴⁻⁵. Studies in the addiction treatment field have shown that participation in 12-step mutual-help organizations (MHOs) following treatment, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), is related to higher rates of remission from substance use disorder⁶⁻⁹ (SUD) and simultaneous reduction in health care costs¹⁰⁻¹³.

A number of clinical Twelve-Step Facilitation (TSF) interventions have been developed to enhance rates of patient engagement with freely available recovery-focused MHOs, and increase remission rates among adults¹⁴⁻¹⁸. Despite young adults comprising the largest segment of the treatment population, comparatively less research has been conducted specifically in this age group. Moreover, research shows that young adults are qualitatively different than older adults¹⁹. Young adults entering SUD treatment, for example, have higher rates of psychiatric distress and co-morbidities, and are less likely to follow through with continuing care recommendations²⁰. They also face greater recovery challenges than older adults as there are fewer abstainers in their age-range in the general population²¹, making it more difficult for young adults to find abstinent or recovery-supportive social contexts. Also, only about 15% of AA and NA members are under the age of 30, making it more difficult for young adults to identify and engage with the older adult majority of 12-step MHO members²²⁻²³. Consequently, straightforward implementation of TSF strategies shown to be effective for adults may need adapting to optimize their use with young adults.

While several quantitative studies show benefit for 12-step participation for individuals in this age-range²⁴⁻²², they provide little guidance on how to enhance TSF strategies for young people. In prior work with adolescents, we conducted qualitative work to understand what young 12-step MHO attendees liked and found helpful about participation and reasons for discontinuing 12-step participation²⁶. Responses primarily fell into the domains of “Universality,” “Support,” and “Instillation of hope” in regards to what youth liked most about attending AA/NA. Regarding reasons for AA/NA discontinuation, the majority of responses fell into the domains of “Boredom/Lack of Fit” and “Relapsed.” Although the sample size was small (n=53), the results from this study provided important insights into youth experiences of 12-step groups that can inform treatment. However, given that adolescents and young adults face diverse life-context challenges and are inherently different due to social and psychobiological developmental differences, one cannot presume that young adults would respond similarly to adolescents with respect to what they find most and least helpful about attending 12-step groups. Subsequently, to extend our previous work and to help inform TSF strategies for young adults, the goal of this study was to use qualitative methods to investigate the self-reported experiences of 12-step participation, non-attendance, and discontinuation in a large clinical sample of young adults. Knowing which aspects of MHOs, in particular, appeal to young adults could be used to emphasize positive gains and experiences that may help attract young adults leaving treatment to engage in similar MHOs. Further, learning about which aspects of MHOs young people do not like,

and why they discontinue attending groups, can help clinicians develop clinical strategies for young people that may help “inoculate” them against potential pitfalls young people commonly encounter during and after treatment, or assist them in overcoming barriers to attendance, and thus improve outcome. Alternatively, it could help identify patients that might be better suited to non-12-step organizations, such as SMART Recovery, LifeRing or other alternatives²⁷. To this end, the aim of this study was to help answer four fundamental questions: (1) what do young adults find most helpful about attending 12-step MHOs? (2) What do young adults like least about attending 12-step meetings? (3) What reasons do young adults report for discontinuing 12-step group attendance? and (4) if a young adult never attended a 12-step meeting, what are some of the reasons for not attending? Similar to previous work in this area among adults²⁸ and adolescents²⁶, theoretical frameworks (e.g., group therapy theory) were used wherever possible to help guide clustering of patients’ responses.

METHODS

Participants

The study was conducted in accordance with ethical standards regarding human subjects and was approved by the independent Institutional Review Board at Schulmann Associates. Study participants were young adults ($N = 302$; 18-24 years) entering a private residential SUD treatment program in the Midwestern United States. A total of 607 young adults were admitted during the recruitment period (October 2006 to March 2008). To ensure sufficient representation of all ages within the target range (18-24 years), a stratified sampling procedure was used to select potential participants. All patients aged 21-24 years and every second patient aged 18-20 were asked to participate in the study. Of those approached ($n = 384$), 64 declined. Seventeen participants withdrew between enrollment and the baseline assessment. The final sample of 302 represents 78.9% of those approached (see Kelly et al.²² for more details). Average age was 20.4 years old ($SD = 1.6$). Participants were predominantly male (73.8%) and all were single. Most were Caucasian (94.7%); 1.7% identified as American Indian, 1.3% identified as African American, and 1.0% as Asian (1.4% reported “other” or missing). At admission, 23.8% were employed full- or part-time, and 31.8% were students. Almost half had completed high school (43.4%) and 39.7% had attended college. The most commonly reported “drug of choice” was alcohol (28.1%) and marijuana (28.1%), followed by heroin or other opiates (22.2%), cocaine or crack (12.3%), and amphetamines (6.0%). Small proportions reported benzodiazepines (2.0%), hallucinogens (1.0%), or ecstasy (1.0%) as their drug of choice. A small number of participants ($n=5$) reported more than one drug of choice, such that these proportions do not sum to 100%.

Treatment

Treatment was based on an eclectic and multidisciplinary residential approach for SUD, based on the abstinence-based, 12-step framework of AA²⁹. Services were comprehensive and multi-faceted, employing evidence-based interventions based in twelve step facilitation, motivational, cognitive-behavioral, and family therapy approaches. Programming included clinical assessment, individual and group therapy, and specialty groups, such as relapse

prevention, anger management, eating issues, dual disorders, gender issues, and trauma. Integrated mental health care was available on-site, including assessment, therapy, and medication management. Average length of stay was 25.6 days ($SD = 5.7$, ranging from 4 to 35 days). The majority (83.8%) was discharged with staff approval. Regarding the representativeness of our clinical sample, we compared our private treatment sample with available public residential programs in this age range using the Treatment Episode Data Set [TEDS]), and across a sample of private adult outpatient and residential programs³⁰. We found that compared to same-age, public sector, residential patients our participants are comparable in terms of gender (33% vs. 34% female), marital status (95% vs 92% never married), education (51% vs 53% did not complete high school), unemployment (30% vs 32%), and not being in labor force (e.g., student; 53% vs 54%), but we have a higher Caucasian majority (95% vs 76%). Primary substance at treatment entry was similar with the highest for alcohol (28% vs 21%) marijuana (27% vs 31%), cocaine (12% vs 14%) and opiates (21% vs 18%). Compared to all adults across all types of programs treated in private programs our sample was similar across these indices except for a greater Caucasian majority (95% vs. 71%), which is a limitation. However, we anticipate that results here will be broadly generalizable to youth treated for SUD. In terms of representativeness among U.S. treatment programs, participants were more likely to be Caucasian than other 18–24 year olds treated in public sector residential treatment³¹ (76%) or adults (18+) in private sector treatment³² (71%). They were comparable in terms of gender, marital status, and employment³². Regarding treatment payment source, 61% was from insurance and 35% from family. Also, 34% of the sample came from areas with households below the U.S. median household income (\$50,221); 50% of the sample came from households in areas where the median household income was below \$56,000.

Procedure

Research staff conducted assessments at intake, discharge, and at 3, 6, and 12 months post-discharge. Interviews were completed in person or by telephone, and self-administered surveys were completed online or returned by mail. Participants were reimbursed \$30 for the baseline, discharge, and 3-month assessments, and \$40 for the 6- and 12-month assessments. Follow-up rates were 87% ($n = 264$) at discharge, 82% ($n = 248$) at 3 months, 72% ($n = 219$) at 6 months, and 71% ($n = 214$) at 12 months.

Measures

Demographics—Demographic characteristics, including age, gender, ethnicity, education, and marital status, and drug of choice were extracted from patients' records.

12-Step Appraisals—Four items from the Multidimensional Mutual-help Meeting Activity Scale³³ were used to collect qualitative information regarding participants' appraisals of 12-step groups. At each assessment participants were asked to respond to the following questions: (1) If you never attended any 12-step meetings, what were some of the reasons why you did not attend?, (2) What do you find most helpful about attending 12-step meeting such as AA or NA?, (3) What do you like least about 12-step meetings?, and (4) If you stopped going to AA/NA meetings, why was that?

Data Analytic Plan

Responses to the appraisal questions were coded into unique domains. With the exception of responses to why participants never attended any 12-step meetings, which utilized data collected at baseline, all other responses were those collected during the 6-month follow-up point. The 6-month time point was chosen for two specific reasons. First, by this time point a majority of the participants were no longer in residential treatment and were living independently (i.e., on their own, with their families). Therefore, it was believed that attendance to any 12-step meetings would occur as a function of inherent interest in attending a MHO meeting instead of a requisite of one's treatment or living situation. Second, waiting until six months after treatment discharge potentially increased the number of responses to why young adults discontinued attending 12-step groups, providing us with a more comprehensive picture of why young adults discontinue 12-step participation during this important early recovery phase.

Meetings in 12-step MHOs are run in groups. Accordingly, the therapeutic factors of group psychotherapy theory outlined by Yalom³⁴ were utilized as a framework to categorize responses regarding what young adults found most helpful about attending 12-step meetings. Frameworks from work by Kelly and colleagues²⁸ examining reasons for 12-step non-attendance and dropout were employed to serve as a guide to categorize participants' responses regarding what they found least helpful about attending 12-step meetings, and reasons for non-attendance and drop-out.

An iterative approach was used to establish the response categories by two of the authors (AKL and JFK). All responses were categorized into domains made sense conceptually. To the extent possible, the authors fully exploited the data and allowed for the emergence of additional categories that would best account for the participants' responses. This method resulted in six rationally-derived categories to classify responses to what young adult participants thought was most helpful about attending 12-step meetings, ten categories to classify responses to what young adults found least helpful about attending 12-step meetings, eight categories to classify reasons why young adults discontinued attendance to 12-step meetings, and seven categories to classify why young adults chose never to attend a 12-step meeting. Two of the authors (AKL and JFK) met regularly to check on consistency of ratings during the iterative approach to establish response categories. To establish face validity and reliability of the constructed domains, two additional raters (Masters-level research assistants unrelated to the study) independently coded the open-ended responses into the best-fitting domains. Inter-rater agreement among the raters was calculated utilizing Krippendorff's alpha, which accommodates multiple raters³⁵.

RESULTS

As reported in more detail previously²², at treatment intake 108 participants (35.9%) had attended any 12-step meetings. At the 3-month follow-up assessment, 87.6% of the sample (n=212) attended at least one 12-step meeting in the past three months, 81.0% of the sample (n=175) attended at least one meeting in the three months prior to the 6-month follow-up assessment, and 75.5% of the sample (n=162) attended at least one meeting in the three months prior to the 12-month follow-up assessment.

What Do Young Adults Find Most Helpful about Attending 12-Step Meetings?

The domains, sample response items, and the frequency of responses falling into each category are presented in Table 1 and Figure 1. Inter-rater agreement for this question was $\alpha = 0.72$ (95% C.I.: 0.67 – 0.76). The most common responses ($n=106$, 42.9%) fell into the “Universality” (e.g., removing sense of isolation and validating experiences) or “Cohesiveness” (e.g., a sense of belonging, acceptance, and validation) categories. Initially these two domains were coded separately; however, given the similarity of the two domains’ definitions, it was difficult to discretely place some participants’ responses clearly into either category. Consequently, the two domains were collapsed into one. This category accounted for the most responses. The next domain was “Instillation of Hope” (e.g., being inspired/encouraged by another member who has overcome a similar problem; $n=58$, 23.5%), followed by “Altruism” (e.g., members help each other, support; $n=31$, 12.6%). Notably, responses about 12-step specific factors (e.g., powerlessness over drugs/alcohol, service work) occurred rarely ($n=3$, 1.2%), suggesting that general group therapy factors were more important to these young adults in early recovery/post-treatment.

What do Young Adults Like Least about 12-Step Meetings?

The domains, sample response items, and the frequency of responses falling into each category are presented in Table 2 and Figure 2. Inter-rater agreement for this question was $\alpha = 0.82$ (95% C.I.: 0.78 – 0.85). The most common responses ($n=50$, 24.9%) fell into the “Structure of Meetings” (e.g., length of meetings, repetitive information) category, followed by the “Motivation and Interest” (e.g., bored, having to motivate self to go; $n=30$, 14.9%), “Other Group Members” (e.g., other members’ attitudes/opinions/personalities; $n=29$, 14.4%), and “Age Differences” (e.g., older members; $n=21$, 10.4%) categories. Importantly, there were only two responses (0.99%) that fell into the “Unhelpful” category, indicating that nearly all young adults found attending 12-step meetings helpful in their recovery.

Reasons Young Adults Discontinued 12-Step Attendance

The domains, sample response items, and the frequency of responses falling into each category are presented in Table 3 and Figure 3. Inter-rater agreement for this question was $\alpha = 0.89$ (95% C.I.: 0.84 – 0.93). The most common responses ($n=20$, 29.9%) fell into the “Logistical Barriers” (e.g., factors making it difficult to attend meetings) category. The next most common responses ($n=154$, 22.4%) fell into the “Motivation and Interest” (e.g., lack of motivation, not interested in attending) category. Notably, though age differences was cited as one of the more common responses regarding what young adults liked least about attending 12-step meetings, age differences was an uncommon reason ($n=2$, 3.0%) young adults cited as to why they stopped attending meetings.

Reasons Why Young Adults Never Attended 12-Step Meetings Prior to Treatment

The domains, sample response items, and the frequency of responses falling into each category are presented in Table 4 and Figure 4. Inter-rater agreement for this question was $\alpha = 0.78$ (95% C.I.: 0.74 – 0.83). The most common responses ($n=59$, 41.0%) fell into the “No Perceived Need or Problem” category. The next most common responses fell into the “Other” category ($n=27$, 18.8%). This category included responses that could not clearly be

placed into any of the other categories and the types of responses were varied, including responses such as, “I didn't think it would be helpful,” “Wouldn't feel completely anonymous,” and “Tried other things instead.” Of importance, responses regarding concerns about the efficacy of 12-step groups (e.g., “I didn't think it would be helpful”) was only reported three times. Though only capturing about 15% of responses (n=22), it is important to highlight that “Lack of Knowledge” was cited by young adults as to reasons why they never attended any 12-step meeting. This data suggests that more education could be provided to young adults with a SUD about the availability of, and philosophy behind, mutual help organizations to aid in their recovery.

DISCUSSION

This study examined qualitative data to investigate the self-reported experiences of 12-step participation, non-attendance, and discontinuation among young adults as a means to help inform clinical 12-step facilitation strategies for this age group. Aspects of 12-step meetings that young adults reported they found most helpful centered on social-cognitive factors related to a sense of belonging and validation, and instilling hope for recovery and a more optimistic outlook on one's future. Aspects that young adults reported they liked least about attending 12-step meetings related to meeting structure, and motivation and interest. Responses related to logistical barriers and motivation and interest were the most common reasons young adults reported discontinuing attendance to 12-step meetings. Finally, among those young adults who reported they never attended any 12-step meetings, the most common responses related to the perception that they did not need help or believe they had a drug or alcohol use problem.

What young adults found most helpful regarding 12-step Mutual-help meetings

Results from this study regarding what young adults found most helpful about attending 12-step meetings (i.e., sense of belonging, validation, and hope for recovery and optimism about one's future) parallel those of Kelly et al.²⁶ which explored the same question among adolescents. Most notably, these findings are in line with research that has found that the social aspect of MHOs is associated with long-term abstinence by increasing positive types of support and promoting engagement in larger recovery networks^{28,39}. The findings from the current study highlight that 12-step meetings may fulfill a need among young adults seeking recovery who often struggle to find same-aged individuals in SUD recovery²¹ by providing a recovery-supportive social network. Especially for young adults who may exhibit ambivalence about engaging in MHOs, clinicians might utilize this information by providing psychoeducation about the lower rate of abstainers in this age group in the general population, underscoring the difficulties young adults with more severe addiction problems may face in trying to “go it alone,” and by emphasizing that similar-aged peers in recovery found the sense of belonging, validation, support, and hope offered by 12-step members helpful aspects of attending 12-step groups. Additionally, given that young adults, on average, have less severe addiction severity and experience fewer negative consequences as a result of their alcohol or drug use than older 12-step members, young adults may have lower motivation to attend 12-step groups out of the belief that they will not be able to relate to others. However, clinicians might preemptively challenge this belief by creating a new

social norm; specifically, by explaining to young adults who could benefit from participation in MHOs that their similar-aged peers who attended 12-step groups found that they were able to relate to other group members and that this was what they found most helpful.

What young adults found least helpful regarding 12-step Mutual-help meetings

Aspects of 12-step meetings that young adults reported they liked least about attending meetings similarly centered around non-12-step factors, such as structure of the meetings (e.g., repetitiveness, length of meetings), other group members, and the age difference between themselves and a majority of the other group members. Notably, only 6% of responses were specifically related to 12-step content. These findings suggest that young adults may not be opposed to the tenets of 12-step MHOs. These data could be useful to clinicians facilitating engagement with 12-step groups because the data can be used to potentially mitigate concerns young adults may have about 12-step-specific content, if they are informed that few of their peers cited this as an aspect of MHOs they disliked. Further, clinicians can highlight that 12-step specific content was rarely cited as a reason for discontinuing 12-step attendance among young adults as a way to demonstrate to their patients that, though others might have had the same concerns about 12-step content, it was not so aversive that it prevented them from continuing to attend.

Also of interest is that nearly 15% of responses regarding what young adults liked the least about attending 12-step meetings related to a lack of motivation or a lack of interest to attend 12-step meetings. Though this category ranked second highest with regards to number of responses, lack of motivation does not reflect an aspect of 12-step meetings per se, but rather an individual factor that can significantly influence one's initial engagement and continued participation in 12-step groups. Not only did young adults report that a lack of motivation or interest to attend 12-step meetings was something they disliked about 12-step groups, this also accounted for nearly a quarter of all responses regarding reasons why young adults chose to discontinue attending meetings. Given that previous research has established the consistent association between motivation and treatment engagement and outcome⁴⁰⁻⁴³ this is a crucial area that needs to be assessed and addressed by clinicians referring young adults to MHOs post-treatment. It would be important to understand what additional factors may be contributing to a young adult's low motivation so that focused work can be done to boost motivation and, possibly, engagement and participation. If lack of interest is related to misinformation about MHOs then psychoeducation might be provided to correct any misperceptions. If motivation is the issue, then motivational techniques ought to be applied to enhance 12-step facilitation among this age group or to engage young people with continuing care alternatives to 12-step MHOs.

Reasons for Discontinuation from 12-step Mutual-help organizations

Logistical barriers (e.g., lack of transportation) were the most commonly reported reasons for discontinuation of 12-step attendance. This data is particularly useful in that it suggests that discontinuation is not exclusively due to loss of interest or the belief that the meetings are not helpful. Instead, this information suggests that if these logistical barriers were addressed then these young adults may have continued to participate in meetings. Older adults²⁸ and adolescents²⁶ also cited logistical barriers as a reason for MHO discontinuation

however it was not reported as often. This divergence may be a function of development stages. Older adults typically are more stable with regards to finances, employment, and relationships, perhaps making it easier for them to locate meetings, make time for attending meetings, and find transportation to meetings. Adolescents typically have the support of family members who may take more of an active role in locating meetings, creating a meeting attendance schedule, and providing transportation. As they emerge into adulthood, young adults are working to achieve milestones that would provide more independence and stability, which may be more challenging to achieve while in early recovery. In this regard, it may be that logistical issues pose a greater obstacle to remaining in 12-step groups than for older and younger members. Consequently, clinicians might work to identify such barriers and problem-solve around these issues when initially referring young adults to MHOs as a way to prevent discontinuation.

Reasons for never attending 12-step Mutual-help meetings at treatment entry

Results from the current study regarding reasons for never attending any 12-step meetings are in accord with the most recent results from the National Survey on Drug Use and Health (NSDUH). According to the NSDUH, of the 20.6 million people aged 12 and older who were classified as being in need of SUD treatment, nearly 95% did not perceive a need for treatment⁴⁴. In the current study, nearly 43% of responses regarding reasons for never attending a 12-step meeting prior to this study was because young adults did not perceive a need for such treatment. Importantly, responses came from young adults initiating residential SUD treatment, suggesting that there was enough impairment due to their substance use to merit intensive treatment at the time of study entry which could have possibly been mitigated had these young adults had a more accurate perception of how their substance use was interfering with their lives or had received a more proactive 12-step MHO referral. It is significant that approximately 15% of responses related to a lack of knowledge about MHOs among young adults. It may be the case that, had young adults known more about 12-step groups (e.g., their purpose, where to find them), then perhaps they would have been more likely to take advantage of them. Though responses to the question of why young adults never attended 12-step meetings previously does not necessarily inform ways to enhance TSF, it does emphasize the need for increased education and discussion about SUD and its presentation, especially among young adults. Additionally, more work can be done to make information about MHOs more available to young adults. Given that the most common point of entry into the medical system for most Americans is through the primary care setting⁴⁵, having educational information about 12-step organizations available to, and adapted for, young adults (e.g., pamphlets) may be beneficial. Further, clinicians working with young adults presenting for a medical issue stemming from substance use can provide brief psychoeducation about MHOs, along with materials that list meeting locations and times, and ideally, connection with an existing 12-step MHO member who can accompany them to their first meeting and help make connections⁴⁶⁻⁴⁷. Increased knowledge of, and engagement with, MHOs among young adults may not only improve remission rates⁶⁻⁹, but could also translate into reduced healthcare costs¹²⁻¹³.

Limitations

Findings from this study should be considered in light of important limitations. First, responses provided came from a homogenous group of patients who completed a 12-step oriented residential treatment program. Therefore, results may not generalize to other types of patients or treatment orientations (e.g., CBT). For example, our sample was predominantly Caucasian (94.7%), whereas other 18-24 year olds in treatment in public sector residential treatment or adults (18+) in private sector treatment tend to be less Caucasian (76% and 71%, respectively)³¹⁻³². As such, the potential responses from more racially/ethnically diverse young adults may not be sufficiently represented. Further, though our sample is representative of the US median household income, results may not generalize to young adult patients in resource-limited areas. Second, due to the nature of qualitative data, responses were open to interpretation, making it a challenge to categorize ambiguous responses. Unfortunately, no follow-up questions were asked of participants to clarify their answers. For example, in response to what young adults found most helpful about attending 12-step meetings, several people responded with “the people.” Since there was no way to determine what the participants were implying with this response, its meaning had to be inferred in order to summarize responses into categories. The inter-rater agreement across the four topic areas, however, was relatively high, indicating raters deduced largely the same meanings from the responses. Last, the data did not fit perfectly to the theoretical framework used to categorize the responses regarding what young adults found most helpful about attending 12-step meetings. This suggests that Yalom's group therapy theory constructs, while helpful, may not provide the optimal fit for understanding community MHO processes. For example, “the fellowship” was often cited as an aspect that young adults found most helpful. In considering what the fellowship provides, it does remove a sense of isolation, validates one's experiences, and increases one's sense of belonging and acceptance (i.e., “Universality” and “Cohesiveness.”). However, there seems to be another quality about the fellowship that these two therapeutic factors do not capture; for example a sense of camaraderie which is defined more as a mutual trust and friendship among people who spend a lot of time together. “Camaraderie” may better reflect the spirit of the fellowship than “Universality” and/or “Cohesiveness.” Overall, the fact that the data did not fit the framework completely implies that there may be more going on in 12-step MHOs than that which would be found in formal group therapy, and these other factors may be some of what makes attending 12-step meetings helpful to long-term recovery.

Conclusions

Young adults have the highest rates of SUD in the general population and represent the largest proportion of treatment admissions. Continuing care strategies, including 12-step facilitation interventions, are important in order to enhance outcomes for individuals with severe alcohol and other drug problems. Successful engagement with community-based resources such as these may become even more important in helping to reduce health care costs within growing accountable care organizations. Though TSF interventions have proven helpful among adult samples, a straightforward implementation of adult-oriented TSF may not address the different clinical and life-context challenges faced by young adults. This qualitative study in a large clinical sample of 300 young adults investigated, described, and discussed the phenomenology of 12-step exposure on entry to, and in the year following,

residential SUD treatment. Findings highlight qualitative insights across four important content areas (likes, dislikes, reasons for discontinuation, and reasons for non-attendance) that will help inform, and potentially enhance, strategies intended to engage young people with community-based recovery focused 12-step organizations, as well as to identify patients for whom non-12 step organizations or other continuing care may be more appropriate.

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Figure 1.
Response Categories Regarding What Young Adults Found Most Helpful about Attending 12-Step Meetings

Figure 2.
Response Categories Regarding What Young Adults Liked Least about Attending 12-Step Meetings

Figure 3.
Response Categories Regarding Reasons Why Young Adults Discontinued 12-Step Attendance

Figure 4.
Response Categories Regarding Reasons Why Young Adults Never Attended 12-Step Meetings

TABLE 1

Frequency of Responses (n=247), Organized by Category, Regarding What Young Adults Found Most Helpful about Attending 12-Step Meetings

Response Category	Category Description	Sample Responses	Frequency of Responses (%)	Rank
Universality/Cohesiveness	Removing sense of isolation and validating experiences/A sense of belonging, acceptance, and validation	“Being around others that are the same way.” “Meeting people that I relate to and being able to talk about anything freely.”	106 (42.9%)	1
Instillation of Hope	Being inspired/encouraged by another member who has overcome a similar problem	“Helpful to see people with 20 years sobriety and know I can get there.”	58 (23.5%)	2
Altruism	Members help each other; support	“Support by others there.”	31 (12.6%)	3
Other	Any response that did not clearly fit into any of the other categories	“Gives me a place to go.” “Keeping recovery fresh in my mind.” “Reminds me of powerlessness.”	29 (11.7%)	4
Catharsis	Relief from emotional distress through free and uninhibited expression of emotion	“Being able to vent to others.”	23 (9.3%)	5

TABLE 2

Frequency of Responses (n=201), Organized by Category, Regarding What Young Adults Liked Least about Attending 12-Step Meetings

Response Category	Category Description	Sample Responses	Frequency of Responses (%)	Rank
Structure of Meetings	Aspects of how meetings are conducted	"Having to go over the rules at the beginning of every meeting."	50 (24.9%)	1
Motivation and Interest	Lack of interest in meetings/Lack of motivation to attend	"Finding motivation to get there."	30 (14.9%)	2
Other Group Members	Dislike of other members' attitudes, opinions, personalities	"People who don't take it seriously."	29 (14.4%)	3
Age Differences	Other members are not similar in age	"Most people are a lot older."	21 (10.4%)	4
Logistical Barriers	Aspects of being able to attend meetings	"Meetings are hard to get to."	17 (8.5%)	5
Other	Any response that did not clearly fit into any of the other categories	"Being around smoking."	15 (7.5%)	6
Nothing	Enjoys all aspects of attending meetings	"Nothing I don't really like."	14 (7.0%)	7
12-Step Specific Content	12-Step content specifics, such as reading from the Big Book and references to God/Higher Power	"How focused on God it is."	12 (6.0%)	8
Social Anxiety	Discomfort being around others	"Talking in front of a large crowd."	11 (5.5%)	9
Unhelpful	Did not find 12-Step meetings helpful	"They weren't helpful."	2 (1.0%)	10

TABLE 3

Frequency of Responses (n=67), Organized by Category, Regarding Reasons Why Young Adults Discontinued 12-Step Attendance

Response Category	Category Description	Sample Responses	Frequency of Responses (%)	Rank
Logistical Barriers	Factors making it difficult to attend meetings	"Lack of transportation."	20 (29.9%)	1
Motivation and Interest	Not interested or not motivated to continue attending meetings	"Never wanted to go in the first place."	15 (22.4%)	2
Relapsed/Not Intent on Sobriety	Relapsed or did not plan on staying sober	"Relapsed." "Wasn't that serious about recovery."	14 (20.9%)	3
Not Helpful	Did not find meetings helpful in their recovery	"They weren't helpful."	5 (7.5%)	4
Other Group Members	Dislike of other members' attitudes, opinions, personalities	"Can find the right group of people."	5 (7.5%)	4
Other	Any response that did not clearly fit into any of the other categories	"No support."	4 (6.0%)	6
In Jail	Young adult was in jail	"In jail."	2 (3.0%)	7
Age Differences	Other group members were not similar in age	"Felt alone with no one there my age."	2 (3.0%)	7

TABLE 4

Frequency of Responses (n=144), Organized by Category, Regarding Reasons Why Young Never Attended 12-Step Meetings

Response Category	Category Description	Sample Responses	Frequency of Responses (%)	Rank
No Perceived Need or Problem	Did not perceive that there was a problem, or that help was needed	"No problem with alcohol." "Never felt the need to go."	59 (41.0%)	1
Other	Any response that did not clearly fit into any of the other categories	"Only go if required." "Tried other things instead." "Wouldn't feel completely anonymous."	27 (18.8%)	2
Lack of Knowledge	Did not know about 12-Step Organizations/Did not know how to access 12-step meetings	"Didn't understand what they were for." "Don't know where meetings are."	22 (15.3%)	3
Lack of Interest	Had no interest in attending meetings/Didn't occur to attend meetings	"Didn't want to go." "Never thought to go."	22 (15.3%)	3
Perceived Inability to Relate to Other Members	Did not believe he/she could relate to other members	"Everyone I know in AA is older." "Younger than others – didn't think I'd fit in."	8 (5.6%)	5
12-Step Specific Factors	12-Step content specifics, such as reading from the Big Book and references to God/Higher Power	"Don't believe in powerlessness."	6 (4.2%)	6