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# "It Might Actually Work This Time"



Benefits and Barriers to Adapted 12-Step Facilitation Therapy and Mutual-Help Group Attendance From the Perspective of Dually Diagnosed Individuals

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#### Abstract

Most U.S. healthcare professionals encourage mutual-help group involvement as an adjunct to treatment or aftercare for individuals with substance use disorders, yet there are multiple challenges in engaging in these community groups. Dually diagnosed individuals (DDIs) may face additional challenges in affiliating with mutual-help groups. Twelve-step facilitation for DDIs (TSF-DD), a manualized treatment to facilitate mutual-help group involvement, was developed to help patients engage in Double Trouble in Recovery (DTR), a mutual-help group tailored to DDIs. Given the promising role that TSF-DD and DTR may have for increasing abstinence while managing psychiatric symptoms, the aim of the current study was to systematically examine reasons for TSF-DD and DTR attendance from the perspective of DDIs using focus group data. Participants were a subset (n = 15) of individuals diagnosed with an alcohol use disorder as well as a major depressive, bipolar, or psychotic disorder who participated in a parent study testing the efficacy of TSF-DD for increasing mutual-help group involvement and reducing alcohol use. Analyses of focus group data revealed that participants construed DTR and TSF-DD as helpful tools

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in the understanding and management of their disorders. Relative to other mutual-help groups in which participants reported feeling ostracized because of their dual diagnoses, participants reported that it was beneficial to learn about dual disorders in a safe and accepting environment. Participants also expressed aspects that they disliked. Results from this study yield helpful empirical recommendations to healthcare professionals seeking to increase DDIs' participation in DTR or other mutual-help groups. **Keywords:** barriers, double trouble in recovery, dual diagnosis, focus groups, mutual-help, qualitative, treatment engagement, twelve-step, twelve-step facilitation therapy

earlyhalf of the adults in the United States who experience a substance use disorder have a comorbid mental disorder (Substance Abuse and Mental Health Services Administration, 2010). Individuals diagnosed with both a substance use disorder and a comorbid mental disorder (dually diagnosed individuals [DDIs]) experience greater symptom severity and poorer outcomes than individuals with a single diagnosis (Burns, Teesson, & O'Neill, 2005; Margolese, Malchy, Negrete, Tempier, & Gill, 2004). Although integrated treatment programs designed for DDIs appear to be modestly effective in reducing outcome disparity (Horsfall, Cleary, Hunt, & Walter, 2009), only 18% of substance use disorder treatment programs meet criteria for DDI-capable services (McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2012), and lack of treatment seeking and engagement continue to be critical issues. Thus, patient attitudes toward 12-step facilitation therapy adapted for DDIs (TSF-DD) and Double Trouble in Recovery (DTR), a mutual-help group designed to meet the unique needs of DDIs, were solicited to facilitate treatment and mutual-help group participation. Focus group participants were dually diagnosed with an alcohol use disorder and one of the following comorbid disorders: major depressive, bipolar, or schizophrenia or another psychotic disorder.

Mutual-help groups, such as Alcoholics Anonymous (AA), are viable support options for DDIs. DDIs affiliate with and receive abstinence-related benefits from AA at rates comparable with non-DDIs (Bogenschutz, Geppert, & George, 2006). Mutual-help groups provide valuable social support for DDIs, who often struggle with complex social disadvantages (Aase, Jason, & Robinson, 2008). However, severe mental disorders, particularly psychotic disorders, may be associated with lower AA attendance rates (Bogenschutz & Akin, 2000). In addition, some DDIs feel uncomfortable discussing mental disorder symptoms and psychiatric medication among AA members who advocate for abstinence from all drugs, including medications. Although AA members are generally accepting of DDIs, most AA contact persons feel that specialized mutual-help groups offer a better fit (Meissen, Powell, Wituk, Girrens, & Arteaga, 1999).

DTR, a specialized 12-step-based mutual-help group, was designed to address the needs of DDIs in a supportive environment where members can discuss issues pertaining to dual diagnosis without fear of stigma (Vogel, Knight, Laudet, & Magura, 1998). DTR groups are not considered formal treatment. Instead, DTR groups are typically held in a community meeting space such as a church or hospital and are led by DTR members themselves rather than mental health professionals. Meetings are 60–90 minutes long, free, and welcome everyone. Activities in meetings include hearing stories told by members pertaining to their recovery, introduction of new members, and time for members to raise concerns and receive support from the group.

Consistent DTR participation has been associated with increased medication adherence and improvement in psychiatric symptoms and substance use outcomes (Magura, 2008; Rosenblum et al., 2014). Mediators of DTR efficacy are similar to established mediators of AA, including social support and readiness to change, but also include unique mediating factors such as reciprocal learning, in which attendees educate one another regarding issues pertaining to being dually diagnosed (Laudet, Cleland, Magura, Vogel, & Knight, 2004; Magura, 2008). Although DTR has shown beneficial outcomes among attendees, attendance rates may be improved if more was known about DDIs' perceptions regarding DTR or about how experiences in DTR meetings may affect DDIs' DTR attendance.

TSF was created to improve mutual-help group engagement (Nowinski, Baker, & Carroll, 1992). TSF is a manual-based treatment centered on 12-step principles such as complete abstinence from alcohol and other substance use, humility, and social support. However, TSF treatment is delivered in an individual format, with the primary goal of facilitating patient entry into a mutual-help group as a supplement to or after formal treatment. There have been few clinical trials evaluating its efficacy for DDIs. One trial of TSF versus integrated cognitive behavioral therapy for dually diagnosed veterans showed increased mutual-help group attendance initially but not over time (Worley, Tate, McQuaid, Granholm, & Brown, 2013). Thus, modification of TSF to meet the needs of DDIs may render TSF more accessible and effective. In a pilot study, Bogenschutz (2005) found that TSF modified for DDIs was indeed associated with increased mutual-help group attendance and decreased substance use; however, factors affecting the decision of DDIs to attend adapted TSF treatments have not been extensively examined.

The data for this study were gathered during a randomized clinical trial of TSF-DD (Bogenschutz et al., 2014). Participants

randomized to attend TSF-DD attended an average of 5.5 of 12 sessions offered. Participants receiving TSF-DD attended an average of 3.2 mutual-help group meetings (e.g., AA or DTR) per month at end-of-treatment (12 weeks) and 2.8 meetings per month at 36-week follow-up. Although the main effect of treatment on drinking outcomes was not significant in this study, post hoc dose-response analyses found that more TSF-DD attendance was associated with better clinical outcomes. Furthermore, increases in mutual-help group attendance predicted subsequent increases in the proportion of days abstinent from alcohol and decreases in the number of drinks per drinking day (Bogenschutz et al., 2014).

Given the promising role that adapted TSF-DD and DTR may have for increasing abstinence while managing psychiatric symptoms, the current study sought to systematically examine reasons for TSF-DD and DTR attendance from the perspective of DDIs. It was hypothesized that attempts to increase TSF-DD and DTR attendance would be most effective if based on the opinions and needs of DDIs and elicited in a safe atmosphere. Thus, this study describes DDIs' perceptions of TSF-DD and DTR using data from two focus groups conducted near the end of the TSF-DD trial. Focus group transcripts were analyzed to identify benefits of and barriers to TSF-DD and DTR attendance for the purpose of informing healthcare providers working with DDIs on how to most effectively enhance treatment and mutual-help group engagement and attendance.

#### METHOD

#### **Parent Study**

The parent study tested the efficacy of adapted TSF-DD with 121 patients recruited from a psychiatric outpatient treatment center (Bogenschutz et al., 2014). All current patients in the Dual Diagnosis Program were contacted to complete a brief screening survey and to assess interest in study participation. Individuals who met study eligibility criteria and consented to participate were randomly assigned to receive 12 weekly sessions of TSF-DD (n = 83, 68.6%) or treatment as usual (n = 38, 31.4%). Primary Diagnostic and Statistical Manual of Mental Disorders (4th Edition) psychiatric diagnoses were major depression (n = 56, 46.3%), bipolar disorder (n = 43, 35.5%), and schizophrenia or other psychotic disorder (n =22, 18.2%). All participants also had an alcohol use disorder, and 40 participants (33.1%) had a concurrent additional drug dependence diagnosis. Participants were assessed at treatment intake; at 4-week intervals during treatment; and at 3, 6, and 9 months posttreatment (12 months in total). Two focus groups were implemented near the end of the study to understand participants' perspectives about TSF-DD and DTR. All components of this study were discussed with participants, and written informed consent was obtained. Participants were compensated for study participation, as per institutional review board approval.

Adapted TSF-DD. TSF-DD was adapted from TSF, an empirically supported, manualized individual treatment in which patients with substance use disorder meet weekly with a trained counselor to promote abstinence (Nowinski et al., 1992). TSF-DD is based on AA principles but is delivered as a formal, one-on-one treatment rather than in a mutual-help-group format. TSF was adapted for DDIs by including education about the relationship between psychiatric disorders and substance use, adherence to psychiatric medication, and targeted social skills training (Bogenschutz et al., 2014). The primary goal of TSF-DD was to encourage individuals to engage in DTR or other mutual-help groups in the community during and after treatment. **DTR mutual-help groups**. DTR groups were not offered as part of the parent study intervention; however, participants who were randomized to attend TSF-DD treatment were strongly encouraged to attend DTR meetings and traditional mutual-help groups.

#### Focus Groups

Two committed DTR members serving as consultants to the study moderated two 90-minute focus groups. One facilitator had extensive previous training and experience in conducting focus groups. The facilitators were selected because of their familiarity with DTR and their shared characteristics (i.e., dual diagnosis) with focus group participants to maximize the level of comfort participants had in sharing their thoughts. Facilitators developed questions to guide the focus groups in collaboration with study investigators. Facilitators met with study investigators and were provided with a final version of the focus group question sheet including guidelines for conducting the focus groups such as an emphasis on using a reflective listening style. Focus group questions included in the study protocol are provided in Table 1.

Participants who had been assigned to receive the adapted TSF-DD were invited to participate in the focus groups via a

## TABLE 1Guideline Focus Group<br/>Questions as Approved in<br/>the Study Protocola

Focus Group Questions

- 1. What did you know about DTR before participating in TSF?
- 2. What were the good things about TSF?
- 3. What were the good things about DTR?
- 4. What were the things that were not so good about TSF?
- 5. What were the things that were not so good about DTR?
- 6. What would make TSF work better for you?
- 7. What would make DTR work better for you?
- 8. If there was a period of time where you were going to DTR, then stopped going for a while, and then returned to DTR, what made you come back?
- 9. If you are attending a 12-step group other than DTR, why do you find other 12-step meetings more helpful than DTR?

<sup>a</sup>Focus group facilitators were instructed to use these questions as a guideline for facilitation. Facilitation was conducted utilizing reflective listening; as such, not all focus group questions were asked in each group if facilitators felt that the question had already been addressed by participant discussion. mailed letter to each participant's residence and during reminder telephone calls for follow-up assessments. Division of the focus groups was based on participant preference and was nearly even, with seven individuals participating in one focus group and eight individuals participating in the other. When TSF-DD and DTR were mentioned as acronyms, facilitators explicated these terms to ensure participant understanding. The focus groups were audio-recorded and transcribed by an independent research assistant.

#### Focus Group Analysis

Data from the focus group transcripts were analyzed utilizing an iterative group review process guided by an inductive, grounded theoretical perspective (Glaser & Strauss, 1967; Strauss & Corbin, 1998). The first four authors conducted initial open coding, a process of labeling text to identify and formulate ideas suggested by the data (Emerson, Fretz, & Shaw, 1995). The use of open coding dictated that codes were developed based on participants' statements rather than questions asked by focus group facilitators. This resulted in some codes being created even when the topic of the code was not directly addressed through the focus group questions. Coding discussion was conducted until consensus was reached on an initial coding structure of six core domains based on transcript content: (a) positive and (b) negative aspects of DTR, (c) positive and (d) negative aspects of adapted TSF-DD, (e) barriers to TSF-DD and DTR attendance, and (f) perceptions of traditional AA/Narcotics Anonymous (NA) meetings. The fourth author coded the transcripts using Nvivo software version 8 (QSR International, 2008). The first and fourth authors then together read through the transcript text that had been coded under each core domain to finalize coding decisions. Any remaining discrepancies were resolved through discussion.

#### RESULTS

#### Focus Group Participants

Two sets of preliminary quantitative analyses were conducted to evaluate the representativeness of the focus group participants in comparison with those who did not participate. Fifteen of the 83 TSF-DD participants (18%) participated in the focus groups. Statistical analyses comparing the demographics, psychiatric functioning, substance use and consequences, readiness to change, and mutual-help group attendance at treatment intake of focus group participants with nonparticipators in the TSF-DD condition are shown in Table 2. The only statistically significant difference between the focus and other TSF-DD participants was that the focus group participants were older; however, these analyses may be underpowered because of the smaller number of focus group participants. Effect sizes are included in the last column of Table 2 to quantify the representativeness of focus group members.

Additional statistical analyses assessed if there was differential improvement of psychiatric symptoms, alcohol use, mutualhelp group attendance, or related psychological outcomes between the focus group participants and nonparticipants over

TABLE 2 Comparisons Between Focus Group Participants and Non-Focus-Group   Participants Randomized to the TSF-DD Intervention Group at Treatment Intake <sup>a</sup>				
	Focus Group ( $n = 15$ )	Non-Focus Group ( $n = 68$ )	p Value	Effect Size <sup>b</sup>
Demographics				
Gender (% female)	7 (47)	31 (46)	.88	.02
Age in years	47.86 (6.27)	41.60 (9.65)	<.01	.68
Ethnicity (% Hispanic)	4 (27)	25 (37)	.46	.08
High school graduate or equivalent	8 (53%)	43 (63%)	.52	.07
Unemployed	11 (73%)	48 (71%)	.71	.04
Psychiatric functioning				
SCID <sup>c</sup> diagnosis				
Major depression	8 (53%)	30 (44%)	.70	.09
Bipolar	4 (27%)	26 (38%)		
Psychotic	3 (20%)	12 (18%)		
Brief Symptom Inventory <sup>d</sup>				
Global Severity Index	1.58 (0.59)	1.80 (0.77)	.34	29
Substance use/consequences				
Proportion abstinent days <sup>e</sup>	0.61 (0.30)	0.51 (0.30)	.22	.33
Drinks per drinking day <sup>e</sup>	11.30 (4.42)	13.21 (9.51)	.45	21
Alcohol-related consequences <sup>f</sup>	11.27 (4.25)	12.45 (3.03)	.32	36
Current drug dependence <sup>c</sup>	2 (13%)	20 (29%)	.20	.14
Average blood alcohol content <sup>e</sup>	0.25 (0.11)	0.24 (0.22)	.91	.05
Readiness to change <sup>g</sup>				
Ambivalence	14.20 (3.91)	14.50 (3.15)	.75	09
Problem recognition	27.73 (4.40)	29.35 (5.33)	.28	31
Taking steps	33.20 (5.39)	31.35 (5.99)	.28	.31
Abstinence self-efficacy <sup>h</sup>				
Temptation	41.36 (17.96)	48.27 (14.82)	.13	44
Confidence	27.86 (13.25)	35.21 (18.24)	.16	42
Mutual-help group (MHG) attendance <sup>e</sup>				
Any MHG attendance	6 (40%)	24 (35%)	.73	.04
Proportion days attending MHGs	0.03 (0.06)	0.03 (0.07)	.96	0

TSF-DD = 12-step facilitation for dually diagnosed individuals.

<sup>a</sup>On the basis of chi-square tests for categorical variables and *t* tests for continuous measures. <sup>b</sup>Phi or Cramer's *V* for categorical variables (none were significant) and Hedges's *d* for continuous measures. <sup>c</sup>Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (4th Edition). <sup>d</sup>BSI (Derogatis & Melisaratos, 1983). <sup>e</sup>Form 90 (Miller, 1996). <sup>f</sup>Short Inventory of Problems (Miller, Tonigan, & Longabaugh, 1995). <sup>g</sup>Stages of Change Readiness and Treatment Eagerness Scale (Miller & Tonigan, 1996). <sup>h</sup>Alcohol Abstinence Self-Efficacy Scale (DiClemente, Carbonari, Montgomery, & Hughes, 1994).

the course of the study. Ten 2  $\times$  2-way analyses of variance (ANOVAs) were conducted, with focus group participation as the between-participant factor and time as the within-participant factor. Each ANOVA evaluated an outcome assessed at treatment intake and the final follow-up assessment (9 months posttreatment). Both groups exhibited significant decreases across the course of the study in the global severity of the Brief Symptom Inventory (Derogatis & Melisaratos, 1983), drinks per drinking day, average blood alcohol content, problem recog-

nition (Stages of Change Readiness and Treatment Eagerness Scale; Miller & Tonigan, 1996), and temptation to drink (Alcohol Abstinence Self-Efficacy Scale; DiClemente et al., 1994) and significant increases in proportion days abstinent and abstinence self-efficacy (Alcohol Abstinence Self-Efficacy Scale; DiClemente et al., 1994). No significant between-group differences were found for all 10 ANOVAs, suggesting that the self-reported functioning of the focus group and non-focusgroup participants was, on average, equal.

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#### Focus Group Analysis

Participant statements corresponding to each of the six core domains of interest were organized into several emerging content areas.

Positive aspects of adapted TSF-DD. Participant comments in the positive aspects of TSF-DD domain reflected three main ideas. The first, learning and self-awareness, included comments pertaining to benefit gained from learning novel information about mental and substance use disorder symptoms and how to manage mental disorders. Many statements in this category corresponded with 12-step concepts, such as realization of the harm participants caused to others through their substance use and the value of accepting responsibility for one's actions. Some participants reflected that the TSF-DD reading materials and information from the TSF-DD counselors provided insight into their behavior. For example, "[TSF-DD] was great in the sense that I had a guide to help pull me back in line. It was necessary for me to have someone to point out the different ways to do things." The second idea, caring/positive environment, reflected the perceived value of the participanttherapist relationship. One participant said, "You got from the conversations that they [TSF-DD therapists] were really concerned about you." Another stated, "He [TSF-DD therapist] put a lot of good things in my head, you know?" The positive relationships described between participants and their therapists seemed to have fostered a sense of hope within the context of the TSF-DD treatment, as characterized by one participant's statement, "I felt relieved. Like, oh my God, it might actually work this time." Finally, facilitated sobriety emerged as the last idea in this domain. One participant said, "[TSF-DD] helped me not break in the morning, to not drink alcohol in the morning like I used to."

Negative aspects of adapted TSF-DD. Participant comments in the negative aspects of TSF-DD domain were categorized into three ideas. One participant comment fell under the idea of guilt associated with drinking before attendance. This participant recounted, "I had just drank the night before, and I was feeling really guilty, and then the next week I didn't really go because [TSF-DD therapist] could smell the alcohol." The second idea in this domain pertained to a general dislike of the intervention approach. One participant felt strongly that answering questions asked by the counselor was a waste of time, stating "that's [answering questions] okay, I guess, if you ain't got nothing better to do than sit around and nitpick." The final idea in this domain was session filming. TSF-DD therapy sessions were filmed to assess therapist treatment fidelity, and several participants expressed discomfort with being filmed. For example, one participant stated, "What turned me off was kind of being filmed, I guess."

**Positive aspects of DTR.** There were three emergent ideas within the positive aspects of DTR domain. Consistent with the dual approach of DTR, the first idea, learning and self-awareness, indicated that participants experienced unique benefit from learning information about their dual disorders. One participant noted, "I learned a lot my first time [at DTR].... I learned that I am bipolar and what bipolar symptoms are.... it made

me understand why I did some of the things I did in my previous years." Another participant further endorsed this sentiment, stating, "But the Double Trouble, I learned about my mental illness and better ways of dealing with it." Within the second idea in this domain, safe/accepting environment, participants reflected that DTR created a "safe space" in which they felt comfortable and welcomed. One participant noted, "It was actually a relief to me, to go into a room with people who are just like me." Feeling safe in meetings set a foundation for participants to honestly discuss their mental disorders. The ability to discuss psychiatric medication was highly valued. For example, one participant stated, "They accept you, because you have mental problems, and you take medication, and they don't put you down for that." Experiencing acceptance as being dually diagnosed among similar individuals was a powerful experience, characterized by the statement, "It just lets me know that I'm not the only one, that there are others out there that are tortured." The final idea was facilitated sobriety. One participant stated with regard to DTR meetings, "It started helping me out a lot, it really did. I've been clean for a year, a huge period of time."

Negative aspects of DTR. Two ideas were categorized under the negative aspects of DTR domain. In regard to the first, meeting size, one participant complained that attendance was low, whereas another expressed a desire to cap attendance to a small number. Minimizing meeting size was related to participants' mental disorders, "some people's disorders, I guess, keep them [meetings] tending towards small." Another participant disagreed with this sentiment, stating, "There wasn't enough people participating...when I was going, there was very few people going." The second idea pertained to sharing in meetings. The discomfort of speaking in meetings seemed to be related to discussing disorders in general, characterized by the statement, "I don't really like to talk about it too often.... I just don't like to go around telling people my issues." Another participant expressed frustration that discussions in DTR were repetitive from meeting to meeting.

Barriers to TSF-DD and DTR meeting attendance. Two main ideas consistently emerged as barriers to TSF-DD and DTR meeting attendance. First, transportation difficulties were evident in reference to using public transportation to travel to meetings. For example, one homeless participant recounted an altercation with a transportation security officer: "He kicked me out.... I was getting high, though. He said I sit too long, though...and that's why I quit going." Other participants felt that taking the bus was too time consuming. The second idea, meetings and sessions unavailable/inconvenient, described practical concerns about the lack of DTR meeting availability and the inconvenient timing of both TSF-DD sessions and DTR. One participant contrasted the infrequency of DTR meetings compared with the frequency of traditional AA meetings, and others had employment-related scheduling conflicts. Another participant suggested that DTR meetings be offered more frequently, stating, "So the concept is wonderful, but something like that, if you want it to happen, you've got to make it more available ... you know ... locations,

different times." Participants also suggested that being provided with session reminder cards or telephone calls would be helpful.

Perceptions of traditional AA/NA meetings. Although opinions regarding traditional AA/NA were not directly addressed through focus group facilitator queries, participants spontaneously related positive remarks about DTR to negative perceptions of traditional AA/NA. Two of the focus group participants had concurrent diagnoses of drug dependence at treatment intake and thus may have attended NA meetings as well as AA or DTR meetings. The first idea in this domain, judgmental atmosphere, indicated that participants felt ostracized from AA/NA because of their dual diagnosis. For example, discussion related to psychiatric medications was unwelcome because of traditional AA/NA philosophy against using "drugs" of any kind. One participant remarked, "The thing I didn't like about AA is because they don't believe in medications and things like that...so I liked Double Trouble better." Another participant went without seeking any support for over a year after being publically admonished by an AA member for taking medication, stating, "I was an outcast, they just didn't like the idea that I was taking medication." The second idea in this domain, negative storytelling/complaining, encompassed participants' dislike of the negativity they noticed in AA/NA. Several participants reported being negatively affected by "war stories" told by AA/NA members, as evidenced by one participant's comment, "AA meetings they talk about war stories and all you want to do is drink." The final idea related to negative views of the phenomenon was known as "13th stepping," in which senior, usually male, members use meetings as an opportunity to seduce newcomers. For example, one participant stated, "Half the people are in there looking...for somebody to get sex from. You know, it's a meat market."

#### DISCUSSION

This study utilized a qualitative approach to identify attitudes toward adapted TSF-DD and DTR with the goal of understanding engagement and participation from the perspective of DDIs. Participants identified both positive and negative aspects of TSF-DD and DTR. Many construed TSF-DD and DTR as helpful tools in the understanding and management of their dual diagnoses. In particular, they felt acceptance and fellowship when discussing their psychiatric symptoms and psychiatric medication at DTR meetings. They also expressed aspects of TSF-DD and DTR that they disliked, practical barriers to attendance, and aspects they disliked of traditional mutual-help groups such as AA. As healthcare provider referral is the point of mutual-help group entry for many traditional 12-step members (Humphreys, 1997), and likely for many DDIs, results from this study yield helpful empirical recommendations to healthcare professionals that may serve to increase DDIs' participation in DTR or other mutual-help groups (Laudet, 2000).

Discussion of positive aspects of both adapted TSF-DD and DTR occurred in each focus group. Thus, one recommen-

dation is that healthcare professionals may enhance TSF-DD and DTR attendance by highlighting the unique aspects of these programs. Consistent with previous literature (e.g., Magura, 2008; Matusow et al., 2013), participants in this study highlighted the value of gaining knowledge about their dual disorders from other DTR attendees. Participants enjoyed the accepting group environment, which might further contribute to open sharing of information. Explaining these benefits to DDIs, especially those who may associate DTR with less accepting traditional mutual-help groups, may reinforce participation.

Although comments regarding adapted TSF-DD and DTR were largely positive, focus group participants expressed issues associated with both. Healthcare professionals working with DDIs should validate the sentiments of those who disagree with the tenants of 12-step programs or dislike group settings. Feeling that the meeting size is unsuitable or being reticent to share information in a group setting will clearly persist no matter the type of meeting attended. Timko, Sutkowi, Cronkite, Makin-Byrd, and Moos (2011) found that greater need fulfillment by dual-focus groups such as DTR was associated with greater improvement in both psychiatric and alcohol outcomes among DDIs referred to such programs. As such, clinicians working with DDIs who do not wish to attend mutual-help groups should strive to fulfill the benefits derived from DTR, including reciprocal learning and a safe environment to talk about issues, through other avenues.

Third, practical barriers to both TSF-DD and DTR attendance, including lack of transportation and limited meeting availability, were the most salient issues for participants in this study. Thus, healthcare professionals should try to reduce practical barriers to attendance. Complexities associated with dual diagnoses, including homelessness and criminal justice involvement, may contribute to the limited ability of DDIs to utilize resources to attend DTR, which could explain why some participants noted transportation barriers despite having access to bus passes as part of TSF-DD in this study (Mueser, Essock, Drake, Wolfe, & Frisman, 2001). As suggested by focus group comments, participation in TSF-DD and DTR would also be facilitated by more active healthcare professional participation in the reminder and referral process, such as reminder cards or telephone calls.

Finally, negative sentiments raised by participants regarding traditional AA meetings suggested that healthcare professionals should avoid taking a "one size fits all" approach when recommending mutual-help group attendance and consider encouraging clients to sample various meetings to find the most appropriate fit. Whereas some participants in this study expressed negative sentiments toward AA, other participants and the extant literature suggest that many DDIs do attend and experience benefit from traditional mutual-help groups (e.g., Bogenschutz et al., 2006). Furthermore, some issues raised by participants in regard to AA meetings, such as "13th stepping," are also concerns in DTR meetings (Bogart & Pearce, 2003). Some participants may feel more comfortable attending single gender mutual-help group meetings. As

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Timko and colleagues (2011) note, healthcare professionals should focus their efforts on encouraging DDIs to attend mutual-help groups in general, rather than being overly concerned about the type of meetings attended.

#### Limitations

One limitation of this study concerns the potential for biased facilitation in the focus groups because of involvement of the two facilitators in DTR. However, this limitation was offset by as follows: (a) the facilitators were DDIs and long-time members of DTR and were chosen because of their ability to make focus group participants feel comfortable discussing sensitive issues, (b) facilitators asked open-ended questions and were effective in eliciting further information from participants likely because of their shared experience, and (c) both positive and negative opinions of the treatment and mutual-help groups were obtained.

A second limitation is that questions asked were not identical between the two focus groups. This limitation was mitigated in that (a) the decision to not constrain focus group discussion to the protocol questions was consistent with the reflective listening style adopted by the facilitators and likely enhanced rapport and participants' willingness to share their opinions; (b) facilitators gave participants an opportunity to provide any additional comments at the end of each focus group; and (c) participant comments pertaining to each core domain were coded in each focus group, suggesting that a full range of topics was discussed.

Another limitation is the question of how representative focus group participants were compared with non-focus-group participants in the parent study. The self-selection of focus group attendees may have biased responses: those who participated may have felt strongly toward the intervention or DTR, or their perspectives may also have been influenced by their perceived functioning at the end of the study rather than their personal experiences. In addition, the issue of data saturation is important for qualitative analysis, and the perspectives of 15 people (18% of those randomized to the intervention) may not have been sufficient to adequately capture a full range of views.

Although concerns about potential bias are valid, we found evidence that served to mitigate some of these concerns. Statistical analyses were conducted to assess for systematic differences in baseline characteristics and study outcomes between focus group and non-focus-group members and found only one statistically significant difference; focus group members were older. Focus group participants also exhibited a full range of attendance rates; five had attended three or fewer TSF-DD sessions, and five had attended 10 or more. Similarly, whereas four focus group participants were no longer attending any mutual-help groups at the final follow-up, four others were attending almost weekly or more often. In addition, focus group participants reflected a range of drinking behaviors, including four who were abstinent. In summary, the results of this study are likely representative of a continuum of attitudes, although they may not generalize to younger participants.

The perspectives elicited during this study arise from a subset of participants, and study conclusions are not meant to stereotype DDIs but to inform providers about how to better serve this population through treatment and mutual-help group attendance. A particular strength of our approach was the opportunity to conduct an in-depth examination of participant attitudes rather than relying on anecdotal accounts of treatment providers or study investigators. Adding to the validity of our results is the correspondence between issues raised in our sample regarding mutual-help groups and those mentioned in the extant literature. A final strength of this study is the relative mental disorder severity in our sample, given that individuals are often excluded from participation in substance use disorder treatment trials on the basis of comorbid serious mental disorder.

#### **Future Directions**

Given the largely positive attitudes toward adapted TSF-DD and DTR expressed by participants in this study, future studies should develop and test the efficacy of various strategies to overcome barriers to TSF-DD, DTR, or other mutual-help group engagement. One such intervention that may be particularly well tailored for healthcare professionals working with DDIs is brief motivational interviewing, a therapy designed to explore and resolve client ambivalence about behavior change (Miller & Rollnick, 2013). Carroll and colleagues (2006) found that integrating motivational interviewing into a single intake/evaluation session significantly increased treatment retention at 28 days in a sample of substance users, despite finding no significant effect of treatment on substance use. Other approaches such as integrated case management and Housing First programs, in which participants receive access to stable housing without prerequisite treatment attendance, may also serve to provide DDIs with specialized care to reduce barriers to mutual-help group attendance. However, mixed results regarding the effectiveness of the abovementioned treatment programs with DDIs highlight the need for further research and treatment refinement in this area (e.g., Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2014; Tsemberis, Gulcur, & Nakae, 2004).

Given the significant practical barriers to attendance, the efficacy of alternatives for DDIs who are unable or unwilling to attend mutual-help groups should be assessed. One such avenue for exploration is online recovery resources for DDIs. Online recovery resources, including mutual-help support forums where members can give and receive advice, are widely utilized by the general U.S. population (Hall & Tidwell, 2003). Although DDIs tend to have greater financial difficulties than non-DDIs, the availability of public computers at locations such as libraries and the increased availability and decreased cost of Internet-equipped mobile phones may offset this disparity. Several online forums for DDIs appear to be well utilized (e.g., http://www.mdjunction.com/forums/dual-diagnosis-discussions). In summary, the current study revealed benefits and barriers to TSF-DD and mutual-help group participation from the

perspective of DDIs and highlighted strategies that healthcare professionals may use to meet the needs of this population.

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